

1  
2 (10.00 am)  
3 (Delay in proceedings)  
4 (10.08 am)  
5 MISS ELIZABETH DUFFIN (called)  
6 Questions from MR STEWART  
7 MR STEWART: Good morning. Thank you for coming back.  
8 Since last you were here, you provided us with a further  
9 witness statement WS265/1. Are you content that the  
10 inquiry should adopt that as your formal evidence today?  
11 A. Yes.  
12 Q. Thank you. Just to remind us, can we return to your CV,  
13 which is at page 311-026-001? I think you told us last  
14 time that you retired in March 1997. In the middle of  
15 your career, from 1984 to 1993, you were director of  
16 nursing at the Royal Group of Hospitals and extending on  
17 after the formation of the Trust in 1993 through to 1997  
18 as director of nursing and patient services. So your  
19 span at the top of nursing was long.  
20 Further down the page in the general information  
21 section, the penultimate entry:  
22 "King's Fund Organisational Audit. Surveyor, UK  
23 hospitals."  
24 Were you, in 1996, a King's Fund surveyor?  
25 A. Yes.

1 new hospital, I was in that working group, and there was  
2 just ... It was just very busy so it's hard to say.  
3 I did have the groups and did have assistance with doing  
4 it and tried to involve all the directorates.  
5 Q. You were also tasked, if we go over the page to 002, at  
6 number 4, with:  
7 "Providing professional leadership to the nursing  
8 staff employed in the Trust."  
9 And at number 7:  
10 "To ensure the maintenance of professional standards  
11 and requirements as laid down in the UKCC codes for  
12 nurses."  
13 A. Yes.  
14 Q. Did that take up much of your time?  
15 A. Yes, it did.  
16 Q. You described to us last time how you kept in contact  
17 with the nurses at ward level.  
18 A. Yes.  
19 Q. And you met monthly with the nurse managers?  
20 A. Yes.  
21 Q. Remind us what sort of things you discussed about the  
22 ward-level nursing practices at those meetings.  
23 A. It would really have been if there were concerns or if  
24 there was something that had arisen in one directorate  
25 in relation to nursing practice, we would have shared

1 Q. And you remained so for many years thereafter?  
2 A. Yes.  
3 Q. So you knew, as it were, what to look for in a hospital  
4 in governance terms in nursing terms?  
5 A. Yes.  
6 Q. We also have your job description, setting out your  
7 duties and principal responsibilities and tasks.  
8 That is at 305-158-001. At the top of your job  
9 description, it says you report to and are accountable  
10 to the chief executive.  
11 A. That's correct.  
12 Q. So you had the ear of the chief executive?  
13 A. Yes.  
14 Q. And going on down through your principal  
15 responsibilities at number 3, you were charged with:  
16 "Advising the chief executive and the clinical  
17 directorates on patient-oriented quality assurance  
18 initiatives."  
19 At 5 you were charged with:  
20 "Coordinating the development of patient-orientated  
21 quality assurance strategies in both clinical and  
22 non-clinical directorates."  
23 Did that take up a large part of your time?  
24 A. Yes. I couldn't give you an exact division of it  
25 because there was a lot going on. We were planning the

1 that with the other nurse managers. We would have  
2 decided did we need a policy, did we need a procedure or  
3 did procedures need to be updated. It was issues like  
4 that. Also ensuring that the UKCC codes were made aware  
5 to all staff -- that all staff were aware and any action  
6 that was required from these would have been discussed  
7 and dealt with.  
8 Q. Did you meet with ward sisters?  
9 A. Not that frequently. I would have met with them, I did  
10 try to get around each directorate on a regular basis  
11 and usually I would have met with the ward sisters then  
12 or would have spoken to them at ward level, yes.  
13 Q. Did you have a sense at that time that you knew what was  
14 going on with the nurses, the nursing practices in the  
15 Children's Hospital?  
16 A. Yes, because I had very good -- I would have to say the  
17 nurse managers in each directorate were very good, very  
18 experienced and communicated well.  
19 Q. Did you have to appraise the performance of the nurse  
20 managers in their duties?  
21 A. I did until the clinical directorate system was brought  
22 in in 1993. They would have been appraised then by the  
23 clinical director that they reported to.  
24 Q. And thereafter, after the Trust was formed, who  
25 appraised, did you say, the nurse managers?

1 A. The clinical director.  
2 Q. If I could draw your attention now to paragraph (g)  
3 at the foot of this page where you were charged with:  
4 "Reviewing individually and, at least annually, the  
5 performance of the immediate subordinate staff."  
6 Did that not include nurse managers?  
7 A. No, not from 1990. It would have been the nurse manager  
8 in outpatients and there were some other staff -- there  
9 were two staff who worked with me in the office --  
10 I would have appraised them. But when the directorate  
11 system was formed in 1990, the management responsibility  
12 of the nursing staff then went to the clinical director.  
13 Up until 1990, I would have appraised all the nurse  
14 managers who reported to me.  
15 Q. Was there any difficulty experienced by you in providing  
16 leadership to the nurses and maintaining their  
17 professional standards if you weren't part of the  
18 appraisal?  
19 A. No, because certainly if there was any problems, the  
20 clinical director would have discussed it with me, but  
21 it didn't happen with my regular meetings with them and  
22 they knew they could -- I had an open-door policy that  
23 they could come to me and quite often they came to  
24 discuss issues and seek advice.  
25 Q. You felt comfortable that it was being properly --

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1 A. We did have -- and the nurses and sisters knew that if  
2 there was a query about the management of a case or any  
3 incident, then an investigation should be carried out  
4 and that would include the records and nursing practice.  
5 Q. How was a nurse to know if there was a query about the  
6 management of a case unless there was perhaps a review  
7 or an audit of the case?  
8 A. If something adverse happens, then it should be  
9 investigated and looked at what happened, why it  
10 happened, was there something that should have been done  
11 differently, did it have implications for other  
12 directorates in the Trust. For instance, if there was  
13 a drug incident, that was thoroughly investigated,  
14 really, to see was there something wrong with our policy  
15 that had gone wrong or was it human error.  
16 Q. At that time, would you have considered death as an  
17 adverse outcome to have been a sufficient trigger to  
18 look at the case and whether or not anyone was  
19 indicating a care-management problem?  
20 A. I think as I said before, my clinical practice was in  
21 obstetrics, midwifery, and certainly any death or  
22 stillbirth, we did investigate them all. But that was  
23 part of audit. That was ongoing. So certainly -- and  
24 I think in the early 1990s, we were trying to implement  
25 medical audit and subsequently clinical audit so that

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1 A. Yes.  
2 THE CHAIRMAN: Miss Duffin, roughly, proportionately how  
3 many nurses were there in the Children's Hospital  
4 compared to the rest of the Royal? Would it have been  
5 10 per cent, 15, 20?  
6 A. Probably about 10 per cent.  
7 THE CHAIRMAN: Thank you.  
8 MR STEWART: You told us in your last visit to the inquiry  
9 that after Adam's death there was no audit of the  
10 nursing records and there was no audit of the nursing  
11 practices. It seems that after the death of  
12 Claire Roberts, there was no audit of the nursing  
13 records and no audit of the nursing practices; is that  
14 correct?  
15 A. No, we ... You must be misunderstanding. We were doing  
16 nursing audit from, probably, the late 1980s and  
17 certainly one of the areas that we did audit and did  
18 have a policy for was audit of the records.  
19 Q. Yes, I meant specifically in relation to these two  
20 deaths.  
21 A. Oh no, that was correct.  
22 Q. So in neither case was there audit of practice or  
23 record?  
24 A. Not to my knowledge in those two cases.  
25 Q. In hindsight, was that a satisfactory state of affairs?

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1 everything -- these matters would be picked up.  
2 Q. Does it surprise you that the nurse managers did not  
3 audit the records in Claire's case after her death to  
4 see if a nursing lesson might not emerge?  
5 A. No, because there was a policy in nursing audit where  
6 they submitted a quarterly report to me from each  
7 directorate on the results of their audit. Some nurse  
8 managers did it on a monthly basis, some sisters  
9 preferred to pull so many charts on a weekly basis, some  
10 audited charts when the patient was discharged. But  
11 certainly, every record wasn't audited, it was  
12 a selection of them, and that's what was required by the  
13 King's Fund audit.  
14 Q. I understand. So it doesn't surprise you that this  
15 wasn't done --  
16 A. No, not --  
17 Q. -- in this case?  
18 A. No. Um ... If the nurses had felt that the death was  
19 unexpected, then yes, I would have expected it to be.  
20 Q. Sister Pollock, in her witness statement to the inquiry,  
21 indicated that she felt Claire's death was unexpected.  
22 A. Sorry, can you repeat that, please?  
23 Q. Sister Angela Pollock, the ward sister for Allen Ward,  
24 which was the ward that Claire was admitted into, has  
25 indicated to the inquiry at WS225/2, page 4, at question

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1 7 towards the top of the page:  
2 "Please state whether you regarded the death of  
3 Claire Roberts as expected or unexpected."  
4 And Angela Pollock has responded "unexpected". Does  
5 it surprise you that an audit of the nursing records was  
6 not undertaken after her death?  
7 A. When it was unexpected, the policy probably was that  
8 they would -- whenever they audited the notes that  
9 certain notes ... Her notes maybe were not one that was  
10 picked. I cannot remember what their policy in  
11 Children's was, whether they just did them every three  
12 months or whether they did them on a monthly basis.  
13 Q. But you were responsible because the nursing audit  
14 committee meetings were sent to you, were they not?  
15 A. Yes.  
16 Q. So you can in fact see exactly what was happening, what  
17 sorts of cases were being audited, both in terms of  
18 records and nursing practices?  
19 A. I did not get the detailed report, I got the report on  
20 the audit, the compliance. There were criteria laid  
21 down that they were auditing against, and it was against  
22 that that I would have got the results. And frankly  
23 I cannot recall what all the criteria were. I know  
24 there were things like clarity, signatures, timing of  
25 entries.

1 A. -- so that we would have standards to measure against,  
2 criteria, that if something deviated from what we  
3 normally expected that condition to follow, then that  
4 would have been investigated. And we were starting work  
5 on that. Work was developing on audit, nursing audit,  
6 medical audit very much during the early 1990s and  
7 subsequently leading on to clinical audit and  
8 governance.  
9 THE CHAIRMAN: You see, one of the concerns that has been  
10 expressed on behalf of the Roberts family is that  
11 nothing seems to have been learnt or appreciated from  
12 Claire's death and their particular concern then is: how  
13 do we know this couldn't happen again? I know that  
14 governance and audit was at a different stage of  
15 development in the mid-1990s, but Adam's death, as  
16 a result of what happened during his transplant  
17 operation, was unexpected and there was no nursing side  
18 audit at that time. In fact, you didn't know about  
19 Adam's death.  
20 A. No, I didn't know about this one either.  
21 THE CHAIRMAN: Then the following year, Claire dies, she  
22 arrives in hospital on a Monday evening, she doesn't  
23 respond to treatment and she dies, in effect, on  
24 Wednesday morning, although the actual time of death is  
25 later. She doesn't respond to treatment, her condition

1 Q. As a general proposition, would you think that there  
2 isn't a mortality case that doesn't provide lessons?  
3 A. I really can't answer that.  
4 THE CHAIRMAN: It doesn't matter, Miss Duffin, sure it  
5 doesn't, whether there's a particular concern about  
6 nursing care. If the death is unexpected then, unless  
7 you look at it, you don't know if -- it might turn out  
8 in fact there's nothing wrong with any of the medical or  
9 nursing care. Unfortunately, children die in hospital.  
10 Am I right in believing or understanding that you  
11 don't need to be prompted by a particular concern about  
12 nursing care in order to audit what has happened from  
13 the nursing perspective?  
14 A. No, no, it was ... Nursing audit was a regular thing,  
15 yes, and we should always be looking -- you know, nurses  
16 should be looking at the care they've delivered of every  
17 patient in the ideal world.  
18 THE CHAIRMAN: In 1996, what would have prompted an audit  
19 from the nursing side of the treatment a child received?  
20 A. Probably if the child did not respond or there was some  
21 reason as to something that differed from it.  
22 I can't -- I'm finding it difficult to explain. I know  
23 that certainly in 1994/1995, we started looking at  
24 clinical care -- at care pathways --  
25 THE CHAIRMAN: Yes.

1 deteriorates, and her death is quite unexpected in the  
2 sense that Dr Webb, the paediatric neurologist who was  
3 assisting in her care, went home on Tuesday evening,  
4 expecting that she would recover and was then called  
5 back in when she'd gone into arrest. Even allowing for  
6 audit and governance to be in a fairly primitive stage,  
7 perhaps, that suggests that something has gone wrong or  
8 a number of things might have gone wrong.  
9 A. Yes.  
10 THE CHAIRMAN: But neither on the medical side nor on the  
11 nursing side does anybody really seem to have done  
12 anything in 1996 about it. From the nursing  
13 perspective, are you disappointed by that?  
14 A. Yes.  
15 THE CHAIRMAN: How should an investigation or a review or  
16 a look back over the notes -- or whatever title you put  
17 on it -- how should that have started in November 1996?  
18 A. They should have started with discussion at the ward  
19 level between the senior staff, the nursing and medical  
20 staff.  
21 THE CHAIRMAN: Right.  
22 A. But it's very easy with hindsight to ...  
23 THE CHAIRMAN: I know, but the whole thing about governance  
24 or audit, whatever term you put on it, is that it's  
25 trying to avoid hindsight. It's looking now at: did we

1 do something wrong yesterday or might we have done  
2 something more yesterday; isn't that right?  
3 A. Yes.  
4 THE CHAIRMAN: And when you strip away the titles and all  
5 the papers, that's what you want to do anyway in  
6 a hospital, isn't it?  
7 A. Yes, mm-hm.  
8 THE CHAIRMAN: So there should have been, if I understand  
9 you rightly, some sort of discussion at ward level.  
10 A. Yes.  
11 THE CHAIRMAN: And at the very least, there should have been  
12 the discussion and what that led on to, it might be  
13 a bit difficult to guess at now, but it should have led  
14 on to some sort of concern being expressed.  
15 A. That would be normally the practice that the doctors and  
16 sister would very much, you know, discuss cases and ward  
17 rounds and things afterwards, you know.  
18 THE CHAIRMAN: Let me understand you rightly: this doesn't  
19 depend on a child dying, sure it doesn't, you don't only  
20 react if a child dies. If something else goes wrong in  
21 a child's treatment, you react to that as well, don't  
22 you?  
23 A. That's right, yes.  
24 THE CHAIRMAN: Thank you.  
25 MR STEWART: Just a couple of questions arising out of that.

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1 were audited on an ongoing basis."  
2 So there you suggested that the obligation was on  
3 the nursing manager, but then you suggest the obligation  
4 is perhaps on the ward sister. And then you're not  
5 yourself responsible for appraising the performance of  
6 the nurse manager. So it seems that there's a potential  
7 for the matter to fall between a number of stools.  
8 A. No, the nursing audit programme was driven centrally and  
9 all the nurse managers were on that group. Then they  
10 devolved it to the ward sisters, but the sisters did it,  
11 it was their responsibility on the ward for doing it,  
12 feeding the information back to the nurse managers and  
13 then the nurse managers would have compiled the returns  
14 from their directorate, which was forwarded to my  
15 office.  
16 Q. And did you ever have cause to complain about the  
17 standard of the audits that you were receiving and the  
18 committee meeting minutes that you were receiving?  
19 A. No. I think there were some on occasion, but then they  
20 were expected to have an action plan to deal with the  
21 area of non-compliance, to address it, and then you  
22 expected that that would have been an improved result  
23 the next time.  
24 Q. I see. We've heard that, in 1996, there was no single  
25 nurse manager for the Children's Hospital, but the

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1 In the discussion at ward level, who decides at ward  
2 level if an audit of nursing or review of nursing  
3 records should be undertaken?  
4 A. At ward level, it would be the ward sister.  
5 Q. Ward Sister Pollock gave us a copy of her job  
6 description from that time. It's at WS225/2, page 12.  
7 She was charged with many obligations and duties, but  
8 not a responsibility for audit. Can I suggest, a system  
9 that imposes a duty to decide for an audit to be  
10 undertaken should be set forth in a job description,  
11 surely?  
12 A. Job descriptions wouldn't have gone right down to that  
13 detail then. But I think you could put it under 1.4:  
14 "Co-operates with medical and paramedical staff to  
15 ensure that a high standard of patient care is given."  
16 Q. I think if you allow some time, we'll be able to find  
17 a job description for Nurse Jackson, who was a nurse  
18 manager who, if my recollection is correct, did  
19 specifically include an obligation to conduct audit.  
20 A. Yes.  
21 Q. Can I bring you to one of your own quotes, it's from  
22 WS245/1, page 10? At number 22, the third paragraph  
23 down:  
24 "As part of the nursing audit programme, all nurse  
25 managers were expected to ensure that nursing records

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1 responsibility was split between three individual  
2 sisters; do you remember that?  
3 A. I do now. I couldn't have remembered the dates, but the  
4 DLS have been able to clarify the dates for me as to  
5 when people were doing --  
6 Q. Why was that? Were there three people acting up into  
7 the role of nurse manager?  
8 A. I can't honestly recollect the details, but it was the  
9 directorate manager -- I think it was an interim measure  
10 because things were ... I think the clinical director  
11 changed and that, and there was, you know, ongoing that  
12 they wanted to, I suppose, wait until they decided who  
13 was being the clinical director and what they wanted.  
14 Q. Can you remember which of the nurse managers had  
15 responsibility for Allen Ward?  
16 A. No, I can't.  
17 Q. When the ward sister in Allen Ward was unable to  
18 undertake her duty on the ward, it is said that she  
19 would have arranged cover for herself and she would  
20 normally have obtained cover from an F-grade sister.  
21 But in 1996, there weren't, until the end of the year,  
22 many F-grade sisters about, so the responsibility  
23 devolved to a sister on an E-grade; do you remember  
24 that?  
25 A. That would have been the normal practice throughout the

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1 Trust, that there would have been a sister, the G grade,  
2 and then they were supported by an F grade and then  
3 E grades, and then the D grades, staff nurses.  
4 Q. Was that ever a cause for concern or did it give rise to  
5 problems?  
6 A. No.  
7 Q. Was there a difficulty in finding numbers of  
8 adequately-graded sisters to fill those roles? Was  
9 there a staffing shortage?  
10 A. No. Staffing ... If there were any problems with  
11 staffing shortage, it would have been brought to my  
12 attention and I have no memory of any.  
13 Q. Were you in fact responsible for the staffing levels of  
14 nurses in the Children's Hospital?  
15 A. No, that was all devolved. I wasn't responsible for it  
16 from 1990; it was devolved to the clinical directorate,  
17 the budget.  
18 Q. The nursing budget was then --  
19 A. The nursing budget. But I did have sight of the  
20 staffing requirements in the annual business plans.  
21 Q. And of course, if problems had arisen, they would have  
22 been brought to you --  
23 A. Yes.  
24 Q. -- whether you had responsibility for the budget or not.  
25 A. Yes.

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1 continued to intensify."  
2 Does that not provoke some recollection of  
3 a problem?  
4 A. No, no.  
5 Q. When you had your responsibility for organising the  
6 application to the King's Fund for accreditation in the  
7 mid-1990s, would you have considered staffing levels as  
8 one of the issues you'd have looked at?  
9 A. I can't remember all the standards from it, but  
10 certainly there would have been -- I know there were  
11 standards around the employment of staff, the  
12 recruitment and employment that staff were of  
13 appropriate grades and experience. But it certainly  
14 didn't go into staffing details. The organisational  
15 audit was really looking at the overview, at the systems  
16 and procedures that were in place throughout the Trust;  
17 it didn't go down into the depths in each ward or  
18 department.  
19 Q. But doesn't a system or a procedure depend completely  
20 upon there being an adequate level of staff to actually  
21 make it function?  
22 A. Yes, and we had our policies for calculating nursing  
23 staff for the different departments. That's what the  
24 nursing budget was based on.  
25 Q. Do you remember the details of your application and the

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1 Q. And were problems brought to you?  
2 A. Not from Children's, no.  
3 Q. The Children's Hospital produced a document in 1996  
4 called "Getting it together: a strategy for Children's  
5 Services". I don't know whether you remember this,  
6 WS266/1, page 28. It's a rather grainy copy of the  
7 cover of this document. Does that ring bells? This is  
8 in relation to the Children's Hospital. Page 50 of that  
9 document, about ten lines down:  
10 "Though the Royal Belfast Hospital for Sick Children  
11 has the advantage of having paediatric trained staff in  
12 all disciplines, workload pressures are evident,  
13 particularly among nursing staff, and in certain medical  
14 areas."  
15 Does that ring any bells with you?  
16 A. No.  
17 Q. The next page, page 51, and the first major paragraph of  
18 that:  
19 "It was acknowledged that nursing and medical staff  
20 are under considerable pressure of work, but there were  
21 cases where mothers felt that standards of care were  
22 inadequate or insensitive. The first phase of  
23 redevelopment of the Royal Belfast Hospital for Sick  
24 Children will alleviate some of these problems, but the  
25 Trust is concerned that the pressure on staff has

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1 process you went through to obtain accreditation?  
2 A. Yes.  
3 Q. The responsibility was placed squarely on your shoulders  
4 to achieve this accreditation for the hospital.  
5 A. Yes.  
6 Q. It must be a major part of your career at that stage.  
7 A. Yes.  
8 Q. Do you remember the first time the survey took place in  
9 1995, at which provisional accreditation was granted?  
10 A. Yes.  
11 Q. You do?  
12 A. Vaguely, yes.  
13 Q. It took place in November 1995.  
14 A. Right, yes.  
15 Q. Can you remember whether arrangements were put in place  
16 at that time? Do you remember when in November?  
17 A. I don't. I couldn't have told you which year the first  
18 accreditation process took place in. I couldn't.  
19 I have been told it's 1995, so I do know that we had  
20 a 18-month run-in, time to prepare for it.  
21 Q. Yes. Well, do you remember the time when the hospital  
22 was gearing up for its second survey with the King's  
23 Fund in 1996?  
24 A. Yes.  
25 Q. Because we've received an interesting piece of

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1 information attached to a diary that there was a mock  
2 survey arranged for 22 October 1996.  
3 A. Right.  
4 Q. What would the mock survey have entailed?  
5 A. The purpose of the mock survey was for the Trust itself  
6 to assess how we were complying with the standards  
7 before we forwarded the forms back to the King's Fund  
8 prior to the official survey taking place. I think we  
9 did the mock survey about six months before the actual  
10 survey was due to happen and we had a lot of  
11 documentation to complete, the directorates had to do  
12 and departments, and that all had to be forwarded to the  
13 King's Fund, as I say, prior.  
14 We did it six months before, which was recommended  
15 by the King's Fund, because it then gave us a benchmark  
16 of where we were and what further action needed to be  
17 taken to -- if we wanted to achieve accreditation when  
18 the surveyors inspected.  
19 Q. Was the mock run like a sort of dress rehearsal, a dry  
20 run?  
21 A. Yes.  
22 Q. Were various individuals, the personnel in the hospital,  
23 brought together to do what they would have to do on the  
24 day of the real survey?  
25 A. Yes.

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1 Q. So it was left up to the individual ward sisters,  
2 individual doctors or left up to who?  
3 A. It would have been the clinical director and the nurse  
4 managers in each directorate.  
5 Q. Can you remember, was a specific instruction given by  
6 you on behalf of the accreditation team that they should  
7 arrange cover and should make sure --  
8 A. No.  
9 Q. It was simply left to their common sense, was it?  
10 A. It was common sense, yes.  
11 Q. I see. Was there any focus as part of the King's Fund  
12 accreditation application on adverse clinical incidents?  
13 A. Sorry, can you repeat?  
14 Q. In relation to the King's Fund application process that  
15 you were running, did you have to satisfy any particular  
16 criteria in relation to the adverse clinical incident  
17 procedures you had in place?  
18 A. I can't honestly remember, but it doesn't ring a bell  
19 and I think, in the mid-1990s -- I think it was more ...  
20 There was health and safety and the other thing ... We  
21 didn't have critical incident reporting forms or  
22 anything, it was a statement book, is what my memory is.  
23 Q. I'll come to that in a second, if I may. Can I draw  
24 your attention to page WS061/2, page 232? This is the  
25 health and safety policy, November 1993. This was the

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1 Q. What would that involve for the clinicians, the sisters,  
2 the nurses and the doctors? What would have their role  
3 been in the mock survey?  
4 A. It would have involved the senior people. It wouldn't  
5 have involved every nurse, it would have involved the  
6 nurse managers and whoever they had designated to  
7 spearhead it in their directorate.  
8 Q. A ward sister?  
9 A. It could have involved some of the consultants who were  
10 involved in it as well at the directorate, and other  
11 disciplines. It went through all the disciplines in the  
12 hospital.  
13 Q. So on the day of the mock survey, those individuals  
14 would have been engaged with the mock survey and not  
15 engaged with their normal day-to-day tasks with patient  
16 care?  
17 A. Yes.  
18 Q. What sort of cover did you arrange for people that were  
19 doing the dress rehearsal to cover for their patients?  
20 A. I didn't arrange any cover; that was arranged within the  
21 directorates. It was up to the individual directorates  
22 to arrange cover. We sent them the programme of when  
23 we would be visiting that directorate and they decided  
24 who would participate in the interview. Then it's up to  
25 the individual to arrange cover.

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1 policy, so far as we can ascertain that, was extant in  
2 1996. I'll take you to page 061/2, page 241. This is  
3 within the overall health and safety structure. There  
4 was a medical risk management group set up and it had  
5 responsibilities for, amongst other things -- it had  
6 specific responsibilities, further on down the page at  
7 (iii):  
8 "The medical risk group has specific  
9 responsibilities for untoward incident report  
10 (clinical)."  
11 If we go down to the composition of this important  
12 committee, we see, third in line:  
13 "Director of nursing services (represented)."  
14 Do you recall this committee, this group?  
15 A. Yes, I do now, yes.  
16 THE CHAIRMAN: You were on it itself? When it says  
17 "represented" there, does that mean that either you were  
18 on it or you nominated somebody to be on it for you?  
19 A. It meant that there was someone nominated.  
20 THE CHAIRMAN: And who was that, do you know?  
21 A. I can't remember. I cannot honestly remember.  
22 THE CHAIRMAN: Okay.  
23 MR STEWART: That person would have been reporting back to  
24 you?  
25 A. They would have reported back, yes, to the nurse

24

1 managers group.  
2 Q. Reported to you?  
3 A. What?  
4 Q. Would that individual you had nominated or placed on the  
5 group to represent you have reported back to you?  
6 A. They would have reported back to me, but also to the --  
7 at my meeting on a monthly basis.  
8 Q. So you'd have been kept informed then --  
9 A. Yes.  
10 Q. -- of the procedures for "untoward incident reporting  
11 (clinical)"?  
12 A. Yes.  
13 Q. What were they in 1996? What was the procedure for  
14 reporting an untoward clinical incident?  
15 A. It would have been, as I say, on the statement book, and  
16 it would have been probably to Dr Murnaghan, to his  
17 office, and, if it was a nursing incident, it would have  
18 been reported directly to me.  
19 Q. Can I ask you about the statement book, first of all?  
20 Mr McKee, in some of his submissions to the inquiry, has  
21 made reference to the statement book procedure. Can you  
22 remember how it worked?  
23 A. I remember the books and they had to be filled in.  
24 I can't remember whether it was duplicate or triplicate,  
25 but all the details would have been filled in on that

25

1 in place at that time for doing exactly that. The  
2 likelihood is I would have been -- there would have been  
3 a discussion."  
4 So she doesn't seem clear about any process there  
5 for initiating a reaction to an adverse clinical  
6 incident and she was a ward sister.  
7 A. Yes.  
8 Q. Do you remember before the Trust came into being that  
9 there was a process whereby untoward incidents might be  
10 reported to the Health Board?  
11 A. I can't honestly remember. I know certainly I would ...  
12 I think I was responsible to the chief of -- CANO in the  
13 Eastern Board until -- I think it was 1998. I would  
14 have reported things to her if there was anything. But  
15 that was 1984 to whatever, when we had districts and  
16 then when the districts changed. There have been that  
17 many changes.  
18 THE CHAIRMAN: Is that before the Trust was founded?  
19 A. Yes.  
20 THE CHAIRMAN: And the Trust was founded, I think, in 1993.  
21 That's the start date, isn't it?  
22 A. Yes.  
23 MR STEWART: Perhaps I can just pursue this a little bit  
24 more with you at page WS061/2, page 321, to see if this  
25 document provokes any recollection with you. This

27

1 and then forwarded to -- I think it was probably the  
2 medical risk management group now.  
3 Q. And how would an untoward clinical incident have been  
4 defined in 1996?  
5 A. I can't remember. I can't recall the exact details.  
6 It would have been -- um, anything that wasn't expected.  
7 Q. Yes. Would you have relied upon nurses to make reports  
8 of untoward clinical incidents?  
9 A. Yes.  
10 Q. And you'd have hoped that sisters and nursing managers  
11 and doctors and everyone would have played their part?  
12 A. Yes.  
13 Q. Were people given guidelines as to what they should  
14 report and what they need not report, the dos and  
15 don'ts?  
16 A. I can't recall, but certainly the sisters would have  
17 been very good at filling in any incidents and making  
18 sure that they were filled in properly.  
19 Q. Okay. Ward Sister Pollock was asked about this very  
20 issue on 30 October 2012. Can we look, please, at  
21 page 206 of her evidence, taken on 30 October 2012 at  
22 line 11? She's asked about what she should do in terms  
23 of follow-up or investigation or searching around after  
24 an incident. And she answers at line 11:  
25 "I can't recall that we had any particular process

26

1 is January 1991, it's called "Circular ET5/90  
2 (amended)."  
3 It is for the reporting of untoward incidents. If  
4 you go down to section 1, this is for reporting to the  
5 board of an untoward incident. Section 1:  
6 "Summary of current notification procedures. The  
7 board currently has notification procedures in place in  
8 regard to: (i) notifying the coroner about any death  
9 which may be the subject of an inquest."  
10 As a matter of interest, do you remember that? Do  
11 you remember any notification procedures about  
12 notification a coroner at that time?  
13 A. No, but certainly we would have implemented that  
14 circular.  
15 Q. Over the page at page 322, section 2, which is strangely  
16 headed:  
17 "Proposal regarding notification of untoward  
18 incidents."  
19 But it seems that this was nonetheless an active  
20 protocol:  
21 "The board wishes to ensure that it receives prompt  
22 notification of any untoward incident. Unit general  
23 managers ..."  
24 That's, I suppose, the equivalent of  
25 a chief executive; would that be right?

28

1 A. Yes. Sorry, if I could clarify: when I was appointed in  
2 1984, we were a district, and then at some -- I think it  
3 was 1988, unit general managers were ... Maybe it was  
4 slightly before that. And at that point, yes, then  
5 I would have reported to the general manager, but  
6 I would have had to report to the chief admin nursing  
7 officer, and I think it was probably around 1990 that  
8 that changed.  
9 THE CHAIRMAN: The chief administrative nursing officer,  
10 that's CANO, C-A-N-O?  
11 A. CANO, that was in the Eastern Board. And I can't  
12 remember the exact date it changed when I no longer  
13 reported to her, but I then reported to the unit general  
14 manager.  
15 THE CHAIRMAN: The bit I'm missing is: what exactly is it  
16 that you're reporting? What is the untoward incident  
17 that you're reporting?  
18 A. That could be anything abnormal, you know. It could  
19 be ...  
20 MR STEWART: Usefully, there are criteria set out further  
21 down the page. At sub-paragraph 1 what was required  
22 was:  
23 "An effective reporting system be maintained to  
24 ensure that all untoward incidents are notified to the  
25 UGM and its staff are familiar with the procedure."

29

1 a possibility of perhaps negligence, it should be  
2 reported?  
3 A. Yes.  
4 Q. How was that actually put into practice?  
5 A. It would have been through, I suppose, initially through  
6 the statement books and also informing the medical  
7 director's office.  
8 THE CHAIRMAN: Can you give us an example? I don't want  
9 names of patients, right? But can you give us one or  
10 two examples of untoward incidents which were reported  
11 that you were involved in reporting or being notified  
12 about, which had any aspect of nursing care to them?  
13 A. Um ... No, I think one was ... One that I would have  
14 been involved with was where an allegation -- a nurse  
15 had mistreated a patient.  
16 THE CHAIRMAN: Right.  
17 A. I can remember there was an incident in a directorate  
18 where a wrong drug was given to a patient and that was  
19 reported.  
20 THE CHAIRMAN: Is that separate from the mistreating?  
21 A. Oh separate, yes.  
22 THE CHAIRMAN: So the mistreating is perhaps being verbally  
23 or physically abusive?  
24 A. Physically abusive.  
25 THE CHAIRMAN: And the second element is a wrong drug being

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1 Then under "criteria":  
2 "For assessing those cases which should be reported,  
3 include any incident which might suggest there has been  
4 a failure in professional standards of care and  
5 treatment."  
6 Just the top paragraph (a).  
7 A. Yes.  
8 Q. So it looks like, in the early 1990s, the hospital was  
9 expected to have in place a system whereby an untoward  
10 clinical incident be reported.  
11 A. Yes.  
12 Q. Do you remember that system?  
13 A. Yes. But I can't remember the details and I think it  
14 was something that became more formalised with clinical  
15 audit, with audit which came subsequent.  
16 Q. If there was a system here with which all basic and  
17 supervisory grades were supposed to be familiar with,  
18 presumably information was circulated telling people the  
19 type of incidents they should report?  
20 A. Yes.  
21 Q. And the criteria would appear to be an incident which  
22 might suggest there has been a failure in professional  
23 standards of care and treatment.  
24 A. Yes.  
25 Q. Might that suggest, and it's tentative, but if there's

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1 given to a patient.  
2 A. Mm. That was by a doctor.  
3 MR STEWART: So broadly speaking, was it left up to the  
4 doctors and nurses whether they should report their own  
5 errors or report the errors of their colleagues?  
6 A. It would have been -- it would have originated at ward  
7 level, at the ward sister level, and that ... With the  
8 doctors on the ward.  
9 Q. It was left to them to report themselves if necessary?  
10 A. To fill out a report and to inform up the line, whoever  
11 their manager was.  
12 Q. What happened to that circular after the Trust came into  
13 being in 1993? Did it continue?  
14 A. It would have, and then I think too, with organisational  
15 audit, we would have been looking at developing other --  
16 revising. We had to revise some of our documents.  
17 I remember that some areas that we didn't have a policy  
18 or a procedure for, that we had to make them,  
19 disseminate them. One of the things of the King's Fund,  
20 it was all very well having the paperwork and the  
21 policies and procedures, but there was a big emphasis on  
22 the dissemination of that information to the staff. And  
23 as a surveyor, when you were visiting the wards, one of  
24 the things was, you spoke to staff, you could pick the  
25 staff nurse or a sister or even a domestic, and question

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1 them to see if they had the knowledge of what was deemed  
2 to be important procedures or policies.  
3 THE CHAIRMAN: In other words, there's no point in having  
4 a policy unless the staff know about it.  
5 A. Unless it's implemented and the staff know about it.  
6 THE CHAIRMAN: So you would do a random check to see, for  
7 instance, if a nurse knew about this policy?  
8 A. Yes.  
9 THE CHAIRMAN: Okay.  
10 MR STEWART: So would it be fair to say that the procedures  
11 developed under this circular would have been continuing  
12 on into the 1990s and through?  
13 A. Yes.  
14 THE CHAIRMAN: But with greater emphasis on the nurses being  
15 aware of the policies?  
16 A. Sorry?  
17 THE CHAIRMAN: With a greater emphasis on the nurses being  
18 aware of the policies.  
19 A. That's right.  
20 THE CHAIRMAN: And on presumably, also, doctors being aware  
21 of the policies.  
22 A. Yes.  
23 THE CHAIRMAN: And the reason for that is that's a better  
24 way of ensuring that the policy is followed?  
25 A. Yes.

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1 I cannot remember the detail.  
2 Q. The inquiry has seen no trace of any such guideline or  
3 policy.  
4 A. Right.  
5 MR STEWART: I have no further questions.  
6 THE CHAIRMAN: Are there any more questions for Miss Duffin?  
7 Thank you very much for your time. You are free to  
8 leave again. Thank you very much indeed.  
9 (The witness withdrew)  
10 THE CHAIRMAN: Ladies and gentlemen, we'll take a break now  
11 for about 10 or 15 minutes. After that, Professor Young  
12 will come to give evidence. In large measure, he'll do  
13 so in relation to his involvement from late 2004 with  
14 the review or a case note review of aspects of the care  
15 and treatment of Claire. In that exercise, he  
16 participated along with Nichola Rooney and others.  
17 I want to say on the record that I have known  
18 Dr Rooney for more than 35 years. We grew up in the  
19 same part of Belfast, her husband is a colleague at the  
20 bar, as is her brother. In recent years, my wife and  
21 I have been guests in their home and they've been guests  
22 in ours. It's part of my responsibility that I consider  
23 Dr Rooney's evidence in the same way as everyone else's,  
24 but I particularly wanted Professor Young, if he wasn't  
25 aware of that, to be aware of it before he starts to

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1 THE CHAIRMAN: So you would expect to see incidents being  
2 reported because there's a greater awareness of the  
3 procedure for reporting them?  
4 A. That's correct.  
5 THE CHAIRMAN: So if more incidents are reported, it's not  
6 because things are getting worse in the hospital --  
7 A. No.  
8 THE CHAIRMAN: -- it's because there's --  
9 A. More awareness.  
10 THE CHAIRMAN: -- and they're expected to follow it?  
11 A. Yes.  
12 THE CHAIRMAN: And that's all part of being approved by the  
13 King's Fund?  
14 A. Yes. Because one of the difficulties is with the  
15 reduced work hours -- it is very difficult if someone is  
16 on holiday and a policy comes out, how do you ensure  
17 that they have seen it and are aware of it?  
18 THE CHAIRMAN: Yes.  
19 MR STEWART: So to go back to the work of the medical risk  
20 management group as part of the overall health and  
21 safety strategy, did that group, at which you had  
22 representation, take any steps to produce a policy or  
23 guidelines to assist people in the criteria for  
24 assessing those cases which should be reported?  
25 A. I don't remember. I would like to think they did, but

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1 give evidence.  
2 (11.03 am)  
3 (A short break)  
4 (11.24 am)  
5 PROFESSOR IAN YOUNG (called)  
6 Questions from MR STEWART  
7 MR STEWART: Good morning.  
8 Professor, you provided us with a number of witness  
9 statements. In fact, five in all, WS178/1 through to 5.  
10 Are you content that the inquiry should adopt those as  
11 your formal evidence?  
12 A. I am.  
13 Q. Thank you.  
14 THE CHAIRMAN: If you pause there, I think, professor, it's  
15 right to say that you were asked by the inquiry for one  
16 witness statement, which is the first one, and you gave  
17 that on 14 September.  
18 A. Yes.  
19 THE CHAIRMAN: Subsequently, you volunteered statements on  
20 30 October, 2 November and 26 November. We have called  
21 those statements 2, 3 and 5. Your statement 4 is in  
22 fact not a statement, but something that you refer to as  
23 some additional literature and we are now referring to  
24 it as 4 for the purposes of paginating the  
25 documentation.

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1 To some extent, you clearly are challenging some of  
2 the evidence that was, in particular, given by  
3 Dr MacFaul.  
4 A. Yes. I think my position is that I am very closely  
5 aligned with the views expressed by Dr Scott-Jupp in  
6 general and that I believe that Dr MacFaul is incorrect  
7 in a number of respects. In addition, since --  
8 THE CHAIRMAN: I think incorrect in some respects and maybe  
9 a bit unduly harsh or critical in other respects.  
10 A. Yes, I think that's absolutely what I feel. My  
11 responses have been mainly to Dr MacFaul's comments and  
12 also, as some issues have cropped up in the inquiry -- I  
13 have had information or knowledge, for instance about  
14 the Glasgow Coma Scale, which I felt was important to  
15 draw to the attention of the inquiry, in order to ensure  
16 that full and proper consideration can be given to  
17 everything.  
18 THE CHAIRMAN: Okay. This is a statutory inquiry sitting in  
19 public and I'm quite happy to receive information, which  
20 will improve the evidence before the inquiry, and to  
21 inform me as I come to write the report. It also has  
22 obviously informed the questioning of witnesses like  
23 Dr Scott-Jupp and Dr MacFaul, as you'll have seen from  
24 the transcripts, and you've also corrected me on at  
25 least one issue so far and maybe more today. That's

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1 isn't that right?  
2 MR McALINDEN: Yes.  
3 THE CHAIRMAN: And we're hoping he'll come back to us over  
4 the next day or so. This is what happened at about  
5 11.30 when Dr Stewart saw Claire, then had a discussion  
6 by phone with Dr Bartholome.  
7 MR McALINDEN: Yes.  
8 THE CHAIRMAN: And there was a reduction, but there was also  
9 the administration of further drugs and the question  
10 is: what effect did that administration of drugs  
11 intravenously have on the overall fluid administration?  
12 MR McALINDEN: Yes.  
13 THE CHAIRMAN: Okay. That's one issue. Was there any other  
14 issue in particular? What I'm going to ask Mr Stewart  
15 to do is -- he had planned and lines have been  
16 circulated which are along the governance issues. These  
17 will, inevitably, move into some of the clinical areas  
18 that you have identified for the professor to highlight  
19 because they can't explain publicly what his input was  
20 to what I think he calls the case note review without  
21 going into some of this clinical evidence; isn't that  
22 right?  
23 MR McALINDEN: Yes. Another major issue that should be  
24 addressed, Mr Chairman, is whether the management would  
25 have been different in 1996 from when the review took

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1 pretty much an open book.  
2 Mr McAlinden, on Saturday night, I think you  
3 e-mailed to the inquiry senior counsel 65 lines of  
4 questioning you were suggesting might be followed with  
5 the professor.  
6 MR McALINDEN: There are a significant number of clinical  
7 issues and it would be my submission to the inquiry that  
8 Professor Young can give valuable evidence to this  
9 investigation in relation to.  
10 Just to highlight one: there is an issue over  
11 whether there was a fluid overload or an administration  
12 of more fluid than should have been administered to  
13 Claire after 11.30 pm and some of the experts have  
14 attested to that.  
15 You'll see from the exchange with Ms Anyadike-Danes  
16 that Professor Young has very firm views in relation to  
17 the calculations that took place. If his evidence is  
18 correct, then it would appear that there was indeed  
19 a reduction of fluid to very nearly the level that it  
20 was intended to reduce the fluid to, which would be, in  
21 my submission, a very important piece of evidence for  
22 this inquiry to hear. So that would be one issue  
23 in relation to the clinical --  
24 THE CHAIRMAN: If we just pause there. I think you've asked  
25 the inquiry to ask Dr Scott-Jupp for his view on this;

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1 place in 2004. It's clear that Dr MacFaul is of the  
2 opinion, if anyone presented with symptoms or signs of  
3 encephalopathy or encephalitis, that the standard  
4 practice at that time was to restrict and to consider  
5 the administration of more sodium-rich fluids.  
6 Professor Young has very definite views about that  
7 subject.  
8 THE CHAIRMAN: This might make it a bit easier. I obviously  
9 know what Dr MacFaul has said about that. First of all,  
10 he has said that while many doctors would have followed  
11 his line, it would not have been universally followed.  
12 Secondly, I don't think it attracts majority support,  
13 even from the inquiry experts.  
14 Professor, Dr MacFaul, in my eyes, is saying -- and  
15 this is subject to any other submissions -- that this is  
16 what many people would have done, it wasn't a universal  
17 approach, and Dr Scott-Jupp, at the very least, for one,  
18 disagrees with him.  
19 A. I think that the majority of the expert witnesses who  
20 have looked at this case disagree with Dr MacFaul.  
21 THE CHAIRMAN: I think that's probably right.  
22 A. As I do. Furthermore, I have tried to demonstrate from  
23 contemporary literature and evidence that there were  
24 good reasons for that and for the change in wording in  
25 Forfar & Arneil between the two editions.

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1 THE CHAIRMAN: I understand that. I think, since you have  
2 been following the inquiry, you'll have seen a number of  
3 interventions from me, which have indicated that my  
4 provisional view is that whatever was done overnight on  
5 Monday -- and that's really a combination of Dr O'Hare  
6 and Dr Volprecht -- if there's any criticism of that at  
7 all, it's going to be quite mild on the evidence that's  
8 received so far.

9 And can I say again -- this has to be subject to any  
10 submissions which come in -- that the notion that it was  
11 inappropriate to give Claire that solution on her  
12 admission seems to be a minority one, the minority being  
13 Dr MacFaul, and I'm not inclined, at this stage, to go  
14 along with that.

15 If that assists, Mr McAlinden.

16 MR McALINDEN: I think the other issue, which is a major  
17 issue -- I think it relates both to governance and to  
18 the clinical aspect of the case -- is the references to  
19 the stability of Claire's condition on the Tuesday.  
20 I think that really ties in with the inter-observer  
21 variation issue in the GCS scores.

22 THE CHAIRMAN: Yes. Well, you can take it that -- I've no  
23 difficulty. What I don't think is appropriate is  
24 for ... I'm not going to turn away evidence from  
25 somebody who's clearly qualified to give an expert view.

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1 "Senior lecturer in clinical biochemistry, Queen's  
2 University Belfast and consultant in clinical  
3 biochemistry, Royal Group of Hospitals."

4 So in fact, at the time of Claire's admission, and  
5 her death in hospital, you were in fact a consultant in  
6 clinical biochemistry at the Royal.

7 A. I am and was what's called a "joint appointment clinical  
8 academic". My primary employer is Queen's University,  
9 Belfast. My office is within the university building on  
10 the Royal Victoria Hospital site. My salary is received  
11 each month from the university and I use an university  
12 e-mail address and all my HR issues are dealt with by  
13 the university. The nature of my employment is that  
14 it's a joint appointment, so I also have a role with,  
15 initially, the royal Victoria Hospital and, currently,  
16 the Belfast Health and Social Care Trust.

17 Q. Thank you. Why was that appointment omitted from the  
18 previous CV submitted to the inquiry?

19 A. I was asked for a brief CV, it was omitted for no  
20 reason. I had a five-page CV to hand, which I submitted  
21 to the Trust and was told was appropriate, and came to  
22 yourselves. It has become clear to me during the course  
23 of the inquiry that considerable time has been spent  
24 looking at the CVs of various witnesses and I was keen  
25 that a fuller CV should be available to you.

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1 My concern about the statements which are coming in  
2 was that, in a way, they could be read as a running  
3 commentary, but Professor Young, on the inquiry  
4 evidence, which I really don't think is appropriate to  
5 have a running commentary because that has come through  
6 in some of the statements which have been made and  
7 I think some of the language is a bit regrettable. But  
8 what I'll do is I'll ask Mr Stewart to take the  
9 professor through the professor's CV, ask him to take  
10 the professor through his involvement from when it  
11 started in 2004, and we'll see then, after that exercise  
12 is complete, how many issues there are, which you  
13 suggest might need to be taken any further, remembering  
14 that I do have all this information before me.

15 MR McALINDEN: I'm obliged.

16 THE CHAIRMAN: Mr Stewart?

17 MR STEWART: Thank you, sir.

18 Professor, your CV at 311-008-001. I hope that's  
19 the new one that arrived this morning.

20 A. Yes.

21 Q. Yes, it is. Just one thing I draw attention to.

22 You have, I'm glad to see, corrected an omission from  
23 the previous CV so that under "previous appointments"  
24 you have noted your position between October 1993  
25 to January 1999:

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1 Looking at it this morning, because I don't actually  
2 have a very up-to-date one, and I had to prepare this  
3 one as well. One appointment is missing from this one,  
4 which was declared on any original witness statement, as  
5 I'm sure you are aware, and that was my post as director  
6 of research and development within the Royal Victoria  
7 Hospital, which was from 2002 to 2005, and which was  
8 really an additional responsibility.

9 Q. Yes. I can see that you are anxious to lay this  
10 particular canard to rest, but in 2004, it is correct to  
11 say that one of your employers was the Royal Group of  
12 Hospitals.

13 A. I'm anxious that the inquiry have as full information as  
14 possible of all of my aspects of involvement in this  
15 case.

16 Q. And that you were employed on the Royal Group of  
17 Hospitals site?

18 A. Absolutely, I was based on the Royal Group of Hospitals  
19 site, that's correct.

20 Q. And you were asked to advise Dr McBride of the Trust?

21 A. Yes.

22 Q. And that you were authorised to speak on behalf of the  
23 Trust when you met with Mr and Mrs Roberts?

24 A. Yes. Dr McBride had indicated to me that when I met  
25 with the Roberts family, that I could convey to them

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1 information on behalf of the Trust.  
2 Q. Thank you. Your CV is most distinguished and I can see  
3 that amongst your other accomplishments is an interest  
4 in clinical ethics and you presently chair the clinical  
5 ethics committee of the Belfast Health and Social Care  
6 Trust.  
7 A. That is correct. I have chaired the clinical ethics  
8 committee of the Trust, I think, for about three years,  
9 approximately.  
10 Q. And you also clearly have an interest and expertise in  
11 hyponatraemia.  
12 A. Yes. So I have very extensive experience with  
13 hyponatraemia throughout my professional career. I have  
14 seen many hundreds of patients with hyponatraemia and  
15 certainly, during the 1990s and the early years of the  
16 2000s, I would have been the main expert on  
17 hyponatraemia within the Royal Group of Hospitals and  
18 would have received and carried out frequent  
19 consultations in relation to hyponatraemia.  
20 THE CHAIRMAN: Can I ask you: in your experience, had you  
21 ever come across Professor Gross, who gave evidence in  
22 Adam's case?  
23 A. No. I haven't come across him, no.  
24 THE CHAIRMAN: Because he's also, in effect, presented by  
25 the inquiry as an expert in hyponatraemia and he said,

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1 A. I'm sure we'll come on to this. It's a reflection of  
2 the complexity of Claire's medical condition and also  
3 the difficulty with understanding the contribution of  
4 hyponatraemia, which certainly, in 2004, I felt strongly  
5 had made a contribution, but was not able to quantify  
6 the extent of that contribution.  
7 My interest in disturbances in sodium extends beyond  
8 that in that I have acted as an expert witness in family  
9 court and criminal cases related to sodium metabolism.  
10 So this is an area on which I have a very large amount  
11 of clinical experience on which I've taught and lectured  
12 and where I have also served as an expert witness.  
13 THE CHAIRMAN: Okay.  
14 MR STEWART: Could I simply ask you, for the record, to  
15 explain to us what a clinical biochemist is and does?  
16 A. Yes. Thank you, because I think this is quite  
17 important. One of the difficulties is that a clinical  
18 biochemist is also sometimes known as a chemical  
19 pathologist, and I'm aware, having looked at the records  
20 of the inquiry, that both of those terms have come up at  
21 different times, and it's perhaps not always been clear  
22 that they were referring to the same type of individual.  
23 In addition, Dr MacPaul, in his initial statement,  
24 refers to me on a number of occasions as an adult  
25 physician and criticises my selection by Dr McBride on

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1 not only in the mid-1990s, but even today, it's  
2 significantly misunderstood and often not recognised.  
3 A. Absolutely. It's a complex and difficult condition to  
4 manage and any impression that comes across to the  
5 contrary, I think, is misleading.  
6 THE CHAIRMAN: I don't have that impression. Sorry, let me  
7 correct that. I think in some cases my impression is  
8 it's easier to identify than it is in other cases.  
9 A. It's easily identified, but the response to it is  
10 complex and difficult and it's difficult to get the  
11 cause of the diagnosis correct. I teach extensively on  
12 fluid and electrolyte balance and, of all the  
13 electrolyte disturbances, hyponatraemia is the most  
14 complex and difficult one. That's what we taught in the  
15 early 1990s and still teach to the undergraduate medical  
16 students.  
17 THE CHAIRMAN: And you'll have seen the inquiry opening,  
18 which was presented, the clinical opening, and  
19 a separate document prepared, in which even the Royal's  
20 doctors, the witnesses at the inquest and the inquiry  
21 experts, still have shades of disagreement about what  
22 the actual cause of death in Claire was.  
23 A. Yes.  
24 THE CHAIRMAN: Is that a reflection on the complexity of  
25 hyponatraemia?

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1 that basis. And in fact, I'm very keen to get across  
2 that I'm not an adult physician; I'm a clinical  
3 biochemist. Our training covers both laboratory and the  
4 provision of results, and in addition the clinical  
5 management of biochemical and metabolic disorders. The  
6 training extends right across the entire life course  
7 from prenatal screening to neonatal, to children, and  
8 then through to adults and old age.  
9 Most of us have sub-specialties. My own particular  
10 interests have been in lipid metabolism and nutrition,  
11 so I run an outpatient clinic where I see patients with  
12 disorders of lipids, adults and children, often together  
13 as families.  
14 It's a relatively uncommon specialty within the UK.  
15 There aren't very many of us. I'm trying to understand  
16 Dr MacPaul's failure to appreciate my role. By looking  
17 at his hospital, which is Pinderfields -- which I think  
18 he describes as a medium-sized district general  
19 hospital -- they don't have a chemical pathologist or  
20 a consultant in clinical biochemistry, to my knowledge,  
21 on their staff. So I think he would probably have  
22 limited experience of working with a chemical  
23 pathologist or a clinical biochemist.  
24 Q. So just to further establish your credentials, in 2004  
25 what sort of clinical experience did you have of

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1 hyponatraemia?  
2 A. In 2004, I had seen many hundreds of cases of clinical  
3 hyponatraemia. I had been appointed as a consultant  
4 in -- I think it was 1993 or 1992, which is almost the  
5 same time as Dr Scott-Jupp, in fact, was appointed as  
6 a consultant. Dr MacFaul had been appointed at,  
7 I think, a much earlier stage, and in part I have  
8 a feeling that the disagreements between us arise from  
9 the fact that he had experience of -- much experience  
10 in the 1980s, when I think, from the evidence he's  
11 provided, the management of fluids in encephalopathy was  
12 significantly different. That was really while I was  
13 a student and I think I wouldn't have had particular  
14 knowledge of that experience.

15 So I would have -- whenever the laboratory  
16 identified a very low sodium level, then it would be  
17 referred to me very often, and I would contact the  
18 clinicians on the wards and go and speak to them and  
19 advise on the management of the patient. Out of hours,  
20 so evenings and weekends, then with two or three  
21 colleagues, we provided a 24-hour cover for all of the  
22 Belfast hospitals in relation to biochemical  
23 abnormalities and disturbances, which is still the case.  
24 So if somebody has a very low sodium and clinicians are  
25 concerned about them, then they would generally phone

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1 complaints.  
2 In children, the difficulty, of course, is  
3 because -- mainly, most people think the relative size  
4 of the brain and the skull, the limited space for the  
5 brain to expand. The symptoms of hyponatraemia can come  
6 on much more acutely and may tend to be more severe, but  
7 the principles of treatment and causation are the same.

8 THE CHAIRMAN: The gist of the evidence given to me a number  
9 of times is that while children can bounce back very  
10 quickly from illness, they can also go down very  
11 quickly.

12 A. Absolutely.

13 THE CHAIRMAN: So there's a real time issue that, once  
14 things start to go wrong with a child, there's a greater  
15 time pressure to identify it and put it right?

16 A. Absolutely, I completely agree with that. In adults,  
17 while the principles, management, investigation and  
18 treatment are exactly the same, often there's not the  
19 same degree of acuteness in terms of the danger to the  
20 patient, although hyponatraemia can be fatal in adults  
21 as well.

22 THE CHAIRMAN: I understand.

23 MR STEWART: And did you have a teaching role in respect of  
24 hyponatraemia as well?

25 A. I did. After my appointment as a senior lecturer and

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1 the lab, who would refer them on to us to advise on  
2 management and treatment.

3 My own involvement was -- the vast majority was  
4 in the adult hospital, so in 2004 there were two  
5 chemical pathologists or clinical biochemist, medically  
6 qualified, based in the Royal: myself and Professor  
7 Elisabeth Trimble. Professor Trimble, who's now  
8 retired, ran a metabolic clinic in the Children's  
9 Hospital, so she would have been a familiar figure  
10 there. The vast majority of my practice was in the  
11 adult hospitals and I wouldn't have been in the  
12 Children's Hospital more than probably a couple of times  
13 per year.

14 THE CHAIRMAN: At the risk of opening a book, in very  
15 summary terms, is the treatment of low sodium levels  
16 potentially more or less complicated between children  
17 than adults or does it just depend on each child and  
18 each adult?

19 A. It depends very much on the individual clinical  
20 presentation. However, hyponatraemia in children is  
21 much more dangerous and the reasons for that will have  
22 been heard. So in adult practice, I have seen sodium  
23 levels go down to less than 100 and I have seen a lady  
24 walk into the hospital with a sodium level of 99 and  
25 just feel slightly dizzy and not have any other

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1 consultant in October 1993, I was responsible for the  
2 chemical pathology or clinical biochemistry course,  
3 which formed part of the third year of the undergraduate  
4 medical curriculum, from memory. So I developed that  
5 course and delivered most of it. It's a long time ago  
6 now, but I think there were about probably 20, maybe 25,  
7 lectures in total, and there was an examination of the  
8 students at the end of the third year. Certainly,  
9 hyponatraemia would have formed one component of that  
10 course.

11 There was a major review of the undergraduate  
12 medical curriculum in the late 1990s, and as a result of  
13 that, the specific course I taught in chemical  
14 pathology, clinical biochemistry, was removed from the  
15 curriculum. Since then -- and others will give evidence  
16 on this -- the distribution of teaching has been across  
17 the five years of the curriculum, but I have particular  
18 responsibility for a final-year study day in fluid and  
19 electrolyte balance, which all final-year students  
20 attend, which includes a more detailed discussion of  
21 four clinical cases, three of which involve, from  
22 memory, hyponatraemia.

23 Q. So would it be fair to say in the mid-1990s you were  
24 involved in the teaching of hyponatraemia-related issues  
25 and you were also providing an advisory service, really,

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1 in the Royal for low sodium cases?  
2 A. Yes, but particularly in the adult hospital. I was  
3 very, very rarely ever called to the Children's  
4 Hospital.  
5 Q. Was the case of Adam Strain ever brought to your  
6 attention in 1995 or the mid-1990s and your advice  
7 sought?  
8 A. I had no awareness at all of Adam's case until the  
9 television programme aired.  
10 Q. So when Claire was admitted to the Royal, you were there  
11 as a consultant providing this service. If you'd been  
12 asked to look at Claire's notes in October 1996, would  
13 you have formed the same view as you formed in 2004?  
14 A. Do you mean after her death?  
15 Q. Yes.  
16 A. Yes, I would have done, without a doubt.  
17 Q. And would you have thought it appropriate to refer her  
18 case to the coroner at that time?  
19 A. I would.  
20 Q. Why?  
21 A. Because I would have felt that there was at least  
22 a possibility that the sodium management, fluid  
23 management, had contributed to the events that led to  
24 her death, and I would have felt it was important for  
25 those issues to be aired and for independent external

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1 I would do relative quickly. I can't recall any mention  
2 of a time.  
3 THE CHAIRMAN: I presume the question is meant not whether  
4 there was a time limit, like "We have to have this  
5 tomorrow at noon", but whether there was clearly some  
6 time pressure to get a response.  
7 A. I have no recollection of a specific time limit, but  
8 I felt it was something that needed to be done fairly  
9 rapidly. That was the impression that I had.  
10 MR STEWART: Were you asked to put your opinion in writing?  
11 A. It wasn't suggested to me how I should put my opinion.  
12 Dr McBride had phoned me and asked me to do it on the  
13 phone, so my recollection is that I gave my opinion  
14 verbally to him, as he had asked me to carry out the  
15 review verbally.  
16 Q. I think you said in your witness statement that you did  
17 that by telephone.  
18 A. Yes, that's my recollection, although I am happy to  
19 say -- I know that Dr McBride recalls that there was  
20 a meeting and it's quite possible that there was  
21 a meeting, which I can't remember.  
22 Q. Yes. Did you watch the programme, the UTV programme,  
23 when it was broadcast?  
24 A. No. I'm assuming -- I travel a lot, you know,  
25 nationally and internationally. I've referred earlier

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1 opinion to be received.  
2 Q. When you finally were contacted in 2004, after the  
3 broadcast of the UTV programme, who first contacted you  
4 and what request was made of you?  
5 A. From memory, I was contacted by Dr Michael McBride by  
6 telephone. It was explained to me that Claire's parents  
7 had contacted the hospital and expressed concern that  
8 fluid management and hyponatraemia may have contributed  
9 to her death in 1996. I was asked to review the notes  
10 and to advise Dr McBride whether hyponatraemia may have  
11 contributed to her death and whether, in my opinion, he  
12 should refer the case on to the coroner.  
13 Q. Were you asked to give a view about fluid management or  
14 was that so bound up with the issue of hyponatraemia it  
15 was the same question?  
16 A. It was the same question. The question was whether  
17 there was enough evidence in the notes to suggest that  
18 the case should be referred onwards to the coroner as  
19 a result of the role that fluid balance and  
20 hyponatraemia -- which are completely and utterly tied  
21 up -- may have played.  
22 Q. Were you given a time within which to come back with  
23 your views?  
24 A. I have no recollection of being given a time, but  
25 I recall that it was something which it was hoped

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1 in my CV to my international role with the Federation  
2 for Clinical Chemistry and Laboratory Medicine. I don't  
3 remember whether that was on then, but I've always  
4 travelled extensively and it was quite possible that  
5 I was out of the country whenever the programme was on  
6 television.  
7 Q. When Dr McBride contacted you, did he indicate to you  
8 that this was brewing up into a storm, there was  
9 political interest, public concern, questions being  
10 asked?  
11 A. I have no recollection of that. I was certainly aware  
12 at that time that it was a matter of public interest and  
13 clearly, and more importantly, it was a matter of  
14 interest to the Roberts family.  
15 Q. Yes.  
16 A. And that's always been at the core of this and my  
17 involvement in it. However, there was no sense at all,  
18 as far as I was concerned, of any political and other  
19 pressures and I don't know what you mean by that  
20 comment.  
21 Q. The minister announced this inquiry in,  
22 I think, November 2004. That's a fairly high level  
23 public concern.  
24 A. Okay. In fact, it was certainly the possibility that  
25 Claire's case might be referred onwards to this inquiry.

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1 Q. That subsequently emerged as a possibility, yes.  
2 A. I can't remember when that emerged. I can't remember  
3 whether it was -- whether it emerged at the beginning.  
4 I think it was because I believe that in the notes of  
5 the meeting there's reference -- the first meeting with  
6 the Roberts family, there's reference to the  
7 responsibility of referring the case onwards to the  
8 inquiry.  
9 Q. That's a little bit later than the time I'm focusing in  
10 on, which is when you received the request from  
11 Dr McBride.  
12 A. Probably within a couple of weeks. It's very close to  
13 it and that's why I'm having difficulty recalling.  
14 Q. The question is quite simply this: with an opinion  
15 you are asked to provide on a matter which is of  
16 potentially great public concern, political concern,  
17 concern to the Roberts family, did you think it unusual  
18 that you should be just asked to give an opinion,  
19 a verbal opinion perhaps, nothing more formal?  
20 A. I didn't think it was unusual in that I felt, at the  
21 time, that Dr McBride believed that hyponatraemia  
22 probably had played a role and that he was seeking  
23 confirmation from me that that was the case. If I had  
24 disagreed with that and had recommended anything other  
25 than onward referral of Claire's case to the coroner and

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1 actually reconstruct it all sometimes.  
2 THE CHAIRMAN: Thank you.  
3 MR STEWART: You said one moment ago that indeed it didn't  
4 take you long, when you got the medical chart, to form  
5 your opinion that hyponatraemia was implicated.  
6 A. I think that's correct. So just to be clear on the  
7 process: I was sent the clinical notes, I can't remember  
8 exactly who brought the notes to me or sent them to me.  
9 I also can't remember exactly what the content was,  
10 except I had the clinical notes. I think I probably  
11 spent an hour at most, maybe less, reviewing the notes  
12 before I came to my opinion.  
13 Q. Is that something that could be achieved quite quickly?  
14 In a medical chart, does the most recent addition to the  
15 file appear at the top of the file, as it were?  
16 A. I wish that were always the case because it would make  
17 my job much easier. Unfortunately not, no. There is  
18 meant to be a sequence of records or notes, but it  
19 depends on the size of the chart. But my  
20 recollection -- and I believe it's been referred to  
21 in the minutes -- is that Claire's notes were not  
22 particularly large or comprehensive. So it wouldn't  
23 have -- it definitely didn't take me long. I was  
24 focused on a particular issue, which is the role that  
25 fluid balance and hyponatraemia may have had in terms of

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1 possibly to the inquiry, then I think it would have been  
2 important for me to put that in writing and the reasons  
3 for it. However, since my opinion, which I reached  
4 fairly rapidly, was a very clear and straightforward one  
5 and was going to involve referral onwards, which we  
6 believed is what the Roberts family felt was  
7 appropriate, then I didn't feel under any particular  
8 pressure or indeed thought it was unusual not to submit  
9 my opinion in writing.  
10 Q. And Dr McBride likewise did not ask for anything in  
11 writing from you?  
12 A. No, Dr McBride definitely didn't ask me for anything in  
13 writing because, if he had, I'd have provided it to him.  
14 THE CHAIRMAN: I don't know if you can answer this, but when  
15 you got the impression that Dr McBride had already  
16 formed a view, maybe even a preliminary view, that  
17 hyponatraemia had played a role and he was looking for  
18 you for confirmation of that or otherwise, did you get  
19 the impression that he had formed that view from his own  
20 quick analysis or from what he had been told by others?  
21 A. I'm sorry, I really can't answer that. I don't think  
22 I formed any view. And to be honest it does become  
23 difficult. I know 2004 is more recent than 1996, but  
24 I've read so many papers and e-mails and correspondence  
25 in recent months that it does become difficult to

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1 her death. I was focused on that, I reviewed it and  
2 I reached a fairly rapid conclusion.  
3 Q. I assume you just looked at the discharge summary from  
4 PICU, saw hyponatraemia and said, "That's the question  
5 answered".  
6 A. Not at all. I looked through the notes from --  
7 I remember looking at the GP referral letter, the A&E  
8 note. I remember looking at the written notes and  
9 obviously I looked at the fluid balance chart because  
10 that was something which was important. I think it's  
11 fair to say I paid much less attention to events after  
12 3 am on the morning of the Wednesday, whenever Claire  
13 suffered the respiratory arrest, because really the  
14 contribution of the hyponatraemia had done its damage by  
15 then. So in terms of answering the question which had  
16 been posed to me, the parts of the records after that  
17 were not really relevant.  
18 THE CHAIRMAN: And presumably the 11.30 record or sodium  
19 reading of 121 taken from the test at about 9 o'clock,  
20 I presume that's a significant director of your  
21 attention?  
22 A. Absolutely. So yes, that was important, certainly, and  
23 I commented upon that at the inquest.  
24 MR STEWART: Because your review of the papers or the chart  
25 was focused on the one issue, would it be fair to say

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1 that when one engages in a process like that, perhaps  
2 other things which aren't immediately relevant to the  
3 issue you're focused on, aren't absorbed?  
4 A. I think that's absolutely true. One of the points on  
5 which I have been criticised is my failure to identify  
6 the overdose of midazolam. I have to put my hand up and  
7 say I absolutely did not identify that at any stage and  
8 I regret that. However, I would say in my defence that  
9 it was certainly not at all a focus of my review of  
10 Claire's notes. While I'm an expert, I think, on fluid  
11 and electrolyte balance, biochemical disturbances, the  
12 only drugs I ever prescribe to children are  
13 lipid-lowering drugs, cholesterol-lowering drugs.  
14 I have absolutely no experience at all with the other  
15 drugs that were being used in this case, although  
16 obviously I'm aware of their general indication.  
17 As has been pointed out, I was confident that these  
18 notes were going to be reviewed by external experts and  
19 at least four external experts, paediatricians, went  
20 through the notes, both at the inquest and for the  
21 police investigation, and failed to identify the  
22 overdoses. So certainly I regret that I missed that.  
23 If I had identified it, then I would certainly have  
24 drawn attention to it at the time.  
25 THE CHAIRMAN: Dr Herron has said that if he had picked up

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1 a medical doctor.  
2 A. She's not a medical doctor, absolutely. So although  
3 she, I'm sure, went through the notes, she definitely  
4 could not have been expected to pick up any of these  
5 issues.  
6 MR STEWART: As you've fairly said, your review was focused  
7 on one issue and was comparatively quick. It wasn't  
8 comprehensive and wasn't perhaps as rigorous as  
9 a complete review ought to be.  
10 A. I conducted a rigorous review in the context of being  
11 asked to look at the role that hyponatraemia and fluid  
12 balance may have played in Claire's death. I wasn't  
13 asked to conduct a comprehensive review of her care.  
14 Indeed, if I had been asked to do that I would have  
15 declined because I'm very, very aware of the importance  
16 of anybody carrying out a review or acting as an expert  
17 to limit themselves to the areas of their expertise. My  
18 expertise, as I think I have shown and is apparent from  
19 my CV in relation to laboratory medicine and sodium  
20 fluid balance, I think is very high. But I simply don't  
21 have expertise on some of the other aspects of Claire's  
22 care and I would not have agreed to carry out any review  
23 of her notes in that context.  
24 THE CHAIRMAN: One of the issues about what happened when  
25 Mr and Mrs Roberts contacted is hospital is what the

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1 that point, that in itself is a reason for a referral to  
2 the coroner --  
3 A. Certainly. There's a question --  
4 THE CHAIRMAN: -- because the extent of the overdose is  
5 significant.  
6 A. Certainly this question of the 120 milligrams or  
7 12 milligrams, whatever it was, certainly, absolutely,  
8 that would definitely have been an indication for onward  
9 referral, and if I had picked that up or identified it  
10 at the time, I would certainly have flagged that up with  
11 Dr McBride and subsequently.  
12 THE CHAIRMAN: Yes.  
13 MR STEWART: Your case note  
14 review was the sole case note review conducted on behalf  
15 of the hospital at that time.  
16 A. I am not aware of any other case note review which was  
17 carried out or any intention to carry out another case  
18 note review. Obviously, the notes were looked at by,  
19 I believe, Dr Steen and Dr Sands, who eventually  
20 attended the meeting with me. They would have been  
21 looked at by Dr Nichola Rooney as well, but Dr Rooney  
22 would not have had relevant expertise at all in terms of  
23 identifying or commenting on any of the medical  
24 issues --  
25 THE CHAIRMAN: Because, although she is a doctor, she is not

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1 extent of the review was. You've just distinguished  
2 between the review which you were asked to do and the  
3 one which you could do, on the one hand, between that  
4 and a comprehensive review on the other hand.  
5 Dr McBride has said that with hindsight it might have  
6 been better for him to have instigated what was then  
7 known and had come in a few years earlier as  
8 a root-cause analysis. Have you been involved in  
9 root-cause analysis in any cases?  
10 A. No, I'm aware of root-cause analysis and that they are  
11 carried out. I have never been involved in a root-cause  
12 analysis within the Trust.  
13 THE CHAIRMAN: On a general approach, do they typically  
14 involve more than one person, because it does call on  
15 various expertise?  
16 A. Very much. It's a multidisciplinary review of a case.  
17 I believe that on occasions it can involve an external  
18 person to the trust as well, but it is  
19 multidisciplinary. It would include not only medical  
20 staff and practitioners, but usually nurses, sometimes  
21 pharmacists, and perhaps other disciplines where they  
22 are relevant.  
23 THE CHAIRMAN: So whether we call this a comprehensive  
24 review or a root-cause analysis, then you could have  
25 contributed to that, but not done it?

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1 A. Yes, I think I could have made a very useful  
2 contribution to it in relation to the sodium and fluid  
3 balance.  
4 THE CHAIRMAN: Thank you.  
5 MR STEWART: Can you now recall the steps that took you to  
6 actually meet with Mr and Mrs Roberts? You telephoned  
7 your view to Dr McBride that indeed hyponatraemia was  
8 involved in this case. When were you told that it would  
9 be appropriate for you to meet Mr and Mrs Roberts?  
10 A. I can't remember that, but certainly when I reported to  
11 Dr McBride or shortly afterwards, there was a suggestion  
12 that a meeting should take place with Mr and  
13 Mrs Roberts, where I would explain the findings of my  
14 investigation. I was very happy to participate in that,  
15 but I can't remember exactly when that was agreed.  
16 Q. When you went to Dr McBride to give him your opinion,  
17 this is something you mentioned in your statement to the  
18 coroner, which we find at page 090-052-159 and 160.  
19 It's really the final paragraph of 160 I'd like to draw  
20 your attention to:  
21 "I informed Dr Michael McBride, the medical director  
22 of the Trust, that in my opinion hyponatraemia may have  
23 made a contribution to the development of cerebral  
24 oedema in Claire's case. I advised that it would be  
25 appropriate to consider discussing the case with

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1 the coroner's inquiry, that all of the relevant staff  
2 would give statements and that that would be done under  
3 the aegis of the coroner with, at that stage, the  
4 possibility that Claire's case might also be referred on  
5 to this inquiry, although I wasn't clear at that time  
6 the processes which this inquiry would follow.  
7 Q. When it came to preparing yourself to meet with Mr and  
8 Mrs Roberts, obviously from their point of view they  
9 wanted answers to questions, they wanted  
10 straightforward, honest answers to questions. Did you  
11 think that you were adequately prepared to go and meet  
12 them and answer their questions without an independent  
13 review and without yourself having studied all the notes  
14 rigorously from all angles?  
15 A. Well, at the meeting it was decided that -- and  
16 eventually Dr Steen and Dr Sands and myself attended the  
17 meeting. I was there and certainly had the expertise to  
18 comment on the fluid management and electrolyte issues,  
19 and I believe that Dr Steen and Dr Sands, who were both  
20 paediatric consultants at that time, had the expertise  
21 to comment on the other aspects of Claire's care. It  
22 didn't occur to me at the time that there would be any  
23 need for another independent external view and indeed  
24 I did feel adequately prepared to address the issues  
25 I was going to address in the context of the meeting,

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1 the coroner for an independent external opinion with  
2 access to statements from all of the staff involved in  
3 Claire's care."

4 So you had a bit of a discussion with him. Did you  
5 think this was an appropriate case to get an external,  
6 independent expert view?  
7 A. What I believed would happen -- and I have to say that  
8 this is the only coroner's case I've ever been involved  
9 with in my career -- but I believed that, yes, it would  
10 be appropriate to have an external opinion on Claire's  
11 care and that that would occur in the context of  
12 the coroner's inquiry. That is what I believed at the  
13 time.  
14 Q. Did it occur to you that you could get an external  
15 independent opinion notwithstanding that the coroner was  
16 involved in the case?  
17 A. Since I believed it was going to go to the coroner's  
18 court and that he would get external opinions, I didn't  
19 think that there was any need for another independent  
20 external opinion in parallel to that.  
21 Q. What about the suggestion that all the staff involved in  
22 Claire's case all be asked to give statements? Did you  
23 think that's something that should have been doing  
24 irrespective of the coroner's referral?  
25 A. I understood that that would take place as part of

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1 given my very considerable experience and expertise  
2 in relation to sodium.  
3 Q. I wonder if we can just take an approach to the meeting  
4 itself by going through the e-mails and the various  
5 notes that chart the progress. Can I bring up page  
6 WS177/1, page 18? This is a note that Dr Rooney took.  
7 It's dated towards the bottom:  
8 "6 December 2004, P meeting. Professor young,  
9 Dr McBride and myself."  
10 It's timed at 8.30 am:  
11 "Discussed findings and potential role of fluid  
12 management in death."  
13 Do you recall that meeting at 8.30 in the morning of  
14 6 December 2004?  
15 A. No, I think I've already indicated that I have no  
16 recollection of that meeting. Having seen written  
17 confirmation that it took place, I'm certain that it  
18 did, but I have absolutely no recollection of it at all.  
19 Q. Do you have any recollection as to why Dr Steen wasn't  
20 at that meeting?  
21 A. I have no recollection of the meeting or who attended or  
22 who didn't.  
23 Q. Move down to the next line, 2 pm, there's a further  
24 meeting, the same day:  
25 "Dr Steen, Professor Young and myself met to plan

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1 for meeting."  
2 And it goes on into page 19:  
3 "Agreed that Dr Steen will set context with patient  
4 journey. Professor Young will answer specific questions  
5 relating to fluid management and sodium levels and  
6 explain plan of Trust re coroner. Parents to be offered  
7 follow-up meeting to discuss further questions."

8 Do you have any recollection of that meeting on the  
9 afternoon of 6 December?

10 A. Yes, I do. I do have some recollection of that meeting,  
11 yes.

12 Q. What do you remember?

13 A. My recollections of it are that, firstly, I had carried  
14 out and completed my investigation, my assessment of the  
15 role that hyponatraemia may have played in Claire's  
16 death. Looking now at the records and the fact that  
17 there was a meeting earlier that morning with  
18 Dr McBride, I accept that his recollection is correct  
19 and I assume that, at that meeting, I would have  
20 informed him of the outcome of my investigation.

21 THE CHAIRMAN: That's what Dr Rooney summarises as findings,  
22 "Discussed findings"?

23 A. Yes, that's what I would assume that means and  
24 I definitely remember telling Dr McBride my findings and  
25 I thought it was by phone. I now accept that my

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1 of more difficult consultation. So particularly  
2 a consultation where you were breaking bad news -- and  
3 there was an element of the meeting that was going to  
4 take place, which involved us breaking bad news.  
5 Secondly, a consultation where you were aiming to get  
6 across a large amount of complex information, and  
7 we were definitely going to be doing that in relation to  
8 the meeting. And third, a consultation or meeting where  
9 there was more than one person present, and I was  
10 expecting to meet both Mr and Mrs Roberts.

11 So I felt it was going to be a difficult  
12 consultation in that context and my experience of those  
13 consultations is that they work most effectively if  
14 there's one person there who is handling and dealing  
15 with all of the communication. So my preference would  
16 have been to do the meeting myself with Nichola Rooney  
17 there primarily to support the family and to take notes  
18 and minutes.

19 THE CHAIRMAN: That meeting would deal with the issue which  
20 you could deal with and, if there then needed to be  
21 a separate meeting with Dr Steen, that could go ahead  
22 again with Dr Rooney leading that?

23 A. Yes, it could have done, absolutely. And this is not at  
24 all a criticism of Dr Steen, but I was aware that  
25 Dr Steen and myself maybe have different communication

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1 recollection was incorrect.

2 MR STEWART: It could be both, of course: you could phone  
3 him and then discuss at a later date.

4 A. Perhaps, I don't know. But clearly, a meeting took  
5 place. My recollection of the meeting in the afternoon  
6 is that I was there to tell Dr Steen my findings and to  
7 discuss how to deal with the meeting with the Roberts  
8 family. I believe that my preference at the time -- and  
9 this is I think somewhat borne out by the wording of  
10 a subsequent e-mail -- would have been to meet with the  
11 Roberts family just with Nichola Rooney.

12 I had worked with Nichola previously in the context  
13 of another very difficult set of circumstances. I had  
14 great confidence in her professionalism and we worked  
15 very well together. So I was keen to meet with the  
16 Roberts family just with Nichola.

17 Q. Was there anything about Dr Steen's presence that would  
18 have discomfited you?

19 A. I anticipated that the meeting with the Roberts family  
20 was going to be a difficult one. Let me clarify what  
21 I mean by that. One of my other teaching  
22 responsibilities back in the 1990s was teaching  
23 communication skills to the undergraduate medical  
24 students and we approached consultations in different  
25 ways, and we defined certain characters, certain types

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1 styles and also felt that I would have preferred to use  
2 my own style and approach on its own in the meeting.

3 Whenever we had the meeting in the afternoon, there  
4 was clearly some discussion about the best way to handle  
5 it. Dr Steen, I think, put the view quite strongly that  
6 it was important to be prepared and able to talk about  
7 the clinical journey -- I think that is the phrase which  
8 is used -- which were the events that happened during  
9 Claire's care and the other conditions which she had,  
10 which were outside my immediate expertise.

11 THE CHAIRMAN: That would be a broader discussion?

12 A. Yes. So around the encephalitis, for instance, and the  
13 status epilepticus where I would have had virtually no  
14 experience of those conditions in children, although  
15 some experience of them in adults. We clearly had some  
16 discussion about it and decided at the end that the best  
17 way to proceed was as described and as subsequently  
18 happened, with us all present, and indeed Dr Sands was  
19 present as well.

20 MR STEWART: Yes. So immediately after your meeting with  
21 Dr Rooney and Dr Steen, almost immediately afterwards,  
22 you sent an e-mail to Dr Michael McBride. That's at  
23 139-153-001. It's the lower part of the page, it's at  
24 17.36:

25 "Michael. We met with Heather Steen this afternoon

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1 and reached a measure of agreement about the role of the  
2 hyponatraemia. She wants to be present at the meeting  
3 tomorrow and will deal with any questions about the  
4 clinical journey while I deal with the fluid issues.  
5 Hopefully this will work. Heather has definite views  
6 about the significance of the fluid management that are  
7 not quite the same as mine."

8 In relation to this measure of agreement on  
9 hyponatraemia and a differing of views about fluid  
10 management, can you now remember what those divergent  
11 views were?

12 A. I can, yes. In Claire's case, my feeling, reviewing the  
13 notes, had been that there were three significant  
14 conditions or processes which were taking place. And  
15 this is subsequently being teased out and discussed at  
16 some length, with conflicting views, from a range of  
17 experts. There was status epilepticus, there was  
18 a viral encephalitis and then there was hyponatraemia.

19 All three of those conditions can cause cerebral  
20 oedema. There was absolutely no doubt or dispute that  
21 cerebral oedema had been the ultimate cause of Claire's  
22 death. My view was that the hyponatraemia may well have  
23 made a significant contribution to the development of  
24 the cerebral oedema, although I could not quantify that,  
25 and indeed I think there's still great difficulty

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1 A. As I've indicated previously, I believe that fluid  
2 management and hyponatraemia are so intricately entwined  
3 in this context that I wouldn't really have  
4 distinguished between them when writing this e-mail.

5 Q. So you informed Dr McBride that there was not complete  
6 unanimity of approach, there was a differing of opinion.  
7 Did that trouble you in terms of going to meet the  
8 Roberts, that you'd be giving an explanation, which  
9 might not be the same explanation?

10 A. Not at all. It was agreed that the explanation that  
11 would be given would be mine in relation to the fluid  
12 and electrolyte balance, not Heather's opinion. That's  
13 what discussed in the minute: Heather would cover the  
14 clinical journey and I would deal with the fluid and  
15 electrolyte balance. So it was going to be my opinion  
16 which would be given on that issue.

17 Q. I can understand the importance of that, but would it  
18 not have been more honest with the Roberts to let them  
19 know that "we're not agreed here"?

20 A. The purpose of the meeting, as far as I was concerned,  
21 was to present the result of my view. If Heather did  
22 disagree with it -- and she will speak to that  
23 herself -- I think it would have been up to her.

24 THE CHAIRMAN: But she did disagree with it.

25 A. Yes, but the extent to which she disagreed with it --

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1 agreeing what its contribution might have been.

2 My recollection is that Heather, while acknowledging  
3 that the hyponatraemia may have played a role, felt it  
4 was less likely than me and felt that the  
5 status epilepticus or the encephalitis, particularly the  
6 encephalitis, would have been almost a sufficient cause  
7 on its own. So Heather probably felt that I was putting  
8 a little bit too much emphasis on the possible role of  
9 hyponatraemia, although she accepted that it had played  
10 some role with the hindsight that was available from  
11 2004.

12 I should say at this stage that my view was in no  
13 way at any stage modified by Heather's opinion, nor was  
14 anything that I subsequently said, either at the meeting  
15 with the Roberts family or at the inquest, modified by  
16 Heather's opinion or that of any of the matters. The  
17 opinion I reached was exclusively and completely my own  
18 based on my review of the records and clinical opinion.

19 MR STEWART: Thank you. You go on in this e-mail to say  
20 that:

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

24 What was the difference of views in relation to  
25 fluid management as opposed to hyponatraemia?

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1 I'm giving you my recollection of it and you know, these  
2 are events that were some time ago.

3 THE CHAIRMAN: Yes, I understand.

4 A. And she will have to give her own view on that because  
5 clearly the two of us have not discussed it and I don't  
6 know what she will say on this issue. But the purpose  
7 of the meeting, so far as I was concerned, was to give  
8 my view, which was on the fluid -- the fluid and  
9 electrolyte balance and the hyponatraemia, which was the  
10 view given to Dr McBride, based on which he had made the  
11 decision to refer Claire's case to the coroner.

12 MR STEWART: When you informed Dr McBride in relation to  
13 Dr Steen, "She wants to be present at the meeting  
14 tomorrow", did that reflect the feeling that you'd be  
15 happier doing it by yourself?

16 A. Yes.

17 Q. Then you introduced how you were going to deal with it  
18 and you expressed the view that, "hopefully this will  
19 work".

20 A. Yes.

21 Q. What did that mean? What would work?

22 A. The way that we were proposing to deal with the meeting  
23 in terms of me handling the communication about the  
24 fluid and electrolyte balance and Heather handling the  
25 clinical journey. I have already discussed and

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1 described the reasons why I would have preferred to do  
2 the meeting on my own and I was concerned about the  
3 practicalities of how the meeting would work for the  
4 reasons I've described.  
5 Q. Does it really mean: hopefully then, Dr McBride, Mr and  
6 Mrs Roberts won't realise that there's a disagreement  
7 here, that I don't agree with Dr Steen?  
8 A. Not at all, it absolutely does not mean that. It means  
9 that hopefully between the two of us we'll be able to  
10 give the correct and accurate information to Mr and  
11 Mrs Roberts that they need in an effective way and in  
12 a way that they can understand clearly.  
13 Q. It goes on:  
14 "Nichola will offer the parents the opportunity to  
15 speak with me separately if they wish to."  
16 Just to go forward, were Mr and Mrs Roberts offered  
17 the opportunity to meet with you separately at the  
18 meeting?  
19 A. I believe the answer to that is yes. We'd have to go on  
20 to the note of the actual meeting itself and, from  
21 memory, I believe at the very end that the possibility  
22 of a future meeting was offered. Certainly, I was very  
23 keen that the Roberts family have the chance to meet  
24 with me subsequently if they wanted to, and if they had  
25 any questions that they wanted asked, I would have been

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1 A. Absolutely. That's what I felt, yes.  
2 THE CHAIRMAN: But the other element then is that you -- was  
3 it from the 2 o'clock meeting on 6 December? Was that  
4 when you learned that there was a difference of view  
5 between you and Dr Steen about the extent to which  
6 hyponatraemia may have contributed?  
7 A. Yes, and I wouldn't want this to be overinterpreted. It  
8 was a difference of emphasis.  
9 THE CHAIRMAN: Okay.  
10 A. Three contributory factors. I was placing somewhat more  
11 weight on the fluid balance and sodium than Dr Steen  
12 would have done.  
13 THE CHAIRMAN: Doesn't that actually become an additional  
14 reason, at least with the benefit of hindsight, for  
15 there to be a separate meeting? Because not only  
16 do you have an extra person there, not only do you have  
17 a different style of communication there, but you have  
18 a different interpretation, to some extent at least, and  
19 explanation of what happened to Claire?  
20 A. I think I can see that argument and I would accept that.  
21 At the time, what we were doing -- what I was trying to  
22 do, I think was to weigh up the advantages and  
23 disadvantages.  
24 THE CHAIRMAN: Because it means a second meeting?  
25 A. Yes, it means a second meeting, and the risk therefore

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1 happy to do that.  
2 Q. I don't think that's recorded in the minute, but did you  
3 say that to them?  
4 A. I haven't -- can we call the minute up and the end of  
5 it? I can't actually remember.  
6 Q. We will and we'll examine it with all the other  
7 questions that arise from that.  
8 THE CHAIRMAN: Just before we get that, your preference, as  
9 you've expressed it over the last few minutes, was that  
10 you would have a meeting with Dr Rooney and the Roberts  
11 with effectively just the four of you. And partly, as  
12 I understand it, one of the reasons for that is because  
13 you had a different communication style from Dr Steen  
14 or, for that matter, you have a different communication  
15 style to anybody else.  
16 A. Yes.  
17 THE CHAIRMAN: It wouldn't matter who the other person was,  
18 you have a different communication style, you're giving  
19 parents information, which is perhaps not the  
20 information they want to hear, so it's going to be  
21 a difficult meeting for them.  
22 A. Yes.  
23 THE CHAIRMAN: Therefore if there's one style of  
24 communication coming at the parents, that might make it  
25 a bit easier for them to absorb.

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1 is greater of things being said not quite in the same  
2 way that appear to conflict. We were trying to weigh up  
3 the advantages and disadvantages, plus it was quite  
4 possible that if I met with Mr and Mrs Roberts on my  
5 own, they would have significant questions about the  
6 clinical journey or the encephalitis or the epilepsy,  
7 which I would not really have been qualified to address.  
8 THE CHAIRMAN: And then you run the risk of looking evasive  
9 or unhelpful, which is exactly the opposite of what you  
10 want to be?  
11 A. Exactly, yes.  
12 THE CHAIRMAN: Okay. Thank you.  
13 MR STEWART: Dr MacPaul has suggested that the fact that  
14 there was a disagreement between yourself and Dr Steen  
15 on some issues was itself a reason why you should have  
16 put your view in writing. How would you respond to that  
17 comment?  
18 A. I would say that the differences between Dr Steen and  
19 myself were differences of emphasis. If I'd felt that  
20 they were substantive differences, if I'd felt for  
21 instance that Dr Steen was, saying, "No, I don't accept  
22 hyponatraemia played a role here", then that would have  
23 concerned me. But at no stage did Dr Steen suggest that  
24 at all. Knowledge about hyponatraemia in the Children's  
25 Hospital had moved forwards enormously since 1996. It

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1 was clear that Dr Steen was well-informed and recognised  
2 the problem. What we were talking about in practice  
3 were quite subtle differences of emphasis and, indeed,  
4 as I look through the records of the inquiry to date,  
5 the differences between myself and Dr Steen were  
6 probably smaller than the differences that have emerged  
7 between the various expert witnesses to the inquiry.  
8 Q. At what stage did Dr McBride authorise you to speak on  
9 behalf of the Trust at the meeting arranged on  
10 7 December?  
11 A. I cannot remember. I cannot remember that. But  
12 clearly, I believe I was authorised to transmit the view  
13 of the Trust. And there's a note there, I think, that  
14 I would indicate to the family the decision that had  
15 been made around the referral onwards to the coroner.  
16 So clearly, that was information given to me and  
17 certainly I felt I was acting in that capacity when  
18 I met with the Roberts family.  
19 Q. Did that cause a problem for you, given that you were  
20 speaking on behalf of the Trust and yet Dr Steen wasn't  
21 quite of the same view as yourself, you had a difficulty  
22 there, a conflict?  
23 A. I didn't view that as a conflict. As I've said, the  
24 differences between Dr Steen and myself were ones of  
25 emphasis. I didn't view them as substantive at the

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1 said that to me. I think you will understand that one  
2 of the things which the inquiry is particularly looking  
3 at is not just how Claire died, but how that was handled  
4 afterwards.  
5 A. I do.  
6 THE CHAIRMAN: I think I have to be frank and say it doesn't  
7 look, on the evidence to date, as if things were handled  
8 very well in 1996. That's perhaps a generous  
9 description of what happened in 1996 and into early  
10 1997. Mr and Mrs Roberts then have concerns about what  
11 happened in late 2004 after they saw the television  
12 programme and contacted the hospital. And even then,  
13 what happened at the inquest. The point you made  
14 earlier about revelations which didn't emerge at the  
15 inquest, which have only emerged in this inquiry, and  
16 Mr and Mrs Roberts, I think, must be wondering how on  
17 earth this could all possibly have come about.  
18 I think we can agree it has come about very  
19 unhappily and messily and inadequately, and what I'm  
20 looking at -- I'm not assuming at this stage that you or  
21 anybody else behaved dishonestly or are lacking in  
22 integrity. What we're doing is probing whether any of  
23 that happened. I haven't made any findings at all along  
24 those lines yet.  
25 A. I recognise that, and obviously any upset that I or

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1 time. If there had been significant differences of  
2 opinion between us, then I think that would have given  
3 me a problem. But because there weren't, no, I was  
4 comfortable enough doing the meeting with Dr Steen and  
5 Dr Sands, although for the reasons I've indicated  
6 earlier, my balance, on preference, would have been to  
7 do it just with Dr Rooney.  
8 Q. And coming to 7 December and the meeting --  
9 A. Can I just make a comment?  
10 Q. Yes.  
11 A. Because I was very taken aback and somewhat distressed  
12 myself about the opening and some of the statements that  
13 were made there, particularly in relation, for instance,  
14 to this e-mail, the interpretation that was placed on  
15 it. I have built an entire career based on my integrity  
16 and honesty and I approach everything I do in that  
17 respect.  
18 I'm very, very unhappy that it has been suggested  
19 that there is a cover-up and that, effectively, it has  
20 been alleged that I participated in that and I want to  
21 completely and utterly put it on the record that that is  
22 not the case, never has been the case. In everything  
23 that I have done here, I have attempted to act in an  
24 open, honest and professional way.  
25 THE CHAIRMAN: Professor, I understand why you have just

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1 indeed others might have felt at the way things have  
2 emerged in the inquiry is as nothing compared with the  
3 distress which the Roberts family have had and  
4 I absolutely recognise that. But I just wanted to put  
5 it on record, my complete and utter rejection --  
6 THE CHAIRMAN: Okay, I've got your point. Thank you.  
7 MR STEWART: I'm trying to explore your involvement in the  
8 steps that were taken. So going into the meeting on  
9 7 December, what documents did you have? You had the  
10 medical chart.  
11 A. I can't remember what documents were available in the  
12 meeting. I believe that the medical records were there.  
13 I believe that Dr Steen probably had them. I suspect  
14 I was working, as I often do, from memory.  
15 Q. Were you given a copy of Dr Steen's patient journey?  
16 A. I have no recollection of having been given a copy of  
17 Dr Steen's patient journey, as I think I've said before.  
18 Q. I wonder if WS177/1, page 34, be shown, please. This is  
19 a document, it's the first page of a three-page document  
20 exhibited by Dr Rooney to her witness statement, which  
21 we have assumed -- and until Dr Steen confirms it, it's  
22 only an assumption -- that this was the patient journey  
23 document that was used at the meeting for Dr Steen's  
24 exposition of Claire's case. Does that look familiar to  
25 you?

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1 A. No.  
2 Q. Did you have a copy of the autopsy report at that time?  
3 A. I can't say. I have seen this autopsy report.  
4 I definitely saw it at the time of the inquest.  
5 Q. Yes.  
6 A. But I can't say whether or not I had sight of it at the  
7 time of the meeting with Claire's parents.  
8 Q. It's a very relevant thing to have with you at the  
9 meeting in discussing the cause of her death, isn't it?  
10 A. I just can't recall. I may have had it. I am not  
11 saying I didn't have it.  
12 THE CHAIRMAN: Would you have had the autopsy report for the  
13 purposes of doing your case note review?  
14 A. I may well have had, but I honestly again can't  
15 remember. I can't remember what notes I had at the  
16 time. I remember the clinical notes and I've indicated  
17 the nature of my review at the time, which was focused  
18 very much on the events up until probably 3 am.  
19 THE CHAIRMAN: Okay.  
20 A. So I just can't remember.  
21 MR STEWART: If it wasn't there, would you have asked for  
22 it?  
23 A. Not necessarily in relation to the question I'd been  
24 asked to investigate or determine. I certainly would  
25 have been interested in it and because I've seen it

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1 to you for your approval after the meeting?  
2 A. I can't remember that. If indeed they were, there would  
3 be an e-mail trail, I'm sure, to show it.  
4 Q. We'll come to that:  
5 "Dr Rooney opened the meeting by introducing Mr and  
6 Mrs Roberts to Dr Steen, Dr Sands, Professor Young, and  
7 reassuring them that any questions they feel still  
8 remain unanswered regarding Claire's death will be  
9 addressed, adding that the Trust will meet with them any  
10 time to help them in any way possible. She went on to  
11 outline what she believed were Mr and Mrs Roberts' main  
12 areas of concern."  
13 And these are the main questions that it seems that  
14 the Roberts wanted answers to:  
15 "What led to her sudden deterioration after they  
16 left hospital that day? Was Claire's condition  
17 misdiagnosed? What role, if any, did Claire's fluid and  
18 sodium management play in her death?"  
19 So really, those are the questions, that's what they  
20 want an answer to, and really that's what you're there  
21 to answer for them.  
22 A. Yes. And those are the questions that I did my best to  
23 answer during the course of the meeting.  
24 Q. If you read through this minute, you don't find the word  
25 "deterioration" occur, nor the word "misdiagnosis"

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1 subsequently, I obviously know what it said. But I just  
2 can't remember, sorry.  
3 Q. Because, on the one hand, you open up the chart, you see  
4 that one of the diagnoses on discharge from PICU is  
5 hyponatraemia. You look at the medical certificate of  
6 cause of death, the cause of death entered by Dr Steen,  
7 and it just has "cerebral oedema, status epilepticus".  
8 You'd want to surely correlate the two and find out what  
9 the autopsy was before you went to meet the Roberts  
10 family, wouldn't you?  
11 A. So as I understood it, the purpose of the meeting was to  
12 let the Roberts family know that we would be referring  
13 Claire's case on to the coroner for the cause of death  
14 to be looked at. I think the purpose of the meeting was  
15 not to give the Roberts family a cause of death because,  
16 indeed, I was not in a position to do that.  
17 Q. I think they were there to find out what happened to  
18 their daughter.  
19 A. Absolutely, and in the course of the meeting I did my  
20 very best to give whatever information I had on that to  
21 them, based on the review of the notes which I had  
22 carried out.  
23 Q. Yes. If we can come, please, to the minutes of the  
24 meeting at WS177/1, page 58. Here we have the minutes  
25 circulated afterwards. Were these minutes actually sent

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1 occur, nor the word "hyponatraemia" occur. It seems to  
2 be an odd minute if you're discussing those issues.  
3 A. Firstly, if I talk in general terms about communication.  
4 I hadn't met the Roberts family before the before.  
5 Generally, whenever I communicate with patients, I try  
6 to avoid using technical or scientific language. That's  
7 usually the appropriate course of action. So certainly  
8 I would not have used the word "hyponatraemia", for  
9 instance, during the course of a meeting like this.  
10 I would have talked about sodium and low sodium. Did  
11 you have some other points there?  
12 Q. Can I ask you about that? This is in the light of the  
13 television broadcast where hyponatraemia is the word  
14 that's used. Do you not think that in those  
15 circumstances you might use it?  
16 A. I hadn't seen the television broadcast, as I've already  
17 indicated, and I also believe -- and I'm sure you'll  
18 correct me if I'm wrong -- that the Roberts family  
19 themselves hadn't mentioned hyponatraemia.  
20 Q. Can we go back to your initial introduction --  
21 A. There is hyponatraemia throughout the course of this  
22 document --  
23 Q. Yes.  
24 A. -- we're just not using the word "hyponatraemia". I've  
25 explained why. I view it as a technical or scientific

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1 word that is not a word I would use in normal  
2 communication with patients, at least in that era for  
3 sure.

4 THE CHAIRMAN: Sorry, let's just pause for a moment,  
5 professor, about two points.

6 One is: the hyponatraemia inquiry had been  
7 established by the time this meeting takes place, so  
8 hyponatraemia is a term which, however imperfectly  
9 understood, has now been raised to a level, which it  
10 wasn't raised to in the public's eyes before.

11 Secondly, if we can go back to page 56 of this  
12 document, please, when you said a moment ago ...  
13 I think you said that the Roberts family themselves  
14 hadn't mentioned hyponatraemia.

15 This note at page 56 is Mr Roberts' note of the  
16 meeting. At paragraph 1 he mentioned hyponatraemia  
17 in the third line "typical of hyponatraemia". So  
18 whether Mr Roberts' understanding is perfect or  
19 otherwise, hyponatraemia is a term he's using in his own  
20 note of the meeting.

21 A. My understanding of this is -- I'm just trying to  
22 explain my approach to the meeting. I had never met the  
23 Roberts family before, I had no idea of their likely  
24 educational status or ability to understand complex  
25 language, et cetera.

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1 page:

2 "Professor Young joined in at this point, firstly by  
3 emphasising that he was involved in the case purely as  
4 an independent adviser."

5 Did you say that?

6 A. I can't remember the exact words that I would have used  
7 in the meeting, but since it's written here then I may  
8 well have said it. I would accept that or indeed --  
9 yes, I think probably, and I may have been introduced  
10 in that capacity, I can't remember.

11 Q. Do you understand the difference between being  
12 independent and being seen to be independent?

13 A. I do understand the difference, yes.

14 Q. Would it, in those circumstances, have been important  
15 for you to tell them that whilst you're independent of  
16 view, you were nonetheless employed by the same employer  
17 as Dr Steen and so forth?

18 A. My understanding was that the Roberts family were  
19 already aware of who I was ahead of the meeting. What  
20 I'd like to do, if I can, is to refer back to the  
21 governance summary opening. I think it's paragraph 377,  
22 from memory. This is where I may need some assistance  
23 if I've not got this. I don't know if we can get it up  
24 on the screen.

25 Q. I'm not sure I can assist you in that regard.

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1 THE CHAIRMAN: Right. You meet parents, some of them are  
2 very well educated and some of them aren't.

3 A. Indeed. In general terms, my approach to communication  
4 with patients is to use non-technical language, which  
5 I think is good practice to try and get across the  
6 concepts. I can't say whether I used the word  
7 "hyponatraemia" in the meeting or not. I was responding  
8 to the comment that the word "hyponatraemia" doesn't  
9 occur in Dr Rooney's note of the meeting, and that's  
10 absolutely correct and I'm trying to explain why that  
11 might be. I completely accept that Mr Roberts in his  
12 letter, I think from the next day following the meeting,  
13 has used the word "hyponatraemia", and I suspect that  
14 we would have addressed that subsequently and directly.

15 Certainly, if there's any sense of a desire on our  
16 part in the meeting to avoid using the word  
17 "hyponatraemia", then I would completely refute that.  
18 My whole recommendation was that the case would be  
19 referred on to the coroners.

20 THE CHAIRMAN: Because of hyponatraemia?

21 A. Because of hyponatraemia and, indeed, subsequently to  
22 this inquiry. That's also mentioned.

23 THE CHAIRMAN: Okay, thank you.

24 MR STEWART: I wonder if we can go forward to page 59. This  
25 is where you introduce yourself. It's halfway down the

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1 THE CHAIRMAN: We'll find out over lunch about getting it  
2 put up on the screen. If you want to take me to the  
3 point, do you have that opening there?

4 A. Yes. So paragraph 377 in the opening is Mr Roberts  
5 talking about what had happened. It says in the middle  
6 of that -- I think relating to a phone call on Monday  
7 22 November:

8 "Dr Rooney also advised me that another senior  
9 consultant would be reviewing Claire's fluid  
10 management."

11 THE CHAIRMAN: Right. So you're saying, since Mr Roberts  
12 says that's what Dr Rooney told him and since you were  
13 the person who appeared at the meeting having reviewed  
14 Claire's fluid management that they would know from that  
15 that you were a consultant?

16 A. I can't remember how I was introduced at the meeting.  
17 But I believe and always thought it was clear that,  
18 while being a professor of medicine at Queen's  
19 University, which is my primary appointment, that I also  
20 had a post and a role in the hospital.

21 THE CHAIRMAN: Okay.

22 A. And indeed, I think that's consistent with what's in  
23 paragraph 377 of the opening.

24 MR STEWART: 377 goes on to say:

25 "Dr Rooney advised me that she would like the

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1 medical director, Dr McBride, and a professor from  
2 Queen's, Professor Young, to look at the document."  
3 So it looks as though from Mr Roberts' recollection,  
4 you were being introduced as a professor from Queen's  
5 and if we go to the top of page 58 here, we can see  
6 in the minutes, a record of those present at the  
7 meeting:  
8 "Ian Young, professor of medicine, Queen's  
9 University of Belfast."  
10 A. And that's correct. That is my title and my primary  
11 role.  
12 Q. So I take it you don't think you told the Roberts that,  
13 in fact, you were employed by the Trust?  
14 A. I can't remember. I believe I was introduced --  
15 I believe it was clear, I felt it was clear and it  
16 didn't occur to me otherwise and from paragraph 377, to  
17 which I'd referred, I think Mr Roberts had been told  
18 that a senior consultant would be reviewing the fluid  
19 balance.  
20 Q. Whether that was you or not or was something that was  
21 said is a matter for the chairman.  
22 A. I think I was the only other person who did review the  
23 fluid balance, to the best of my knowledge. I'm not  
24 aware of anybody else having reviewed it.  
25 Q. Did you explain to those present the limitation on your

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1 Q. You can see the problem. The minute records you  
2 emphasising that you're involved in the case purely as  
3 an independent adviser; on the other hand, Dr McBride  
4 recalls authorising you to speak on behalf of the Trust.  
5 There's an apparent contradiction there.  
6 A. Yes. I think obviously I need to address what my view  
7 of that was and why I felt that I was there as an  
8 independent person. Firstly, I had absolutely no prior  
9 knowledge of Claire's case or management and was  
10 completely independent of the clinical team. Secondly,  
11 I was based within Queen's on the Royal site and also  
12 all my clinical work was in the adult hospital, it was  
13 exceptional for me to be in the Children's Hospital.  
14 Thirdly, I clearly had the expertise and knowledge to  
15 provide an opinion into the contribution of sodium and  
16 fluid balance in Claire's case.  
17 There were, at that stage, probably two other  
18 chemical pathologists working in the hospital, both of  
19 whom had clinical commitments in the Children's  
20 Hospital. I was the one who didn't have those  
21 commitments. So on all of those accounts I was --  
22 I think I had the right expertise and distance from the  
23 case to provide an independent view on it.  
24 Q. In terms of presentation, do you think it might have  
25 been better to have given the indication that you were

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1 remit in terms of reviewing the case notes?  
2 A. I think that -- absolutely. I felt that it was clear  
3 that I was focused on the fluid balance and the sodium.  
4 That's the only thing that I talked about, I believe,  
5 within the context of the meeting. If I can go back --  
6 THE CHAIRMAN: If you pause there for a moment, if we go to  
7 page 59 in this document again, I presume you would say  
8 that the minutes support you on this because, if you  
9 look directly above the line, "Professor Young joined  
10 in", the line above that is:  
11 "Mr Roberts queried whether administering the fluids  
12 had influenced her condition."  
13 And that's the point at which you are specifically  
14 noted as having joined in. So you would say that that  
15 bears out that the meeting had started without your  
16 input pretty much and then, when it got to the specific  
17 point about fluid management, it was at that point that  
18 Dr Rooney turned to you or you intervened and you joined  
19 in.  
20 A. Yes, thank you.  
21 MR STEWART: Did you tell the Roberts family that you were  
22 authorised to speak on behalf of the Trust?  
23 A. Again, I can't remember what exactly I said. All I have  
24 is the note of the meeting here. So if it's recorded  
25 here, then yes, I'm sure I did.

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1 independent of mind, but not necessarily independent of  
2 the Trust?  
3 A. It wasn't a distinction which, I must admit, I made in  
4 my mind at the time. I'm relatively used to seeking  
5 independent opinions within the Trust in the context of  
6 my work as the chair of the clinical ethics committee --  
7 although it's not relevant to this case at all -- but  
8 particularly in the area of withdrawal of treatments  
9 towards the end of life. The GMC have issued guidance  
10 on that and they refer to seeking a second opinion from  
11 an independent -- and they use the word "independent" --  
12 senior consultant who will often be someone from  
13 a different discipline. That's what's advised in those  
14 very difficult circumstances. Certainly, I felt that  
15 was analogous to the sort of role that I was performing  
16 in this case. Indeed, I did give independent advice,  
17 I gave very clear advice that that case should be  
18 referred on for an independent external opinion, which  
19 I've put in writing and I thought that that was going to  
20 take place through the coroner.  
21 Q. Well, I suppose we can all bandy advice around --  
22 A. I'm not quite sure what that means.  
23 Q. Well, can I introduce you to page WS061/2, page 422?  
24 This is a Department of Health circular on the reporting  
25 and following up of serious adverse incidents. It

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1 derives from June 2004 and can I bring you to page 425  
2 at paragraph 13?

3 "In those situations where a body considers that an  
4 independent review is appropriate ..."

5 And you were brought in to review and you're  
6 claiming to be independent:

7 "It is important that those who will be conducting  
8 it are seen to be completely independent."

9 "Seen to be completely independent", that seems to  
10 be the Department of Health's view of what might be  
11 appropriate and best practice. Would you agree that  
12 that probably represents good sense?

13 A. I think this document is in the context of serious  
14 adverse incident reporting; am I correct?

15 Q. Yes.

16 A. So I accept absolutely, in the context of serious advert  
17 incident reporting, that that was the view of the  
18 department in 2004, yes.

19 THE CHAIRMAN: Then that leads us back into the question of  
20 the extent of the review which was prompted by Mr and  
21 Mrs Roberts contacting the hospital. That's really not  
22 an issue for you, with respect, professor; that's really  
23 an issue for Dr McBride.

24 A. At no stage, certainly, did I think I was looking at any  
25 sort of serious adverse incident or being asked to

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1 A. I think I've already indicated in response to your  
2 earlier question that I don't think I had a copy of the  
3 patient chart.

4 Q. The next question is: were you sufficiently and  
5 adequately prepared for that meeting?

6 A. Certainly. In terms of addressing fluid and electrolyte  
7 balance and the role that it may have played in Claire's  
8 death, then I was absolutely completely and properly  
9 prepared for it. I think what we're talking about now  
10 is the accuracy of a minute, we're not necessarily  
11 talking about the information that was given to Claire's  
12 parents in the meeting. So I can't comment on whether  
13 this is an accurate minute of what was said or whether  
14 it's a mistake in the minute.

15 Q. We can go back to the patient journey -- I won't do  
16 that -- but it also had inaccuracies contained within  
17 it. If those mistakes were given as part of the patient  
18 journey in that meeting, would you agree with me it's  
19 not a very good bit of work?

20 A. I have no recollection of whether those inaccuracies  
21 were given in the context of the clinical journey or  
22 not. It's clear from the minute of the meeting -- and  
23 is also my recollection -- that Dr Steen was handling  
24 this part of the meeting and giving the details about  
25 the clinical journey. If indeed she gave inaccurate

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1 conduct a review of a serious adverse incident. To be  
2 honest, I'm not sure if in 2004 I would have been aware  
3 of this document.

4 MR STEWART: No, you may be forgiven because I don't think  
5 Dr McBride necessarily was either.

6 Can we look, please, at the first page of the  
7 minute, which is WS177/1, page 58? I'm interested  
8 in the quality of the information which was given to  
9 Mr and Mrs Roberts. I'm interested also in the accuracy  
10 of the minute itself. If we go down to halfway down the  
11 page, to the paragraph:

12 "Claire arrived in A&E on the evening of Tuesday  
13 21 October. The history given to staff was vomiting in  
14 school that day ... Claire arrived at A&E at around  
15 8 pm."

16 There are a number of seeming inaccuracies in this  
17 short portion of paragraph. It wasn't Tuesday  
18 21 October, it was Monday 21 October, and the history  
19 recorded there is certainly not one that she had been  
20 vomiting in school that day. She didn't arrive at  
21 Accident & Emergency at 8, she arrived at 7, and so  
22 forth. By the time the patient journey was being  
23 outlined to Mr and Mrs Roberts by Dr Steen, had you got  
24 a copy of the chart before you, were you able to spot  
25 that this wasn't perhaps necessarily accurate?

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1 information at the time of the meeting and I failed to  
2 pick that up, then clearly I'm sorry and I would  
3 apologise for that. I would have thought, however, that  
4 if she had actually said, for instance, that Claire was  
5 admitted on Tuesday evening, then Mr and Mrs Roberts  
6 would, in the meeting, have corrected that.

7 THE CHAIRMAN: Maybe we're looking at two slightly different  
8 things. One is that when you're in a meeting like this,  
9 you have a significant message which you want the  
10 parents to receive.

11 A. Mm.

12 THE CHAIRMAN: So some of what might be regarded as the  
13 smaller details might not affect them receiving that  
14 important message from you. But isn't one of the  
15 important things whether, particularly for doctors --  
16 and for lawyers too for that matter -- that you engender  
17 the confidence of the people you're meeting by getting  
18 the facts right?

19 A. I think that's absolutely correct. And if there are  
20 inaccuracies in this minute, then I greatly regret that.  
21 As I say, there are two slightly separate things here  
22 I think. One is the information that was given to the  
23 Roberts family at the meeting and the second is the  
24 minute of the meeting. I guess all I'm trying to say  
25 is that the two are not necessarily the same. It could

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1 be that inaccurate information was given. I certainly  
2 wasn't aware of that at the time; I would have corrected  
3 it. It could be that the minute of the meeting is  
4 inaccurate in terms of some of the details. I know that  
5 if I had reviewed this minute -- and I'm not saying  
6 I did or didn't because I can't remember. I know if  
7 I had reviewed this minute that I would have been  
8 focused very much on the second half, the parts where  
9 I was talking about the fluid and electrolyte balance.  
10 THE CHAIRMAN: Mr and Mrs Roberts, I have never got the  
11 impression that they want us to dwell or focus on  
12 insignificant, minor errors -- that cannot possibly be  
13 Mr and Mrs Roberts' main concern -- but there is  
14 something of a recurring theme through the  
15 documentation, which is that once a fact gets into the  
16 records inaccurately, it stays there, doesn't it?  
17 A. Yes, absolutely, and other witnesses have commented on  
18 that. It's something that I regret, something that we  
19 all encounter in all clinical practice. You trace back  
20 a piece of information and it turns out somebody made  
21 a mistake six or seven clinic visits ago, but it's very  
22 easy for it to persist. It gets echoed.  
23 THE CHAIRMAN: And the problem is that in 99 cases out of  
24 100, it doesn't matter, but in Claire's case it's an  
25 aggravation for Mr and Mrs Roberts.

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1 and Mrs Roberts. And equally --  
2 THE CHAIRMAN: That's almost a perfect definition of what  
3 you did say to them in two lines, isn't it?  
4 A. Not quite. I don't know whether you want me to address  
5 that now.  
6 THE CHAIRMAN: Go on.  
7 A. I indicated earlier that one of my concerns in preparing  
8 for the meeting was the enormous amount of really quite  
9 complex information that we were going to be giving to  
10 the Roberts family. And that's based on a long  
11 experience of talking to patients and their families in  
12 difficult circumstances. There's a substantial evidence  
13 base around this, that -- particularly in  
14 emotionally-charged settings -- when you're  
15 communicating with people, they have more difficulty  
16 recalling exactly what information is given to them.  
17 What we would normally do or try do -- and if I'd  
18 been running the meeting myself, what I would have done  
19 is you give the important messages first because those  
20 are the ones that are most often accurately remembered.  
21 And then you go through the detail, you recap and  
22 summarise at the end, and then you'll send a record,  
23 a written form of the information of the meeting.  
24 Whenever I received the letter, the notes from the  
25 Roberts families, Mr Roberts the next day, I was amazed

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1 A. Absolutely. That's why I'm apologising if I failed to  
2 pick up on these things.  
3 THE CHAIRMAN: Okay. Can we break for lunch? Is that  
4 a good time? 2 o'clock, professor. Thank you.  
5 (1.02 pm)  
6 (The Short Adjournment)  
7 (2.00 pm)  
8 MR STEWART: Professor, back, if we may, to the minute of  
9 7 December 2004 meeting and a point that you raised  
10 before lunch about whether or not indeed it is a true  
11 and accurate minute.  
12 There were two things -- in fact, they were  
13 highlighted in the inquiry opening, so you may already  
14 be alerted to them. Mr and Mrs Roberts, after the  
15 meeting, were clearly of the view that you had stated  
16 at the meeting that the fluid administered to Claire had  
17 a definite input into her death and you'll find the  
18 quotation for that at 089-003-007.  
19 THE CHAIRMAN: Paragraph 10?  
20 MR STEWART: Paragraph 10:  
21 "Professor Young stated that the fluid type  
22 administered to Claire had a definite input into her  
23 death. He indicated that the input level would be  
24 difficult to quantify."  
25 Which was a very sort of clear recollection from Mr

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1 at just how much information they had been able to take  
2 on board, and I think that's of enormous credit to them  
3 and to their understanding of the situation. I would  
4 want to say that. There is, I think, a contemporary  
5 e-mail from me, and it's somewhere in the exchanges  
6 after this, between myself and Nichola Rooney -- I don't  
7 have the reference -- where I say that, unsurprisingly,  
8 they haven't quite fully understood exactly what we  
9 said.  
10 I can't find the reference there. I don't know if  
11 somebody else will have it, but I know it's somewhere in  
12 the record. Do we want to pause and find it?  
13 THE CHAIRMAN: If you go on making your point and we'll make  
14 a point of finding it before you finish.  
15 A. Clearly, whenever I received Mr Roberts' letter and  
16 questions, I felt the family had understood an enormous  
17 amount, much more than I would have expected, to be  
18 honest, in the circumstances. But there were some  
19 things that indicated -- that were just not quite right  
20 in their response that indicated that we hadn't  
21 successfully got some of the things across.  
22 As a really clear-cut example of that, if we look at  
23 point 9 at 089-003-007:  
24 "Professor Young explained that the fluid type would  
25 not be given to a patient today and that such patients

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1 would have their sodium levels reviewed every 1 to  
2 2 hours."  
3 That's definitely not something that I said. What's  
4 recorded in the minute is that I said 6 hours, and that  
5 would have been in the situation where somebody had  
6 significant hyponatraemia.  
7 So that's just a small example, an unsurprising one,  
8 of something that just wasn't quite picked up correctly  
9 in the meeting. I think the first two lines in number  
10 10 are another example of that.  
11 THE CHAIRMAN: Because of the reference to "type"?  
12 A. No, because of the use of the word "definite".  
13 THE CHAIRMAN: Okay.  
14 A. Because what I said was that it may have had an input  
15 into her death. I'm sure it had an input into the  
16 process by which the hyponatraemia developed, but I was  
17 not definite about whether it had contributed to her  
18 death or not. And for reasons I have given earlier,  
19 I was not really in a position to weigh up the  
20 contribution of the hyponatraemia along with the  
21 status epilepticus and the encephalitis to Claire's  
22 death, which is why I thought this needed to go on to  
23 the coroner and have other experts, external ones, look  
24 at it and comment on it.  
25 MR STEWART: We'll return to the point I'm pursuing in just

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1 WS177/1, page 45. At the second paragraph:  
2 "At the meeting, on my recommendation, we clearly  
3 indicated that, following our case note review and the  
4 expert opinion of Professor Young and others, we were  
5 significantly confident that their daughter's fluid  
6 management was a contributory factor to her death  
7 amongst the many others involved."  
8 So it's not definite, but confident. That's his  
9 version of what he thought was said.  
10 A. Yes. I think, obviously, Dr McBride wasn't present  
11 at the meeting --  
12 Q. Quite.  
13 A. -- and he has picked that up and I'm not sure he won't  
14 perhaps comment on how he formed that view. But I don't  
15 think I would depart significantly from it. I wouldn't  
16 have used the -- I think I would have said "reasonably  
17 confident". I couldn't have quantified the  
18 contribution, but I was reasonably confident that it  
19 would have contributed to her death. But you know,  
20 there's no way I would have used the word "definitely".  
21 Q. In other words, both Mr and Mrs Roberts and really you  
22 and Dr McBride are pretty clear that, at the meeting, Mr  
23 and Mrs Roberts were told that the fluid management may  
24 have had a contribution to the death.  
25 A. I believe what I said in the meeting is "may have made

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1 a second, but for completeness, the e-mail to which  
2 you have referred, WS177/1, page 47, of 13 December,  
3 from you to Doctors Rooney and Steen --  
4 A. And Dr McBride.  
5 Q. -- and copied in to Dr McBride:  
6 "I am happy to be guided by your view as to the  
7 family's wishes. Not surprisingly, they do not seem to  
8 have absorbed all of the information we gave them."  
9 Is that the e-mail?  
10 A. Yes, that's the e-mail I'm referring to. And that was  
11 my contemporary opinion, but I just want to put on the  
12 record: it is not in any way a criticism of the Roberts  
13 family because I was amazed by how much they had taken  
14 on board.  
15 THE CHAIRMAN: In fact, as you explained, it's a compliment  
16 to them that they've absorbed a lot, but not absolutely  
17 everything?  
18 A. That's certainly the sense in which it was intended.  
19 They did better than most people would have in those  
20 circumstances.  
21 MR STEWART: This is just to revert to the point I'm  
22 pursuing at the moment, which is one about the accuracy  
23 of the minute. In relation to that essential point you  
24 were making to the Roberts, Mr McBride has got his own  
25 view as to what was communicated to them. That's

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1 a contribution" and I was unable to quantify it.  
2 I would refer you to the minute of the meeting and the  
3 bottom of page 2 and the top of page 3.  
4 Q. Is that:  
5 "Professor Young explained the treatment today is  
6 very different"?  
7 A. No.  
8 THE CHAIRMAN: Just one second. So that everyone can  
9 follow, page 59 and 60.  
10 MR STEWART: Thank you.  
11 A. Maybe I'm looking at a different ...  
12 Q. Does it appear in the minute?  
13 THE CHAIRMAN: Are you looking for something else,  
14 professor?  
15 A. I am, I think. Yes, sorry, it's the third paragraph up  
16 on page 59.  
17 MR STEWART: The fourth bullet point; is that right?  
18 A. Yes, that bullet point there. That is the one. If you  
19 go down towards the bottom there.  
20 Q. "Professor Young feels"?  
21 A. Yes.  
22 Q. "Professor Young feels this may have contributed to the  
23 swelling of Claire's brain and therefore ultimately to  
24 her death, but that it was not possible to say to what  
25 extent. He added that fitting and a virus infection can

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1 also cause this."  
2 That's quite a long way from --  
3 A. I believe that is an accurate minute of what I said  
4 at the meeting.  
5 Q. So the fluid management may have contributed to the  
6 swelling, but it's not possible to say to what extent,  
7 but fitting could also cause it and a virus infection  
8 could cause it. It's not really very close to what the  
9 Roberts remember, nor to what Dr McBride reports as  
10 what was said.  
11 A. This is the minute of the meeting. Nichola Rooney and  
12 Dr Steen and Dr Sands, all of whom were also present, no  
13 doubt, can comment on whether they think it's an  
14 accurate minute or not. What I'm saying is that  
15 I believe this is an accurate minute, a record of what  
16 was said to the Roberts family. I'd like to highlight  
17 a couple of things since we're talking about it, and it  
18 relates to the fact that I didn't use the word  
19 "hyponatraemia" earlier, to which the chairman drew  
20 attention.  
21 This is very typical of my style of communication  
22 and I think it's accurately recorded. I talked about  
23 "fitting" rather than "status epilepticus". And  
24 I talked about "a virus infection" there rather than  
25 "encephalitis". It's typical of the way I would be

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1 determine the relative contributions of the three ...  
2 THE CHAIRMAN: Yes, but I just wanted to get this right in  
3 case I misunderstood it this morning. When you sent  
4 your e-mail to Dr McBride, the three issues were  
5 status epilepticus, encephalitis and hyponatraemia. You  
6 said:  
7 "All three can cause cerebral oedema, which in turn  
8 caused Claire's death. My view was that hyponatraemia  
9 made a significant contribution. Dr Steen thought that  
10 there was a difference of emphasis between [you]; she  
11 thought it was less likely than the other two."  
12 A. Yes. So if we imagine three slices of a pie making up  
13 the whole, the question is: what size are the three  
14 slices?  
15 THE CHAIRMAN: And that perhaps can never be measured. But  
16 your point is, when you're referring to  
17 status epilepticus and encephalitis, you're reflecting  
18 the views of others on those two issues. The one issue  
19 on which you contribute a view -- and you think it's  
20 a matter which was of some significance -- is the  
21 hyponatraemia.  
22 A. So from my own -- obviously, I'm a clinician. From my  
23 own general medical knowledge, I would have been aware  
24 that both status epilepticus and encephalitis could be  
25 causes of cerebral oedema. So what I was saying there

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1 trying to communicate this sort of information.  
2 THE CHAIRMAN: Yes.  
3 A. It's in line with what I have explained to you, that  
4 I felt there were three pathological processes which had  
5 contributed to the cerebral oedema, which was the  
6 ultimate cause of Claire's death; they were  
7 hyponatraemia, status epilepticus and encephalitis. And  
8 that's really what I'm trying to say there in what  
9 I would have considered to be lay language.  
10 THE CHAIRMAN: Does that mean that you are saying that you  
11 believe that Claire did have status epilepticus?  
12 A. No, and I was asked about this earlier in my witness  
13 statement. I do not have the expertise to determine  
14 whether or not Claire had status epilepticus. In saying  
15 that, I was relying on the opinion of a consultant  
16 paediatric neurologist, who had been looking after her,  
17 which was clearly recorded in her clinical notes.  
18 THE CHAIRMAN: And similarly with encephalitis?  
19 A. That is correct. So clearly, I had seen references to  
20 both of those conditions within her clinical notes,  
21 whenever I reviewed them. I was aware that those were  
22 the three processes which, in my opinion, could have  
23 contributed to cerebral oedema in her case and I was  
24 trying to get that across to the family and the fact  
25 that I felt further scrutiny, if that was required, to

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1 was reflecting that knowledge, but certainly I would not  
2 have had sufficient expertise to tease out the relative  
3 contributions in a child who I felt had been very  
4 seriously ill and where clearly the clinicians had been  
5 struggling to reach a definite diagnosis.  
6 THE CHAIRMAN: Thank you.  
7 MR STEWART: You felt able to give evidence to the coroner  
8 about the causes of death to be entered into the death  
9 certificate.  
10 A. I was specifically asked by the coroner, having listened  
11 to all of the evidence, what I would have written on the  
12 death certificate at the time, and I, along with I think  
13 all the other witnesses who appeared at the coroner's  
14 court, made an attempt at that.  
15 Q. And that was on the basis of what you had read and what  
16 you had heard as opposed to your own first-hand expert  
17 knowledge?  
18 A. Absolutely. It was based partly on my first-hand  
19 knowledge as regards the possible contribution of  
20 hyponatraemia, but also based on the two expert  
21 opinions, external ones, which I had read, and also the  
22 comments of the clinicians who were involved in the  
23 case. I think that the formulation which I came up  
24 with, which I don't have in front of me here, was in  
25 fact very similar to that of the two expert external

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1 paediatricians.  
2 Q. Can I ask you about whether any differences of opinion  
3 emerged as between you and Dr Steen at the meeting on  
4 7 December?  
5 A. During the meeting?  
6 Q. Mm.  
7 A. I was very much focused in the meeting at the  
8 information exchange and dealing with the questions that  
9 came back. So I certainly wasn't thinking about opinion  
10 or forming opinions during the course of the meeting.  
11 Q. There are a couple of sentences or paragraphs here at  
12 page 59 at the very bottom:  
13 "Professor Young explained that treatment today is  
14 very different. At the Royal Hospitals, lessons have  
15 been learnt regarding management of sodium levels in  
16 children, which is still not the case in many UK  
17 hospitals. Dr Steen added that textbooks still  
18 recommend previous thinking on fluids. Professor Young  
19 continued that the use of fifth-normal saline is in fact  
20 now banned in the Royal Belfast Hospital for Sick  
21 Children, with a different type of fluid used today to  
22 avoid ..."  
23 That sounds as though you were having an exchange of  
24 views and you really are sort of correcting her a bit.  
25 A. Not at all. It doesn't read like that to me at all.

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1 experiences which led to the guidance, right?  
2 A. It's because of the lessons which had been learned --  
3 THE CHAIRMAN: And Dr Steen then says:  
4 "The textbooks still recommend previous thinking on  
5 fluids."  
6 And that's either an indication that we are now  
7 ahead or a way of saying -- a different, defensive  
8 interpretation.  
9 A. Sorry, I now understand the point, I do. Thank you.  
10 No, certainly my recollection of the meeting -- and this  
11 is the first time that possible interpretation has ever  
12 occurred to me, and I've read this minute quite a few  
13 times. My clear recollection of Dr Steen's comment was  
14 that textbooks, which other people are using, still  
15 recommend this, but because of what has happened in  
16 Northern Ireland and the lessons we have learned, we  
17 have moved on and are doing something different.  
18 THE CHAIRMAN: Yes, okay.  
19 MR STEWART: There's another example of a possible differing  
20 of a line, and that's page 61. The second paragraph,  
21 third line down:  
22 "The professor added that with the viral infection,  
23 seizures and fluids administered, it is difficult to say  
24 what their relative contribution would have been.  
25 Dr Steen also added that it is very difficult to

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1 THE CHAIRMAN: Let me pick that up from Mr Stewart.  
2 The lessons which you've referred to as having been  
3 learnt, "which is still not the case in many UK  
4 hospitals", by the time this meeting is taking place,  
5 Raychel Ferguson has died, and the department has put  
6 together a committee, which has brought out the  
7 hyponatraemia guidelines.  
8 A. That's correct, yes.  
9 THE CHAIRMAN: And that's what you are referring to there,  
10 is it?  
11 A. Absolutely. Although this inquiry is dealing with  
12 tragic cases, tragic circumstances, many avoidable,  
13 Northern Ireland, in many ways, led the world in terms  
14 of developing the guidelines.  
15 THE CHAIRMAN: Absolutely.  
16 A. And some of the literature, which I refer to in my  
17 previous papers clearly highlights that in other  
18 countries, probably even other parts of the UK, many  
19 children continue to die from hyponatraemia when  
20 Northern Ireland had guidelines in place.  
21 THE CHAIRMAN: I think this is the point that Mr Stewart was  
22 asking you about a reading of this paragraph -- and what  
23 he was really asking you to comment on was this: that  
24 sentence, which has you saying that it's still not the  
25 case in many UK hospitals, that's because of our unhappy

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1 evaluate how much the fluids contributed to the  
2 situation."  
3 It sounds as though she's trying to undermine what  
4 you're saying or trying to give a slightly different  
5 spin on it.  
6 A. Again, I never have considered that before and I see  
7 that possible interpretation. I had no sense of that  
8 at the time. We had agreed a particular approach, which  
9 is that I would address the fluid and electrolyte  
10 issues. Certainly, I didn't feel in the context of the  
11 meeting at the time that Dr Steen was trying to take  
12 away from my interpretation. What I've said there is  
13 accurate and it's what I've explained previously: that  
14 the difficulty for me was the relative contribution of  
15 the three processes that I've described.  
16 Q. After the meeting, the minutes were forwarded to you to  
17 be checked and e-mail correspondence ensued. WS177/1,  
18 page 72. This is the day after that meeting, it's  
19 8 December, and Nichola Rooney has, I think, circulated  
20 some draft minutes and there is Dr Sands, I think,  
21 coming back:  
22 "Dear Nichola. I see a problem. We don't actually  
23 know what the second U&E sample was taken, only when the  
24 result was noted. There may be no way we can be  
25 certain. Claire would have had to have extra lines put

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1 in for her infusions. We nearly always take that  
2 opportunity to take blood samples at such times and  
3 it is possible, perhaps likely, that the U&E sample was  
4 taken at that time. If so, the result would have come  
5 back in a pile of reports around 5 pm or so. That's why  
6 I wanted to have another look at the chart to see if  
7 there were any --  
8 A. Sorry, can I just take you back a bit? You said the  
9 minutes were sent to me for checking.  
10 Q. Yes.  
11 A. It may have been, I just can't remember.  
12 Q. Here we are, page 70. That's you on 8 December also,  
13 the second lower e-mail there:  
14 "Nichola. Best wishes, Ian. Nichola, I have made  
15 some changes which are highlighted in red, including  
16 changes to deal with the timing of the blood sample  
17 issue. The notes are in my office on the top floor of  
18 Mulhouse. If any one wants to look at them, they're on  
19 the table. I'll be in London for the rest of the week."  
20 A. Thank you.  
21 Q. So obviously the draft is going round and everyone is  
22 commenting on whether it's fair or accurate. But the  
23 point I wanted to take you to occurs on the next page,  
24 71. This is from Nichola Rooney, 8 December, to  
25 Andrew Sands, but copied in also to yourself. We're

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1 professor. One is that a minute should be an accurate  
2 record of what was said, but the second point is that if  
3 there is a factual uncertainty then how is that carried  
4 forward? Is it absorbed into the minute, which means  
5 the minute may become an accurate document, but it's not  
6 necessarily an accurate minute, or is it dealt with  
7 separately?  
8 A. I take the point. Can we just go down to see what  
9 Dr Sands actually asked? I haven't got that.  
10 MR STEWART: I'm sorry. If we go back to --  
11 A. Or the point --  
12 Q. -- page 72. It's the top e-mail and he says:  
13 "We don't actually know the timing of the second  
14 U&E."  
15 He suggests that it probably was in the evening.  
16 A. That's okay. Do we have the first draft of the minute,  
17 I wonder, to see what was being said and what he was  
18 drawing attention to?  
19 Q. I don't know, but we do have the minute at page 59,  
20 where we can see, the second line:  
21 "Blood levels were checked, probably around 9 pm."  
22 So what has been inserted there in answer to this  
23 conundrum is "probably around 9 pm". If we go back to  
24 Dr Rooney's e-mail at page 71, she says:  
25 "They thought it most likely to be 9 pm as once

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1 going back to the query that Dr Sands raised about the  
2 time that the second sample was taken. She writes:  
3 "Okay. I think Heather and Ian searched hard, but  
4 couldn't find the time. They thought it most likely to  
5 be 9 pm as once every 24 hours would have been typical.  
6 Perhaps it's better to say we don't know when and all we  
7 really know for sure is the time it was noted in the  
8 medical chart, ie 11.30. What do you think? I can  
9 change the minutes accordingly and add in 'there is no  
10 way of knowing for sure'. Nichola."  
11 Was this the usually way minutes were written up?  
12 A. I think if there's uncertainty about the accuracy of  
13 a minute, it's good to circulate it and check with those  
14 who were present.  
15 Q. Yes, but this is actually a debate about what should be  
16 put in the minute in terms of what was accurate,  
17 therefore what should have been said at the meeting, not  
18 what was said at the meeting.  
19 A. So I can't actually comment about what was said at the  
20 meeting, because the only -- I have no clear  
21 recollection of it, just a sense of the meeting. All  
22 I have is the minute. And looking at the minute,  
23 I think we've done our very best to make sure that  
24 there's accurate information within the --  
25 THE CHAIRMAN: I think there's a slight tension here,

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1 every 24 hours would have been typical. Perhaps it's  
2 best to say we don't know when and all we really know  
3 for sure is the time it was noted in medical chart, ie  
4 11.30. What do you think? I can change the minutes  
5 accordingly and add in that there's no way of knowing  
6 for sure. Nichola."  
7 Somehow the minute is then altered to put in  
8 something which then should have been said or could have  
9 been said, but there must remain doubt as to whether it  
10 was said.  
11 A. Can we go back to the minute? Do we have two versions  
12 of the minute and do we know that those words were added  
13 in?  
14 Q. No.  
15 A. No, we don't?  
16 Q. No.  
17 A. So we don't actually know what was --  
18 THE CHAIRMAN: We know what the end result was; we don't  
19 know what the earlier drafts were.  
20 A. I just wanted to be clear on that.  
21 MR STEWART: There was a draft, you made some amendments,  
22 corrections to it in red.  
23 A. Absolutely.  
24 Q. I don't have the original version with your amendments  
25 or indeed what was probably there beforehand, except

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1 only that we know that Dr Sands picked that up as  
2 a problem because he wasn't able to identify the time  
3 the second sample was taken.  
4 A. He picked up a problem from the first draft of the  
5 minute, is my interpretation of his e-mail; do you  
6 disagree with that?  
7 THE CHAIRMAN: I'm not so sure it's picking up a problem  
8 from the draft or being able to answer an issue which  
9 had been raised. There are two things going on  
10 simultaneously: there's a draft minute, but there's also  
11 a series of questions which have come in from Mr and  
12 Mrs Roberts, and this is perhaps an effort to combine  
13 the two.  
14 A. I understand. I'm doing my very best to help the  
15 inquiry here.  
16 MR STEWART: I think, with respect, the draft letter from Mr  
17 Roberts, although dated 8 December, would not have been  
18 received at the time this email correspondence was --  
19 A. Thank you. That's very helpful. So this was our  
20 attempt to get it. I can't recall either what was  
21 actually said at the meeting on this point or what was  
22 in the first draft. What I can say is what went out  
23 in the version that's there and we can return to that --  
24 THE CHAIRMAN: Page 59.  
25 A. -- about the timing of the --

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1 accurate information. It was circulated to a number of  
2 people, clearly I made some points on it and changes,  
3 and I can't remember what those would have been. But  
4 it would have been in an effort to capture the large  
5 amount of complex information that was being given  
6 at the meeting to make sure it was accurate and that  
7 there was a written record of it for the Roberts family.  
8 Q. Thank you. Then of course these issues had to be, in  
9 large part, revisited when Mr and Mrs Roberts' letter  
10 arrived and a response was required.  
11 A. I'm not sure it was revisiting the issues. They asked  
12 some very sensible and intelligent questions, which  
13 expanded on some of the issues which had been raised  
14 at the meeting, and I don't think it's fair to say it's  
15 going over the same ground again.  
16 Q. All right.  
17 THE CHAIRMAN: In some instances, it's developing points --  
18 A. Yes, absolutely.  
19 MR STEWART: Can we go, please, to WS177/1, page 43? This  
20 is a small part of the --  
21 A. Are we moving off the note of the meeting now?  
22 Q. Yes.  
23 A. Can we go back, please, because you had said to me that  
24 you would raise at this point the issue of whether  
25 I offered to meet with the Roberts family.

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1 THE CHAIRMAN: Page 59, please.  
2 A. -- sample. I know that that was my view and those words  
3 "probably around 9 pm" may have been my suggestion to  
4 put in. That is quite possible because when I reviewed  
5 the notes, what I had concluded is that because the  
6 phenytoin sample was taken at I think 9 pm, that my  
7 assumption was that the blood for electrolytes had been  
8 taken at the same time, although I didn't actually know  
9 that because it wasn't documented in the notes. But  
10 generally, when you take a sample from a child, as  
11 you will have heard from other witnesses, you don't want  
12 to take more than one sample.  
13 So certainly, that wording, "probably around 9 am  
14 [sic]", reflected what I believe to have been the case  
15 and certainly is in an effort to ensure an accurate  
16 record. That's for definite. Unfortunately -- and I do  
17 take your point -- I can't be certain whether it was  
18 said in the meeting or not, and if that's been an error,  
19 certainly it was with the best of intentions, I think.  
20 MR STEWART: Maybe the intentions were good, but it must be  
21 troubling if a minute is circulated and signed off by  
22 everybody as a true, accurate and faithful account,  
23 whereas, in fact, it is not.  
24 A. Sorry, I can't accept that at all. I think this was  
25 a honest effort to get a record of the meeting and

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1 Q. Yes.  
2 A. And that's at the bottom of page 4 of the minute.  
3 THE CHAIRMAN: That's page 61 in our record.  
4 A. "Professor Young added that he would be happy to meet  
5 with Mr and Mrs Roberts again."  
6 Okay? So I just wanted that to be clear since you  
7 seemed to have been doubtful about it previously.  
8 MR McALINDEN: Mr Chairman, before we move off that meeting,  
9 would it be possible for Professor Young to deal with  
10 the specific criticisms raised by Dr MacFaul in his  
11 substantive report, which is at 238-002-074,  
12 paragraph 353 up to 368? That really relates to the  
13 advice given to the family by Professor Young, really  
14 minuted in page 2, the bottom half of page 2 of the  
15 minute.  
16 THE CHAIRMAN: Right. This is paragraph 353 to 369, is it?  
17 MR McALINDEN: Yes.  
18 THE CHAIRMAN: Okay.  
19 A. Do you want me to comment on that?  
20 THE CHAIRMAN: I think Mr McAlinden is suggesting that since  
21 these are criticisms made by Dr MacFaul, in which he  
22 says:  
23 "Incorrect information was given to the parents."  
24 You see that at 354. Let's see how we get through  
25 this. The minute says:

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1 "Treatment today differs from that used eight years  
2 ago."  
3 And he says that's not correct.  
4 A. I suppose, chairman, this relates to some of the  
5 correspondence and additional reports, which I have sent  
6 to the inquiry. They were really a response to various  
7 quite specific and direct criticisms, which Dr MacFaul  
8 made of the information that I gave to the Roberts  
9 family at that meeting. These are really quite  
10 substantive issues, which go right back to the clinical  
11 issues that were discussed previously.  
12 THE CHAIRMAN: Right. It's this document which was in part  
13 at least responsible for the supplementary statement you  
14 volunteered.  
15 A. Yes. That's correct. Clearly, I very strongly reject  
16 any suggestion that I gave incorrect information to  
17 Claire's parents on these points. The first one -- and  
18 they relate closely to Dr MacFaul's opinions on the  
19 clinical management of Claire with which you said,  
20 at the outset, I disagree. I find myself closely  
21 aligned with Dr Scott-Jupp.  
22 THE CHAIRMAN: Yes.  
23 A. And strongly in disagreement with Dr MacFaul, who  
24 criticised me, I have to say, in some very stark terms  
25 originally, using the out-of-date textbook and made very

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1 particularly referring to at paragraph 355, isn't it:  
2 "Treatment today differs from that used eight years  
3 ago"?  
4 A. He's referring to the initial treatment and then the  
5 second issue is: would treat have been different in  
6 2004? It is unequivocally true -- I have no idea how  
7 Dr MacFaul can say otherwise -- that a child like Claire  
8 coming into the Children's Hospital in 2004 would have  
9 received different fluids than she would have done in  
10 1996. I have no understanding of why he has made the  
11 criticism. The information which I gave was accurate.  
12 I would be happy to talk about it at some length, but I  
13 do think I have probably covered it in my written  
14 submissions.  
15 THE CHAIRMAN: Yes, I understand, thank you.  
16 The next, 357, is:  
17 "The doctor gave her standard fluid intravenously,  
18 which is the textbook recommendation."  
19 And that's where you get into the whole textbook  
20 issue.  
21 A. It is and, again, I am happy to go through that. I was  
22 very unhappy to see that in his subsequent report he's  
23 again wrongly attributed information to Forfar & Arneil,  
24 and if you want me to go through that, I'm happy to do  
25 so.

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1 strong and specific criticisms of the information  
2 I gave. And really, I felt I had to respond to that  
3 because it was completely unreasonable on his part.  
4 MR STEWART: Do you feel that you have responded in full and  
5 on paper?  
6 A. I have responded in full and on paper. What is unclear  
7 to me is the extent to which my views are accepted. And  
8 in Dr MacFaul's subsequent follow-up, particularly  
9 in relation to the initial fluid management, where he  
10 quotes from the correct edition of the textbook, he  
11 again introduces a number of inaccuracies and omissions  
12 by incorrectly -- has the incorrect chapter, refers to  
13 sections and quotes around maintaining homeostasis,  
14 which are not in the encephalopathy section at all, but  
15 in the section dealing with hemiplegia. I have the  
16 edition of the textbook here with me.  
17 THE CHAIRMAN: I have picked up the gist of your response  
18 and I think I said to you at the start today that  
19 I recognise that the criticism which Dr MacFaul has  
20 raised about the initial fluid management on the Monday  
21 evening into Tuesday morning is not reflected or  
22 supported by the views of the other inquiry experts,  
23 never mind others who were actually involved in treating  
24 Claire or who subsequently became involved, such as  
25 yourself. I think that's the issue which he's

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1 THE CHAIRMAN: I've got your point that, even when he goes  
2 to the right edition, he goes to the wrong sections.  
3 A. He quotes information about Claire's fluid balance  
4 without indicating which section is of the textbook it  
5 is in and I only found this out last night, or whenever  
6 I was preparing and checking for this appearance today.  
7 He does correctly quote from -- we can look at what he  
8 said and I can highlight the issues. He does correctly  
9 quote from the encephalopathy section, but then goes on  
10 and includes a lot of further information from a section  
11 about -- I can get the exact wording, but it's about  
12 children with hemiplegia or paralysis of half of the  
13 body and he doesn't make it clear at all that it's from  
14 a different section.  
15 THE CHAIRMAN: Okay. Then 359 is:  
16 "With the sodium level of 121, the doctor responded  
17 appropriately."  
18 This is where there's an issue, which is I think you  
19 do want to deal with, about what happened when  
20 Dr Stewart came along at about 11.30 and found that the  
21 sodium level had dropped to 121.  
22 A. I want to be fair to Dr MacFaul -- and let me go back  
23 and qualify my earlier comments. I have the 1996  
24 edition of Forfar & Arneil, which is the third printing  
25 of the 1992 edition. There is just a possibility that

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1 there has been some other change, okay? So I do want to  
2 be fair to Dr MacPaul. There's a scientific  
3 disagreement between us, but that's all.

4 This point about the sodium level at 121 and the  
5 response, I think, despite all of the clinical -- I know  
6 you don't want to hear this, but despite all of the  
7 experts who have commented on what fluids Claire  
8 received after 11.30 pm, I firmly believe that they have  
9 still got it wrong, for reasons that I'm happy to  
10 discuss.

11 THE CHAIRMAN: Let me correct you on one thing: you  
12 shouldn't say "I don't want to hear this" because I've  
13 listened to weeks of conflicting evidence, so I'm not  
14 hostile to receiving your view, if your view is  
15 different, despite the fact that it's different,  
16 professor. I'm not cutting out alternative views. In  
17 fact, this inquiry would be a lot, lot shorter if I did  
18 cut out conflicting views.

19 A. The inquiry opening, the draft version, which I had  
20 seen, attributed certain views to Dr Scott-Jupp about  
21 what had happened at 11.30 -- and there wasn't  
22 a reference. So I asked and indeed the inquiry kindly  
23 provided a reference for his views. When I received  
24 that and checked them and looked at it, I was unhappy,  
25 not with what Dr Scott-Jupp had said, because I think

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1 THE CHAIRMAN: Yes.

2 A. So therefore, the critical issue in terms of Claire's --  
3 what actually happened with Claire's fluids, and this is  
4 what I would have felt at the time, it underpins some of  
5 the comments for which I've been criticised. The  
6 critical issue would have been what volume of fluids did  
7 Claire receive after 11.30 pm, not after 11 pm.

8 Now, if we go -- I'm not sure if we can get up the  
9 fluid balance chart.

10 THE CHAIRMAN: Give us one moment. We're in file 090.

11 MR STEWART: 090-038-135 and maybe 133.

12 A. That's correct. So this is the information I would have  
13 been looking at whenever I made the comments about  
14 Claire's fluids having been restricted, along with the  
15 intention, which was stated in her notes, which was to  
16 restrict the fluids by two-thirds to 41 ml per hour.

17 In the amount column there, which is the second  
18 column from the left, you have the running total of the  
19 0.18 per cent saline. So what you see, for instance, at  
20 2300 hours, it's 1,014. At 24:00, it goes to 1,037.  
21 That indicates that there were 23 ml of 0.18 per cent  
22 saline given at that point.

23 You'll see at 24:00 hours, beside the 1,037, it says  
24 "H" in the column, just beside the 1,037. I believe  
25 that means "halt" or something like that. Because you

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1 he's done a very good job and he's been a very thorough,  
2 independent expert to the inquiry. I provided some  
3 calculations, which I understand had been submitted to  
4 the inquiry, and I'm conscious that maybe people haven't  
5 had chance to respond to them.

6 THE CHAIRMAN: I think we're waiting for a response from  
7 Dr Scott-Jupp.

8 A. Okay. If I can go to where he discusses this issue, and  
9 it's in his supplementary report, "request to additional  
10 questions".

11 THE CHAIRMAN: The reference for this is 234-003, it starts  
12 at 001. Is that the document? These are his response  
13 to additional questions received on 28 May.

14 A. Yes. And I think if we go down to the next page,  
15 there's a discussion here, I think, about the amount of  
16 fluid which Claire received. It's right down at the  
17 bottom of that paragraph. He runs through  
18 a calculation, the total quantity of IV fluids given  
19 between 23.00 and 02.00, and he comes up with 173.5 ml,  
20 which I think is approximately right.

21 The critical issue -- and I don't think that any of  
22 the expert witnesses have been asked this question or  
23 have done the calculation -- is what happened once the  
24 staff on the ward became aware of the low sodium level.  
25 And that's not at 11 pm; that's at 11.30 pm.

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1 can see that, at 1 o'clock, the cumulative total hasn't  
2 changed. So there has been no further 0.18 per cent  
3 saline given at that time. And then up until 2 o'clock,  
4 you get to 1,070. So you can do the calculation --

5 THE CHAIRMAN: Sorry, does that mean if 1,037 means "halt",  
6 that explains why there's no increase between midnight  
7 and 1 am?

8 A. Yes, I think they stopped the 0.18 per cent saline.

9 THE CHAIRMAN: Then what happens between 1 and 2 am?

10 A. They restart it again and Claire receives an additional  
11 33 ml, 1,070 minus 1,037.

12 THE CHAIRMAN: Okay. You go on with that, please. That  
13 doesn't make any apparent sense because she wasn't seen  
14 by any doctor at 1 am or about 1 am.

15 A. It would have been a nursing decision, I suspect, in  
16 terms of the fluids that were going in at that stage,  
17 based on the medical advice, for reasons I think that  
18 may become clear in a moment.

19 THE CHAIRMAN: Okay. Go on ahead.

20 A. We've then got the middle column, the amount, that's the  
21 midazolam infusion. You can add up the amount of it  
22 which is going in. Then we have the phenytoin, which is  
23 in the last column. One of the problems and one of the  
24 confusions has been that the phenytoin here is not  
25 recorded very well. It's in an "oral" column, firstly,

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1 and we know it was given intravenously. But I think on  
2 the nursing note, and everyone else has agreed -- and  
3 we can call up the reference if anyone wants to -- you  
4 can see the phenytoin was administered between 11 pm and  
5 12 midnight.

6 THE CHAIRMAN: Right. Yes.

7 A. So that was 110 ml of fluid given between 11 pm and  
8 midnight, that's the phenytoin. The issue is how can we  
9 work out what happened? Dr Scott-Jupp has calculated  
10 and we've looked at that, the amount of fluid given  
11 between 11 pm and 2 am. But the critical point when the  
12 action was recommended to reduce Claire's fluids was  
13 11.30 pm. So the calculation which needs to be done and  
14 checked is the amount of fluids Claire would have  
15 received between 11.30 pm and 2 am, which is the last  
16 time we have, I think, an accurate ...

17 THE CHAIRMAN: Do you take 11.30 because that's the timing  
18 of Dr Stewart's note?

19 A. I do, and there is also a note, which says that --  
20 I think at 11.40 -- there was a change in the saline  
21 rate to 41 ml per hour.

22 THE CHAIRMAN: Right.

23 A. Is that in the clinical notes?

24 THE CHAIRMAN: The clinical notes, if we go away from this  
25 page for a moment, are 090-022-056.

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1 Claire's body at the time.

2 A. I don't know if we can call up the first page of the  
3 nursing note.

4 THE CHAIRMAN: I was looking for the phenytoin record, the  
5 clinical note, but we can go on to the nursing note.  
6 You're not talking about the fluid chart, you're talking  
7 about the nursing note?

8 A. Yes. (Pause).

9 THE CHAIRMAN: Let's try 090-040-138, perhaps:

10 "IV phenytoin erected by doctor and run over one  
11 hour."

12 A. Yes. 11 pm. That's the note "and run over one hour".  
13 That's what I felt was the clearest indication of when  
14 the phenytoin was administered.

15 THE CHAIRMAN: Right. Okay. So on that basis, you take  
16 your calculation of phenytoin from 11 o'clock for one  
17 hour.

18 A. For one hour. It was 110 ml and 55, therefore, runs in  
19 up until 11.30. And 55 runs in between 11.30 and 12.  
20 So basically, I have submitted the calculation, I think,  
21 but in essence over the two and a half hour period, you  
22 end up with 44.75 ml of 0.18 per cent saline, just over  
23 6 ml of midazolam, and 55 ml of phenytoin. That gives  
24 a total of about 106 ml of fluid in the two-and-a-half  
25 hour period, which is entirely compatible with the

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1 MR SEPHTON: I think it may be on the next page.

2 090-038-136.

3 THE CHAIRMAN: Thank you.

4 A. Yes. That's the 11.40. It was when the point of the --  
5 yes, it was when the potassium was added. So some  
6 action was taken then and it's got "41 ml per hour" at  
7 that point.

8 In terms of doing a calculation, I've assumed,  
9 because of the clinical time of the low sodium note,  
10 that the change would have been made at 11.30. What you  
11 then have to do is: we know how much fluids were  
12 administered between 11 pm and 12 midnight, and I have  
13 assumed -- but I think it's fair -- that half of the  
14 fluids would have been administered after 11.30. So in  
15 other words, the phenytoin, it says in the nursing  
16 notes, was given between 11 pm and 12 midnight. That's  
17 the one hour period. My assumption would be that half  
18 of it, therefore, was given up to 11.30 and half  
19 afterwards.

20 THE CHAIRMAN: There's inevitably some degree of speculation  
21 in this because the phenytoin, as I understand it,  
22 didn't start until there had been a phenytoin result,  
23 which came back -- and that's one of the issues about  
24 whether the phenytoin should have been given at all  
25 after 11 or 11.30 because of the level of phenytoin in

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1 calculation of Dr Scott-Jupp that we started off with,  
2 which I think is correct, except he had been asked and  
3 had done the three-hour calculation from 11 pm to 2 am.

4 If you work out the rate of that per hour, then it  
5 comes out at about 42 ml per hour, which is almost  
6 identical to the rate which had been suggested by the  
7 doctors at 11.30. So although I can't know this, my  
8 assumption would be that the nurses were adjusting the  
9 IV fluids appropriately by stopping the 0.18 per cent  
10 saline in order to try to meet the request of the  
11 doctors to give 0.41 ml per hour.

12 THE CHAIRMAN: So you don't think she got too much fluid  
13 over this period?

14 A. Not over this period, no. I mean -- sorry, I believe  
15 she got the fluid that was intended by the doctors at  
16 11.30. And this goes back to where we started this  
17 discussion, which is the criticism made of me by  
18 Dr MacFaul and his persistent statement that after --  
19 when fluids should have been restricted, Claire actually  
20 got more fluids, which is what he says repeatedly, than  
21 even what she was getting before. That's simply not  
22 correct. I firmly believe, as I believed at the time,  
23 that her fluids were restricted. Whether or not that  
24 was totally the correct action is something that we'll  
25 come back to, but certainly the doctors intended her

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1 fluids to be restricted and I believe, through the  
2 combined efforts of the doctors and the nursing staff,  
3 that that fluid restriction was in fact delivered after  
4 11.30 pm.

5 THE CHAIRMAN: Well, I'm right, am I, that you said at the  
6 inquest that the amount of fluid Claire was given  
7 between 8 pm and 2 am was greater than planned?

8 A. That was the period between -- I was ... I think that  
9 was in the -- and we could go to it again if you want.  
10 But I believe that's in the transcript of the oral  
11 evidence that I gave at the inquest. One of the  
12 deficits there is that unfortunately we don't know what  
13 questions were being asked. So I believe -- that was  
14 something Dr Bingham had said in his statement.  
15 I believe I was asked a specific question by the coroner  
16 about whether I agreed with that statement, which I did.  
17 It's just that I don't think that at 8 pm to 2 am is  
18 a critical period. And certainly, in relation to this  
19 criticism of me, the question is, "What happened after  
20 11.30?".

21 THE CHAIRMAN: This is actually your question, Mr McCrea,  
22 isn't it?

23 MR McCREA: Yes, it is, and it turns out historically, yes,  
24 it is. I don't wish to give evidence, Mr Chairman, but  
25 I think the note, in fairness to all concerned, is

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1 fluid between 8 pm and midnight was more than  
2 prescribed, but various medications were given during  
3 that time."

4 This is a note which was made in the Brangam Bagnall  
5 file, Brangam Bagnall representing the Trust at the  
6 inquest.

7 A. So I haven't any reason to doubt that for the period  
8 between 8 pm and midnight. I think that's probably  
9 correct. However, I go back to the fact that this  
10 criticism of me is not about the period between 8 pm and  
11 midnight, it's about what happened after 11.30 when  
12 a decision was made to restrict Claire's fluids and the  
13 allegation being that I gave inaccurate information to  
14 Claire's parents and have persisted in doing that.

15 But you know, what I'm attempting to show is that,  
16 at the very least, it's something I genuinely believe  
17 and can argue from the evidence; I think the other  
18 experts have not really considered the question of the  
19 timing properly or haven't been asked the correct  
20 question.

21 THE CHAIRMAN: Do you agree that there are difficulties in  
22 putting this record together to see exactly how much  
23 fluid Claire was receiving at different times? There is  
24 some level of detective work involved in it.

25 A. I absolutely agree, and I'm not being critical of the

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1 between 8 pm and midnight, the reference being  
2 140-043-008. It's my question.

3 A. My apologies for that.

4 MR McCREA: Rather than 2 am, it's 8 pm and midnight, where  
5 the professor answered the question. He agreed that it  
6 was more than should have been provided between those  
7 two times.

8 A. I think we don't actually know what the question was, do  
9 we?

10 THE CHAIRMAN: Well, sorry, we do have on this page -- this  
11 is a question and answer. Does this come from  
12 a Brangam Bagnall file?

13 MR McCREA: Yes.

14 THE CHAIRMAN: If you look at this, professor, at the middle  
15 of the page that's on screen, it says Mr McCrea -- that  
16 was Mr McCrea who's just been on his feet here, who was  
17 the counsel representing the Roberts at the inquest --  
18 and he refers to what Claire's prescription was:

19 "491 ml between 8 pm and 2 am. 458 ml in four  
20 hours, 114.5 per hour, which is far in excess of her  
21 prescribed level of 64 ml per hour. Is this not an  
22 excessive level of fluid? Is this fluid overload?"

23 And you say:

24 "This is not easy. No accurate record of  
25 vomit/urine, nor its sodium sent. I agree: amount of

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1 other experts involved here. I certainly don't intend  
2 to be. I suppose all I'm trying to show is -- I myself  
3 was subject to, again, quite significant criticism --

4 THE CHAIRMAN: Right, your point is that, at the very least,  
5 the evidence is not sufficiently clear to say that you  
6 gave Mr and Mrs Roberts incorrect information at that  
7 meeting?

8 A. Absolutely, but more importantly for the inquiry,  
9 because this is something that's become perpetuated, and  
10 we talked earlier about how errors become perpetuated  
11 within medical records, and I just think because  
12 I genuinely believed from the records, for the reasons  
13 I've explained, that Claire's fluids were restricted.  
14 I just don't want an error to persist in the inquiry and  
15 the various papers as a result of that.

16 THE CHAIRMAN: Okay, thank you.

17 I think that that doesn't quite finish us with the  
18 note that Mr McAlinden wanted your reply to. Could you  
19 give us, please, 238-002-074 and 075 again?

20 We had been looking at 359 about whether the doctor  
21 had responded appropriately with the sodium level at  
22 121.

23 A. Yes. So I'm -- so there were two aspects to that, okay?  
24 One was the rate of infusion, which I have addressed.  
25 The second aspect to that was to change the sodium level

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1 of the intravenous fluid, which is something that  
2 Dr MacFaul says should have been done and which,  
3 therefore, I was wrong in relation to my comment. So  
4 I think I need to address that second aspect of it as  
5 well.

6 THE CHAIRMAN: Okay.

7 A. So I think, again, there are two aspects to this. One  
8 is what was intended to be done and, secondly, what  
9 actually happened. Probably the easier to deal with,  
10 first of all, is what actually happened, given the  
11 calculation which I have been through with you already.  
12 The 106 ml of fluid, which I think Claire received  
13 between 11.30 pm and 2 am, included 45 ml approximately  
14 of 0.18 per cent saline, and the remainder was made up  
15 of the drugs midazolam and phenytoin.

16 We know from previous evidence that both of those  
17 were given in normal saline. Therefore, Claire received  
18 predominantly normal saline between 11.30 and 2 am. You  
19 can do a calculation to work out the net effect of the  
20 sodium content of the total fluids that are received,  
21 and I'm sure Dr Scott-Jupp or Dr Aronson, perhaps, could  
22 be asked to do that. And according to my figures, you  
23 come out at roughly about 0.6 per cent, so certainly  
24 it's above 0.5 per cent saline, so effectively she did  
25 in fact receive fluids with a higher sodium content

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1 speculating if I say that it was a nursing action in an  
2 effort to try to meet the decision of the doctors to  
3 restrict the fluids to 41 ml per hour. So the nurses  
4 were recognising that drugs were going in and that  
5 perhaps there had been -- that otherwise there was  
6 a risk of too much fluid being given. But I mean,  
7 I freely admit that is speculation on my part.

8 THE CHAIRMAN: You would say it's speculation which is based  
9 on the volume between midnight and 1 am not increasing?

10 A. Yes. It's clear that there wasn't any additional -- and  
11 I understand that the "H", which I was puzzling over --  
12 somebody in the Children's Hospital should give evidence  
13 on this -- but I understand the "H" was a signal that it  
14 was stopped, but I don't know that directly.

15 THE CHAIRMAN: And you would say the "H" fits in with the  
16 fact that the total didn't increase?

17 A. Yes. But people who are working routinely in the  
18 Children's Hospital at the time would have to be asked  
19 about that "H" and if it means something to them. I'm  
20 not certain.

21 That's what was the impact of what Claire actually  
22 received after 11.30 pm.

23 THE CHAIRMAN: Sorry, it's curious that Dr Stewart -- I'm  
24 looking back through his evidence when this was raised.  
25 His instinct was to reduce the volume of fluid, but also

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1 after 11.30 pm, although I accept that that was not  
2 what was intended or decided by the doctors at the time.  
3 THE CHAIRMAN: That was the effect of giving the additional  
4 drugs?

5 A. Yes, it was the effect of the drugs being in normal  
6 saline --

7 THE CHAIRMAN: Yes.

8 A. -- and also, the impact, I have to say, of the fact that  
9 her 0.18 per cent saline was greatly reduced and indeed  
10 stopped for an hour, according to the fluid balance  
11 chart. So it was the combination of the two.

12 THE CHAIRMAN: It's a bit hard to see how the decision was  
13 taken -- and I don't think we've heard evidence that  
14 anybody did take a decision to stop the fluids for  
15 an hour at all. Because in fact, one of the big  
16 concerns is after 11.30, when Dr Stewart left and was  
17 hoping and expecting that Dr Bartholome would attend  
18 sooner rather than later, in fact she ended up not being  
19 able to attend at all because I assume she was dealing  
20 with another emergency elsewhere and there was no  
21 further clinical treatment or intervention with Claire  
22 between Dr Stewart and then Claire's arrest.

23 A. I know, and I have also been keeping up with the  
24 evidence as much as I can and I also haven't been able  
25 to see any reason for that. I'm happy to say that I'm

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1 to increase the sodium level. Dr Bartholome agreed with  
2 him on the first, but not on the second, at least  
3 pending her arrival, which didn't materialise. He  
4 thought that Claire's total fluid had increased because  
5 of the Solution No. 18 continuing at a rate of  
6 two-thirds and the phenytoin being introduced over the  
7 next hour. So if that didn't happen, it can only be  
8 because the fluid was stopped for an hour?

9 A. Yes, which it appears to have been stopped for an hour,  
10 from the fluid balance chart.

11 THE CHAIRMAN: Okay.

12 A. As I say, you know, my calculations add up exactly the  
13 same as Dr Scott-Jupp's, except I've just taken the  
14 extra half hour out of the calculation.

15 THE CHAIRMAN: Okay.

16 MR QUINN: Could I ask how that fits with the Claire Roberts  
17 timeline, which is 310-001-001? Because when we put the  
18 purple graph of the midazolam infusion on top of the  
19 blue line of fluids, you can see how it tended to raise  
20 the fluid at the end of the graph. Perhaps the doctor  
21 could be asked to explain his findings in light of the  
22 graph and tell us whether or not he agrees with the  
23 graph.

24 THE CHAIRMAN: But I think is the professor not making  
25 a point which hasn't been made before, that the IV fluid

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1 may have been stopped for an hour?  
2 MR QUINN: Yes, that's why I want to know what is the answer  
3 in relation to -- no one has yet criticised the graph  
4 line as it rises to the right of the page. And when one  
5 puts the midazolam infusion on top of that graph, you  
6 see how it lifts the original graph up to the dark blue  
7 line above, and I just want to know what the professor's  
8 reaction would be in relation to whether or not -- can  
9 we now rely on this graph or do we not now rely on this  
10 graph?  
11 THE CHAIRMAN: If the professor's right that the IV fluid  
12 was stopped, then the graph is wrong.  
13 MR QUINN: Yes.  
14 MR SEPHTON: It's not the same, is it?  
15 A. It's the same, yes. I haven't really seen this graph  
16 before. But I take it that the dark blue line at the  
17 top is the -- is that the total fluid?  
18 THE CHAIRMAN: If you look at the legend at the top, it's  
19 "cumulative fluid".  
20 A. The interesting thing is that you see, between midnight  
21 and 1 am, that that graph levels off --  
22 THE CHAIRMAN: Yes.  
23 A. -- at the top. And that reflects the cessation of the  
24 saline, which is recorded on the fluid balance chart.  
25 THE CHAIRMAN: Right.

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1 A. Is that meant to be a cumulative total or not?  
2 THE CHAIRMAN: The only cumulative total is the dark blue.  
3 A. So what's the scale then, I wonder.  
4 THE CHAIRMAN: The midazolam at the bottom, that sort of  
5 purple line that you've referred to there, that is  
6 a sign of it continuing to be administered.  
7 A. But I suppose what is the scale? As somebody who's used  
8 to looking at graphs, you expect a scale, and I can't  
9 see any scale which is relevant to that midazolam line  
10 because the left hand axis, the left hand vertical axis  
11 is fluid input, which seems to be a total, and the  
12 right-hand axis is the Glasgow Coma Scale. So my  
13 reaction is that the midazolam appears to be  
14 there without any scale to indicate exactly what it  
15 means.  
16 THE CHAIRMAN: Right.  
17 MR FORTUNE: Sir, I'm having a bit of difficulty trying to  
18 understand the purple line because I'm just looking  
19 at the fluid balance chart, 090-038-135. Taking on  
20 board what the professor has said about the halting of  
21 fifth-normal, looking at the midazolam, we have got an  
22 increase at 11 o'clock from 13.9 to 16.8 at midnight to  
23 19.3 at 1 o'clock, and yet the purple line is  
24 effectively flat from midnight to 2 o'clock. Yet the  
25 cumulative total, the light blue or dark blue line, the

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1 A. The graph between 11 pm or 23:00 and midnight is indeed  
2 steeper there and that's reflecting -- that portion of  
3 it reflects the administration of the phenytoin, which  
4 was given over that one hour. I suppose the point I'm  
5 making -- and indeed it's the grey line, I believe,  
6 at the very top that crosses the dark blue one, the grey  
7 arrow that goes down, that's the key point after which  
8 the calculation needs to be made. That fits with the --  
9 that's 11.30, which is what it's saying on this chart,  
10 that the fluids were reduced at that point.  
11 So although I haven't studied this in detail -- and  
12 it's a complex graph -- my initial reaction is that it  
13 fits with exactly what I've explained.  
14 THE CHAIRMAN: The question is: does it get there by the  
15 same route or a different route?  
16 A. I guess I'm used to looking at complex graphs in my  
17 world and my initial reaction is that it fits. I would  
18 have to look at the midazolam at the bottom because  
19 it's ... If I interpret the midazolam at the bottom, it  
20 also stops, according to that graph, at midnight.  
21 THE CHAIRMAN: I think it continues --  
22 A. Does it? Because it's levelled off in the graph. The  
23 midazolam line is the bottom one.  
24 THE CHAIRMAN: Yes, but it doesn't stop. It doesn't stop at  
25 midnight.

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1 top blue line, seems to show something of a small  
2 increase between midnight and 1, unless I'm  
3 misinterpreting it as a straight line, but certainly an  
4 increase thereafter. So is the graph accurate, firstly  
5 so far as the midazolam is concerned and, therefore, if  
6 it's not, does it throw out the cumulative line? I'm  
7 looking at Professor Young and there's a nod.  
8 A. Definitely the midazolam line is not right because  
9 I agree: (a), it doesn't appear to have any axis or  
10 scale to reference it to so you'd expect a scale that  
11 shows the ml per hour; and (b) it makes no sense at all  
12 that it's flat because clearly, from the fluid balance  
13 chart, the midazolam infusion was continuing, if it's  
14 a cumulative total, which I think it is from the shape  
15 of the line.  
16 MR FORTUNE: Is it possible, sir, that the cumulative fluids  
17 could exclude the midazolam? But if so, why should that  
18 be?  
19 THE CHAIRMAN: That wouldn't make much sense, would it?  
20 MR FORTUNE: No.  
21 THE CHAIRMAN: One of the points that was made before is  
22 that the midazolam was given intravenously and then  
23 given in normal saline.  
24 MR FORTUNE: Well, I accept that, but of course, as  
25 Professor Young has agreed, the midazolam line is flat

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1 after midnight until 2 o'clock.  
2 THE CHAIRMAN: Okay. Well, we may have to come back and  
3 look at that. We've gone into this, professor, because  
4 you have a particular issue about this specific  
5 criticism of information given to Mr and Mrs Roberts  
6 at the meeting.  
7 A. Yes.  
8 THE CHAIRMAN: As indicated by Dr MacFaul. Okay.  
9 A. I mean, I don't know -- so I've addressed what actually  
10 happened in terms of the fluids which Claire was given.  
11 I suppose we need to talk about the question of the  
12 decision and why I felt -- why they did or did not  
13 increase the sodium content of the fluids.  
14 THE CHAIRMAN: Well, we have the evidence that Dr Stewart,  
15 who seems to have identified the problem very clearly at  
16 11.30, his instincts was to do that and Dr Bartholome,  
17 in effect, advised him not to, but she was expecting to  
18 go and see Claire very soon afterwards.  
19 A. Whenever I looked at the notes in 2004, and I don't want  
20 to be at all critical of Dr Stewart here, but he's kind  
21 of been held up as an exemplar of accurate  
22 identification of the problem and recording of what  
23 should have happened.  
24 THE CHAIRMAN: You're going to be the first person at the  
25 inquiry to suggest he might not be.

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1 have that sort of fluid overload, so she would have been  
2 described as euvolemic, meaning that she didn't appear  
3 at all puffy and probably that she didn't appear  
4 dehydrated either. So rather than Dr Stewart writing  
5 "query fluid overload", what I would have been looking  
6 for would be "euvolemic", which was in fact the case.  
7 And then sending off the urinary electrolytes and the  
8 urinary osmolality.  
9 THE CHAIRMAN: Sorry, euvolemic means that --  
10 A. It means having a normal volume, not being fluid,  
11 overloaded in the sense of being puffy and not appearing  
12 dehydrated. That's critical because -- and then you  
13 need the urinary sodium and urine osmolality. That's  
14 the other key investigations. You don't need at this  
15 stage a blood osmolality. I know Dr MacFaul referred to  
16 that. The use of a blood or serum osmolality is to rule  
17 out a condition called pseudo-hyponatraemia, which  
18 hasn't really been mentioned to date, I suspect, in the  
19 inquiry.  
20 THE CHAIRMAN: No, it hasn't.  
21 A. It's a condition where there's interference with the  
22 laboratory measurement of sodium, so you get a falsely  
23 low sodium in the laboratory. It was something that was  
24 mentioned by Dr Bingham in the inquest was a possibility  
25 and I intervened to say, no, that I didn't think it was

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1 A. Yes. I think he responded entirely appropriately for  
2 an SHO at his stage, but the idea that that this is  
3 a model response to identifying a patient with a sodium  
4 of 121 is just not correct. So looking at it -- you  
5 know, whenever I teach this to the medical students,  
6 there are certain key things I would have expected  
7 ideally, as an ideal response, that would have been  
8 recorded. And the first would have been an estimate of  
9 Claire's volume status. So whenever we approach  
10 somebody with a low sodium, the key clinical question,  
11 when I get phoned up at 3 in the morning because  
12 somebody's sodium is 115, I want to know from the  
13 doctors, are they dehydrated, are they fluid overloaded,  
14 which means that they have oedema or swelling, or do  
15 they appear to have normal volume? And we refer to that  
16 as being euvolemic.  
17 It's clear, I think, from the notes -- and nobody  
18 has suggested that Claire had any evidence of oedema.  
19 My understanding of the Adam Strain case is that Adam  
20 did have swelling and/or oedema with clear evidence  
21 therefore of fluid overload.  
22 THE CHAIRMAN: Yes, there was some debate about the extent  
23 of puffiness, as it was described, but there was  
24 evidence of some puffiness.  
25 A. Yes. It's clear Claire, from all of the records, didn't

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1 the case. It's due to very high levels of lipids or  
2 protein in the blood, and you get a normal serum  
3 osmolality when you measure it with a machine in the  
4 laboratory, but you're calculated osmolality is low.  
5 Dr MacFaul did refer to the calculation of osmolality.  
6 He didn't give the exact formula, but it's twice the  
7 sodium plus twice the potassium plus the urea, which are  
8 the main osmotically active substances in the blood.  
9 So you do the calculated osmolality and the measured  
10 osmolality. They're normally very, very similar. If  
11 there's a difference, then it raises the possibility of  
12 a pseudo-hyponatraemia, which is absolutely not relevant  
13 here. I wouldn't have asked for a serum or blood  
14 osmolality. In this case, I didn't think it did  
15 anything useful. But the urine osmolality and the  
16 urinary sodium are critically important to understanding  
17 the cause and they were the key investigations. So I'd  
18 have been looking for somebody -- ideally, at a junior  
19 level, in a perfect world -- to at least say "euvolemic"  
20 and then say "urinary electrolytes and osmolality" as  
21 the next step, and then the third step is: do we need to  
22 increase the sodium content? That has to be considered.  
23 Dr Stewart clearly did consider it. So whenever  
24 I looked at it, what are the thoughts that should go  
25 through your mind, what are the considerations in terms

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1 of doing it, and then what do you actually do? The  
2 consideration is whether you think the hyponatraemia is  
3 causing the neurological symptoms. In Claire's case,  
4 the coma and the possible seizures, as they were felt to  
5 be seizures, or non-seizure epileptic activity at the  
6 time.

7 When I reviewed the notes in 2004, I looked at it  
8 and said, "Here are some junior doctors dealing with  
9 a seriously ill child and they've been told by  
10 a consultant paediatric neurologist that she has  
11 non-fitting status epilepticus, an unusual but serious  
12 condition, and that maybe she has a viral encephalitis,  
13 another relatively uncommon, serious condition. She has  
14 been, I felt, neurologically stable", and I'm sure we'll  
15 come back to this. Then we get this sodium result.

16 The question in their minds is: is this sodium  
17 result causing the symptoms or are these other  
18 conditions, which we've been treating all day, are they  
19 a sufficient cause of her symptoms? If you conclude  
20 these neurological conditions, these underlying ones,  
21 are a sufficient cause of her symptoms, then I would  
22 have said restricting her fluids is the right thing to  
23 do and that's all you do.

24 If, on the other hand, you think: hold on, this low  
25 sodium might be causing the neurological symptoms, we

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1 consultants.  
2 A. What I thought happened is that the junior doctors,  
3 whenever I read the notes and looked at them, decided --  
4 and I felt it was a not unreasonable decision given what  
5 they had been dealing with all day -- that the  
6 status epilepticus and encephalitis were enough to  
7 explain the neurological symptoms. They didn't think  
8 that the low sodium was making a contribution and if you  
9 don't think it's making a contribution, you don't give  
10 hypertonic saline, because that in itself has risks  
11 associated with it, which again I know will have been  
12 mentioned at least by the pathologists in terms of  
13 central pontine myelinolysis.

14 Whenever I looked at the notes in 2004, when I was  
15 doing a chart review, that was the chain of events that  
16 was in my mind. That's why I felt that they had taken  
17 appropriate action, in my judgment, at 11.30 pm.

18 To go back to the issue of what they might have  
19 done, considered giving hypertonic saline, there have  
20 been several references -- and Dr Scott-Jupp addressed  
21 it, Dr MacFaul has addressed it as well, and this is one  
22 point where I would differ with Dr Scott-Jupp a little.  
23 Whenever this was discussed with him, he said he would  
24 have increased the saline to 0.45 per cent or maybe 0.9  
25 per cent, believing that Claire had SIADH, which is what

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1 don't have enough from these other clinical conditions,  
2 then you have to take urgent action to raise the sodium.  
3 Now, what does that entail? Well, I know various things  
4 have been discussed, but certainly at the time, if I'd  
5 been asked -- and I believe this goes back to what's  
6 in the Arieff paper, even -- you would have given  
7 hypertonic saline. Now, that in practice in the Royal,  
8 at that time, would have meant 1.8 per cent saline,  
9 which was the usual form of hypertonic saline that would  
10 have been used. To give hypertonic saline in low sodium  
11 in that era would have been very, very unusual and  
12 uncommon. The junior doctors probably had negligible  
13 experience of it.

14 THE CHAIRMAN: And even the registrar?

15 A. Even the registrar -- I think we would have to ask --  
16 but probably would have had negligible experience.  
17 In that era, that's one of the things that would have  
18 been escalated to me quite often or I would have thought  
19 would have had to go to a consultant if you were  
20 thinking of doing it.

21 THE CHAIRMAN: That's one of the points, isn't it?

22 A. Yes.

23 THE CHAIRMAN: What seems unavoidable is that at about 11,  
24 11.30, when the sodium result came through, there should  
25 have been a more serious engagement of a number of

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1 I think was also the cause of the hyponatraemia.  
2 Dr MacFaul just talks about increasing the sodium  
3 content of the fluids. I don't actually know  
4 specifically what he means by that. I would have said:  
5 no, it's hypertonic saline. Dr Scott-Jupp said he would  
6 very rarely have given hypertonic saline -- I think  
7 almost never, in his evidence. And the problem is --  
8 and I wouldn't even necessarily expect a consultant  
9 paediatrician to know this -- that in fact in SIADH, if  
10 you give half-normal saline or normal saline, it seems  
11 intuitively as if it's going to bring the sodium up, but  
12 it doesn't. It's more complex than that. That was  
13 known at the time. I had mentioned this book, this was  
14 the book I was using at the time, it's a very  
15 specialised textbook dealing with acid-base and  
16 electrolyte balance. It wouldn't have been able in the  
17 Children's Hospital, I'm sure. It describes the  
18 evidence, the mechanisms, by which giving even normal  
19 saline will not raise the sodium in SIADH. They're  
20 quite complex, but I'm happy to provide the evidence if  
21 it's of interest. That's reiterated in more modern  
22 reviews. That's why we give hypertonic saline.

23 That information would probably only have been known  
24 to a real specialist in this area in the early 1990s and  
25 possibly even today. I suspect a lot --

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1 THE CHAIRMAN: Are you talking about somebody like  
2 Professor Trimble?  
3 A. Not Professor Trimble, no, I don't think so. The reason  
4 being Professor Trimble is a very, very good doctor, but  
5 she specialised in the inborn errors of metabolism. In  
6 terms of these electrolyte problems, that was not an  
7 area where she would have had particular expertise or  
8 experience. And I recall her asking me to go with her  
9 once or twice to see children with electrolyte problems.  
10 THE CHAIRMAN: Mr Fortune?  
11 MR FORTUNE: Sir, can we be very careful? It's sometimes  
12 difficult to differentiate when the professor talks  
13 about hypo- and hypertonic. There's a reference back on  
14 line 8 of that page to "hypotonic":  
15 "That's why we give hypotonic [sic] saline?"  
16 Is that what you meant?  
17 A. Can I see that? I'm sure it's not. I'm sure I mean  
18 hypertonic.  
19 THE CHAIRMAN: The one thing we can't get for the witnesses  
20 is the running transcript. But thank you, Mr Fortune,  
21 we can correct that.  
22 A. I have not used the phrase "hypotonic saline"; I have  
23 only talked about hyper.  
24 THE CHAIRMAN: We'll get the transcript corrected so that  
25 where it says at page 152 [draft], line 8:

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1 to be ridiculous regime in the Children's Hospital as  
2 the registrar. There's an issue about whether Dr Steen  
3 might have been contacted at that time. There's  
4 an issue about whether Dr Webb might have been contacted  
5 at that time. There's an issue about whether PICU might  
6 have been contacted at that time. But we know the end  
7 result is that none of them is contacted and the next  
8 clinician directed to Claire found her to have arrested  
9 and, at that point, it's too late for anything to be  
10 done.  
11 A. Mm-hm.  
12 THE CHAIRMAN: At that point she's beyond help.  
13 A. Unfortunately, yes.  
14 THE CHAIRMAN: Do you have a view about her being beyond  
15 help at 11.30?  
16 A. This was one of the things which I found most difficult  
17 whenever I was asked about this previously. I think  
18 I was and it may come up in the response to the Roberts'  
19 questions. I thought that probably, even at 11.30, the  
20 process was likely to be so advanced that it was not  
21 easily recoverable. However, there is a chance, I would  
22 have to say, that if other thing had been done then,  
23 that it might have been. And the problem to me, at that  
24 stage, whenever I looked at it -- and the other thing  
25 would have been giving, I think, hypertonic saline, and

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1 "That's why we give hypotonic saline."  
2 That can be corrected to "hypertonic saline".  
3 A. That has to have a higher sodium concentration than  
4 0.9 per cent. The key is that the osmolality of the  
5 fluid you administer has to be greater than the urinary  
6 osmolality in order to bring the serum sodium up. And  
7 usually, normal saline even won't achieve that, which is  
8 why it needs to be hypertonic in the acute management  
9 and that's reflected in all our current guidelines, the  
10 regional ones and the ones that are used  
11 internationally, and also was known, but just, I think,  
12 to a small group of experts in the early 1990s.  
13 THE CHAIRMAN: Let's go back to the night of  
14 22 October 1996. It's Tuesday night. It's about 11.30.  
15 This reading has come through, giving Claire a sodium  
16 level of only 121. She has not appeared to be  
17 responding positively to the drug regime which has been  
18 administered to her. Dr Stewart is called to see her.  
19 He thinks he was called to see her because the phenytoin  
20 response level came through and, coincidentally or  
21 otherwise, the sodium level came through as well. He  
22 then takes or suggests some action and speaks to  
23 Dr Bartholome. She's expecting to come along, but  
24 doesn't. I will take it that she didn't because I know  
25 that she's working overnight under the what seems to me

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1 I know that's not what expert witnesses have said, but  
2 based on my experience that is the thing, if I had been  
3 phoned that night -- which is not likely, that is what  
4 I probably would have recommended or suggested.  
5 But I understood completely why it hadn't been  
6 administered. I felt the decision not to do so, for the  
7 reasons I've explained, was an appropriate one.  
8 THE CHAIRMAN: Okay. Thank you very much.  
9 MR McCREA: Mr Chairman, could I go back to the issue about  
10 fluid overload?  
11 THE CHAIRMAN: Yes.  
12 MR McCREA: Because I think the point that Mr Roberts was  
13 trying to make much earlier is that the notes and  
14 records aren't accurate. Secondly, if one takes the  
15 period from 11 pm to 12.30 pm and looks at the amount of  
16 fluid that Claire, in fact, did receive, you find she  
17 received 110 millilitres, I think, of phenytoin. She  
18 received 23 millilitres of Solution No. 18, and then  
19 received 2 or 3 ml of the midazolam. Divide that, which  
20 is 136 in total, over an hour and a half, and you are  
21 receiving 90.6 in that period of time, which would be  
22 twice plus something more than she should have been  
23 receiving. So it very much depends on when the decision  
24 was to restrict fluids.  
25 THE CHAIRMAN: It depends what your time period is.

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1 MR McCREA: It does.  
2 A. I completely accept that, and I'm sure that that  
3 calculation is correct. But I've outlined why I've gone  
4 from 11.30 pm based on the clinical record, and  
5 certainly in 2004 -- because this in part comes back to  
6 the criticisms that were levelled at me by Dr MacFaul  
7 because of the information which I gave. I hope at the  
8 very least that people will appreciate that I have done  
9 my very best to give accurate information and the  
10 rationale for doing it.  
11 THE CHAIRMAN: I understand your point.  
12 MR McCREA: Mr Chairman, the second point is in relation to  
13 the accuracy of the notes and instructions that been  
14 given. If you decide "H" means halt, then why is it  
15 that the fluids are re-commenced?  
16 A. If I can comment on that? I am not saying for certain  
17 at all that the "H" means halt. That is speculation on  
18 my part. Otherwise I don't know what "H" means.  
19 Somebody who works in the Children's Hospital would be  
20 a better person to ask about that. It is, however,  
21 indisputable, I think, from the fluid balance chart that  
22 the fluids did stop between the -- the saline stopped  
23 between midnight and 1 am.  
24 THE CHAIRMAN: If the entry at 1 o'clock is correct, then  
25 nothing was given.

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1 is the entry made by Dr Steen. Because if you recall,  
2 Professor Young was telling us about the formula as to  
3 how to get the urine osmolality. And if Professor Young  
4 looks down the left-hand column, the relevant  
5 information is available. I know it's a little while  
6 ago, but this is the result of the test recommended or  
7 sought by Dr Stewart.  
8 THE CHAIRMAN: Agreed?  
9 A. Agreed, yes. Yes, the urinary osmolality -- I'm just  
10 looking for the urinary sodium.  
11 MR FORTUNE: 249 is the urinary osmolality.  
12 A. That's the urinary osmolality; I'm just looking for the  
13 urinary sodium, which is the other key thing I'd have  
14 wanted at the time. That's the only thing which is  
15 missing, I think.  
16 THE CHAIRMAN: Okay, thank you. Have we finished then  
17 that -- this all seems like a while ago. Can you give  
18 us again 238-002-074 and 075?  
19 MR McALINDEN: I think, Mr Chairman, there's only one  
20 further substantive criticism relating to  
21 Professor Young. That would be at paragraph 362 on  
22 page 075.  
23 THE CHAIRMAN: This is the point about the CNS observations?  
24 MR McALINDEN: Yes.  
25 A. Yes, and I think the question relates to my -- the

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1 MR McCREA: Depending on what time you start the calculation  
2 and stop it, you can make whatever you wish of the  
3 figures.  
4 THE CHAIRMAN: Well, I don't think that Professor Young's  
5 been quite so random as to make whatever he wishes out  
6 of it.  
7 MR McCREA: No.  
8 THE CHAIRMAN: He's offering an alternative interpretation  
9 of records which are imperfect and bringing together  
10 some strands of evidence to support the analysis he's  
11 given. It's not the only possible analysis, but it's  
12 an analysis.  
13 A. I accept that. For me, what this comes back to --  
14 of course, if it helps the inquiry, then I'm very happy.  
15 But it comes back to the specific criticisms levelled at  
16 me by Dr MacFaul, which I think are not justified at  
17 all.  
18 THE CHAIRMAN: Okay.  
19 MR FORTUNE: I'm just rising at this stage -- this is the  
20 first time we've actually heard any evidence of there  
21 being the "H" there on page 090-038-135. There are,  
22 of course, the signatures of two nurses, Murphy and  
23 McCann, against the relevant lines.  
24 But more to the point, I was going to ask you to  
25 draw Professor Young's attention to 090-022-057, which

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1 information I said about Claire's CNS observations  
2 having remained stable over a period of time. I guess  
3 I probably don't need to go over that evidence, which  
4 seemed to me, whenever I submitted it, to have been  
5 taken on board. Again, I would say that, because of my  
6 work internationally, one of the things I have is  
7 a working group that reports to me on measurement  
8 uncertainty. So this is an area that I have a --  
9 THE CHAIRMAN: As to whether you give a 1 or 2 or a 3 or  
10 a 4?  
11 A. Yes, basically. It's not directly Glasgow Coma Scale  
12 related, but that was why I was aware of the issue  
13 around measurement, variability relating to it. The  
14 question of clinical signs or further deterioration,  
15 I know that's been put to a number of experts. My  
16 honest interpretation of the notes when I looked at them  
17 was that Claire had been seriously ill but stable for  
18 most of the day. That was in keeping with my experience  
19 of hyponatraemia in children and the fact that often,  
20 when things deteriorate badly, it can occur quite  
21 quickly and suddenly. So in a sense, that didn't come  
22 as a surprise to me. And the question has arisen of  
23 whether I accept there was a failure of Claire to  
24 improve, despite being given various treatments.  
25 I didn't interpret that as lack of stability. If other

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1 experts have done so, then I accept that. But again,  
2 just making the point that I made a true and honest  
3 assessment of what I felt her condition was and that was  
4 the entirely independent information I gave to her  
5 parents.

6 THE CHAIRMAN: Okay, thank you. Mr Sephton?

7 MR SEPHTON: Sorry to delay matters still further. The  
8 professor has told us that his view was that this  
9 problem was based on SIADH. I wonder if the inquiry  
10 would ask the professor whether that's in  
11 contradistinction to fluid overload, and if so, what his  
12 reasons are.

13 A. Well, I know these terms have been used quite a bit and,  
14 as somebody approaching this from the position, I think,  
15 of an expert, I've been slightly unclear what is meant  
16 by "fluid overload" whenever it has been used by some  
17 other witnesses. I classify hyponatraemia, as most  
18 modern reviews other experts would do, into  
19 hypervolemic, euvoletic and hypovolemic hyponatraemia.  
20 I associate fluid overload with the hypervolemic  
21 hyponatraemias, which typically occur in somebody with  
22 heart failure or liver failure -- and Reye's syndrome  
23 may have been raised in that context, or renal failure,  
24 where you get oedema or swelling of the body, and it's  
25 due to the escape of fluid out of blood vessels in

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1 THE CHAIRMAN: Which is perhaps different from Adam's case,  
2 which you may or may not know about.

3 A. I know a little bit about Adam's case. My understanding  
4 of it -- and forgive me if I'm wrong -- is that in  
5 Adam's case it was definitely a hypervolemic  
6 hyponatraemia and was due to fluid overload in the  
7 presence of the inability to excrete water. In Claire's  
8 case, she would have had normal kidney function.  
9 Something was stopping the water that was retained  
10 within the blood vessels -- something was stopping it  
11 being reduced. That can only have been SIADH.

12 THE CHAIRMAN: It was accepted in Adam's case that there was  
13 a miscalculation of the appropriate amount of fluid to  
14 give him intravenously before and during his operation.

15 A. Yes.

16 THE CHAIRMAN: So that gives him quite a distinct type of  
17 hyponatraemia in contrast to Claire.

18 A. In my opinion, yes, and from I know of Adam Strain's  
19 case, yes, completely distinct, in a separate category.  
20 That may not be true of some of the other cases and  
21 Claire, but certainly Adam.

22 THE CHAIRMAN: Thank you. Mr Stewart?

23 MR STEWART: Thank you.

24 THE CHAIRMAN: Where were we?

25 MR STEWART: We were in the aftermath of the meeting of

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1 between cells where it causes oedema or swelling.

2 SIADH, in contradiction, is a euvoletic  
3 hyponatraemia. It's sometimes described as  
4 a volume-expanded state, so there is some retention of  
5 fluid, but the fluid is retained within the blood  
6 vessels, which become dilated or expand somewhat to  
7 accommodate the greater effective circulating blood  
8 volume. So whenever I think -- the question in my mind  
9 is: if Claire did not have SIADH, given the fluids that  
10 she received, is there any possibility she would have  
11 developed hyponatraemia? And my answer to that is: no,  
12 no possibility at all. The fluids that she gave [sic]  
13 were at the recommended maintenance level for a child or  
14 slightly more. In the absence of SIADH, I do not  
15 believe she could have developed hyponatraemia unless  
16 there was cerebral salt wasting, which is another  
17 condition I have mentioned, but which I think is a good  
18 deal less common and would be much less likely, but  
19 it would have formed part of my differential in somebody  
20 with neurological disease and hyponatraemia at the time.

21 THE CHAIRMAN: But again, is there a question of degree  
22 about the extent to which the hyponatraemia develops  
23 because of the ... You're saying unless she did have  
24 SIADH, hyponatraemia would not have developed?

25 A. Without SIADH, yes. Absolutely.

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1 7 December and Mr and Mrs Roberts write their letter on  
2 8 December, setting out responses and a series of  
3 questions. And that's at 089-003-006. I understand  
4 that this letter was then circulated to yourself and  
5 Dr Steen and Dr Rooney started to draft a response and  
6 then circulated it and you all made contributions and  
7 tried to address the questions.

8 A. Yes.

9 Q. If I could take you to 139-139-001. We have part of an  
10 e-mail trail where you are discussing the various  
11 contributions. From the bottom, reading up, there's one  
12 from you:

13 "Dear all, having reviewed this draft, I have made  
14 a few minor changes, which I have highlighted in green,  
15 and I have called this version 'draft 3'."

16 Then above it, there's an e-mail from Heather Steen:

17 "Have done a few slight changes -- for example  
18 'November' ... Peter Walby spoke to me yesterday. He  
19 needs the notes for 24 hours to photocopy and send to  
20 a paediatric anaesthetist in GOS who the coroner has  
21 asked to review the case. He also wish to see this  
22 letter. Heather."

23 Above that, from Nichola Rooney on 11 January. And  
24 she refers to the draft as having reached its final  
25 final draft stage. So there was quite a lot of activity

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1 between you to put together a response.  
2 A. I think the activity, as recorded -- and again I'm only  
3 working off the e-mail exchanges -- isn't really between  
4 us all, in fact, is it? Because I'm just looking at the  
5 page there and the e-mail from me certainly goes to  
6 Nichola Rooney, Michael McBride and Heather Steen. The  
7 one above from Heather isn't copied to me.  
8 Q. Yes. Presumably you would not see this note that's  
9 scribbled on it in the upper right-hand side, which is  
10 initialled "APW" and comes from Mr Peter Walby of the  
11 litigation management office.  
12 A. I certainly don't believe I've seen it prior to the  
13 papers being circulated to the inquiry.  
14 Q. Did you know that the litigation management office was  
15 being included in the process of drafting a response to  
16 the Roberts' letter?  
17 A. I have no recollection of that at all. It's several  
18 years ago and clearly I was aware of Mr Walby's  
19 involvement subsequent to meeting with the Roberts  
20 family and before the inquest because I met with him on  
21 one occasion and had some correspondence, but I can't  
22 recall if I was aware at this stage or not.  
23 Q. Well, he's involved himself to the extent that he's  
24 making comments and if you read down through it, he asks  
25 Nichola Rooney:

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1 given were inaccurate. There were small errors of  
2 inaccuracy creeping in, in many cases the same  
3 inaccuracies as crept into the minute of the meeting.  
4 And in other respects, I was going to suggest that the  
5 responses were perhaps superficial and perhaps even  
6 misleading and some of the questions posed weren't  
7 answered. So that's the sort of terrain we're going to  
8 cover.  
9 A. We'll have to cover those points specifically one at  
10 a time.  
11 Q. Of course. The first is the small inaccuracies, and  
12 here we have question 1 on the left-hand side:  
13 "What was Claire's initial diagnosis on admission to  
14 the hospital?"  
15 That is answered, we can see, at 1(a):  
16 "Claire arrived at A&E at 8 pm on the evening of  
17 Tuesday 21 October and the history given to staff was  
18 that she had been vomiting at school that day."  
19 It's the same point again. Little errors.  
20 A. I wonder, just before going on to this, if we could  
21 maybe move a back a little to the process by which the  
22 response was constructed, which I obviously have been  
23 trying my best to understand or reconstruct. So I think  
24 what you said to me -- and I agree with -- is that  
25 Nichola started off by doing a rudimentary response

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1 "Please ensure I get a copy of the final letter.  
2 I will need to send it with the questions to HMC [Her  
3 Majesty's Coroner]."  
4 Were you aware that the responses you were drafting  
5 were going to the coroner as well?  
6 A. Again, I can't say at that stage, but from the records  
7 that I've seen, the correspondence, I suspect I wasn't  
8 aware of that, but I honestly don't know.  
9 Q. I was going to go through some of the responses with you  
10 in some of the same vein as we went through the minute  
11 of the meeting. Some of the same inaccuracies crop up.  
12 THE CHAIRMAN: Could we break now until 4.05 and see how  
13 much more we can get through? Thank you very much.  
14 (3.55 pm)  
15 (A short break)  
16 (4.11 pm)  
17 THE CHAIRMAN: We're looking at the response to the points  
18 raised by Mr and Mrs Roberts.  
19 MR STEWART: Thank you, sir. If I can bring up the relevant  
20 page of the Roberts' letter with the questions on one  
21 side of the screen and the responses on the other, it  
22 might assist. First of all, 089-003-006. And on the  
23 other side of the screen, 089-006-012.  
24 Really, the observations that I wish to take you to,  
25 Professor Young, are that in some respects the responses

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1 without any of the medical evidence.  
2 Q. Yes.  
3 A. Since she had no relevant qualifications to provide  
4 that. And it was then circulated, I suspect, to a group  
5 of people, probably Dr Sands, Dr Rooney and myself. I'm  
6 not sure if we know that.  
7 Q. I'm not sure Dr Sands had any input. If it was  
8 circulated to him, I'm not sure he responded.  
9 MR FORTUNE: I think Professor Young means Dr Steen because  
10 it's Dr Rooney's letter.  
11 A. Apologies. It's been a long day and I'm struggling  
12 a little bit. I meant Dr Steen and we don't think  
13 Dr Sands.  
14 MR STEWART: Dr Rooney, yourself and Dr Steen had an input  
15 and, it seems, Mr Walby.  
16 A. Okay. Then we would have drafted in or filled in parts  
17 of the answers. My belief is that Dr Steen would have  
18 completed and responded to those questions which were  
19 part of the clinical journey, which she had dealt with  
20 in the initial meeting, and I would have responded  
21 in relation to those questions related to fluid and  
22 electrolyte balance. I'm not sure if that can be  
23 reconstructed from the drafts. I received the drafts in  
24 black and white and I'm told that there were colours in  
25 them and thought that it would have probably been

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1 possible to see exactly what parts I contributed to the  
2 answers.  
3 Q. In any event, the suggestion has to be made to you that  
4 if you were conducting any sort of an attempt to  
5 properly answer these questions and you were having an  
6 input, you should have been checking them completely.  
7 A. And I accept that point and am happy to apologise for  
8 the fact that I would have focused here, I believe, on  
9 those questions where I felt I had input. I don't know  
10 if I had the charts at this stage or not. Very  
11 possibly, if I had been doing it, I would have been  
12 working off the minute partly, and we've already  
13 discussed this concept that errors tend to be completed.  
14 THE CHAIRMAN: So if the factual errors in 1(a) themselves  
15 can be traced back to the earlier documentation, that's  
16 the point we covered just before lunch today, isn't it,  
17 it doesn't inspire confidence in the family; it makes  
18 them wonder if anyone is taking their daughter's death  
19 seriously. And that's something that, particularly  
20 in the circumstances of Claire's case, being referred to  
21 back by Mr and Mrs Roberts to the Royal eight years  
22 after her death, it makes it even more regrettable that  
23 that happened at all.  
24 A. Clearly, I regret that significantly and any oversight  
25 on my part in relation to allowing those errors to

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1 "The combination of drugs should not have had an  
2 adverse effect on sodium levels."  
3 Given what we now know about the possible overdoses  
4 of phenytoin and midazolam, I would suggest that that  
5 seems to indicate that there was a failure to review the  
6 drug records.  
7 A. As you're fully aware, and I have commented on earlier,  
8 we had not recognised the presence of the overdose with  
9 midazolam and phenytoin. I've explained why I would not  
10 have noticed that. I have highlighted the fact that  
11 I think it was a difficult thing to spot in the light of  
12 at least four independent external paediatric experts  
13 too, with the inquest too, with the coroner failing to  
14 identify it. So it was an honest and true response  
15 at the time, based on our knowledge, but I accept that  
16 we had failed to identify the overdose of the drugs.  
17 Q. Were you really relying upon Dr Steen to fill in that  
18 part of the response?  
19 A. As you'll appreciate, it's very difficult, at this  
20 distance, to reconstruct it. I had thought today it  
21 might have been possible from the colours on the drafts  
22 if we had those, but from memory I would say almost  
23 certainly that I would have contributed the last line:  
24 "The combination of drugs should not have had an  
25 adverse effect on sodium levels."

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1 persist is something I'd like to apologise for.  
2 MR STEWART: I was thinking that a poor impression will be  
3 formed. When the parents, Mr and Mrs Roberts, can have  
4 no confidence in that level of detail, their confidence  
5 in the rest of it may be undermined. You appreciate  
6 that as a --  
7 A. As a point, yes, I do appreciate that. However, what  
8 I can assure you is, certainly in terms of my  
9 contribution to the letter and its content, that I was  
10 determined to answer the questions as fully as I could  
11 and to the best of my ability.  
12 Q. What about question 4? On the right-hand side, can we  
13 bring up 089-006-013? Question 4 is posed on the left:  
14 "Claire's medication was very important and aimed at  
15 controlling her seizures. Without this medication, her  
16 condition could have deteriorated more rapidly. The  
17 combination of drugs should not have had an adverse  
18 effect ..."  
19 Sorry, that's the answer. The question was about  
20 the administration of the drugs and whether the mixture  
21 could have had a worsening effect and whether the  
22 medication should be stopped and so on. The answer at 4  
23 on the left is that it was very, very important, aimed  
24 at controlling her seizures and, without it, her  
25 condition would have got worse:

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1 THE CHAIRMAN: That would still be your position?  
2 A. Yes.  
3 THE CHAIRMAN: The problem is that Mr Roberts is getting, in  
4 question 4, to a concern which has emerged more starkly  
5 at this inquiry than it did before. So in a sense, for  
6 all the experts and all the lawyers involved at  
7 different stages, Mr Roberts was ahead of us.  
8 A. Absolutely. I'm very happy to accept that. As  
9 I indicated earlier, I was surprised at the detail in  
10 this response. It indicated that Mr and Mrs Roberts had  
11 successfully taken on board a very large amount of  
12 complex information. These were difficult and very  
13 pertinent questions, not questions which it was  
14 completely straightforward for us to answer, but  
15 certainly I was determined to do my best to provide the  
16 best answers I could in the circumstances.  
17 THE CHAIRMAN: And it is a point, isn't it, that while the  
18 combination of drugs should not have had an adverse  
19 effect on sodium levels, the combination of drugs would  
20 have had an adverse effect on other aspects that day?  
21 For instance, to the extent that any of them had  
22 a sedative effect, that's a different issue, and that's  
23 not directly the issue Mr Roberts raised, but it's an  
24 issue which one can get into from him raising questions  
25 about drugs.

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1 A. I think what I would say to that -- I mean, firstly from  
2 a personal level, as I've indicated earlier, I have no  
3 experience in using anti-epileptic drugs in children, so  
4 it wouldn't really have been something I felt able to  
5 comment on. I would say that the sedative effect of the  
6 drugs is not an adverse effect as such, it's one of the  
7 effects that the drugs have and partly my understanding  
8 is that contributes to how they're used in treating the  
9 epilepsy.

10 I guess in response to these questions, we could  
11 have written essays, probably, in some cases, and could  
12 have provided a very large amount of information.  
13 Probably when you see the comments I've made about the  
14 sodium to the inquiry, you'll realise I had a huge  
15 amount of information and knowledge about it.

16 Certainly, I was trying to provide focused and  
17 accurate answers to the questions, which would help to  
18 provide some information in the knowledge that the case  
19 was moving on to the next level and was going to  
20 the coroner, possibly to the inquiry here.

21 THE CHAIRMAN: In a sense, there's almost cross-purposes  
22 here because Mr Roberts and Mrs Roberts are raising the  
23 issue of the anticonvulsants and antibiotics in terms of  
24 sodium level and your answer to that is that shouldn't  
25 have an adverse effect on sodium level.

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1 doctors overnight. But nothing was picked up from it.  
2 Let's set aside hyponatraemia for a moment, let's set  
3 aside what sort of hyponatraemia it might have been.  
4 Let's set aside all that and let's set aside the fact  
5 that this is an inquiry which is focusing, but is not  
6 exclusively restricted, to hyponatraemia. Is what  
7 happened to Claire not a classic example of a child  
8 dying, where many people should have sat around together  
9 and said, "Medically, how did this happen? And in terms  
10 of hospital management and governance, what can we do to  
11 avoid this?"

12 A. I would certainly accept those comments. Although I'm  
13 not aware of the details of the other cases, I suspect  
14 myself that Adam Strain's case was a very unusual,  
15 special set of circumstances. And I think I can half  
16 understand why that didn't necessarily strike the  
17 doctors as having much wider applicability. My own view  
18 is that Claire's case probably did have much wider  
19 applicability and there was more potential to learn  
20 general widespread lessons from it. I wasn't working in  
21 the Children's Hospital in the mid-1990s and others will  
22 come and will address the issues around governance,  
23 et cetera. The things you've said about the pressure  
24 that staff were working under is, I think, absolutely  
25 true, and we heard something about that earlier today.

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1 A. Yes.

2 THE CHAIRMAN: But that does lead into other issues about  
3 the prescription of those drugs, whether that  
4 prescription was appropriate, but in this time after the  
5 UTV documentary has been broadcast, the focus is on  
6 hyponatraemia, the focus is on fluid balance, which  
7 becomes a related, but rather different area.

8 A. I accept that. Certainly whenever I responded, I felt  
9 I was addressing mainly the fluid and the sodium issues.  
10 The broader aspects of Claire's case were somewhat  
11 outside my expertise. I felt this was a very  
12 complicated case and indeed, to an extent, I think that  
13 has been borne out by all of the disparate opinions.  
14 I could not have given a sort of certain, clear answer  
15 to these questions.

16 THE CHAIRMAN: Just when you say that: Claire's case is  
17 a complicated case medically, isn't that right?

18 A. Yes.

19 THE CHAIRMAN: But is that not exactly the sort of case that  
20 doctors and, to some extent, nurses can collectively  
21 learn something from?

22 A. Absolutely, it is, yes.

23 THE CHAIRMAN: For instance, what happened to Claire on 22  
24 and 23 October highlighted specific issues about, for  
25 instance, the overwhelming level of pressure on the

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1 I can't say that we have moved forward enormously,  
2 and you may cover some of the journey at later stages of  
3 the inquiry. Now we have morbidity and mortality  
4 meetings, where any case like this would definitely be  
5 considered in the sort of way that you have described,  
6 I would like to think. But certainly, any patient who  
7 dies, particularly in circumstances which are unusual --  
8 and, at the very least, these were unusual  
9 circumstances -- I think nowadays there ought to be  
10 careful consideration of what lessons can be learned.

11 THE CHAIRMAN: I think my point is a bit stronger than that,  
12 professor. My point is: in 1996, it should have been  
13 obvious that however many lessons were learned from it,  
14 people sat down together to see if lessons should be  
15 learned from it. It's even the first step which I'm  
16 concerned is lacking.

17 A. Yes. I understand. I don't think I have enough  
18 knowledge to comment on exactly what happened in 1996.

19 MR FORTUNE: Sir, to assist Professor Young, you will recall  
20 that Dr McKaigue talks about a mortality meeting taking  
21 place. We have no idea what was actually discussed at  
22 that meeting because, of course, it was the practice  
23 that there be no minutes. But that was clearly the  
24 ideal opportunity for everybody connected with Claire's  
25 case and, indeed, senior managers to be involved.

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1 THE CHAIRMAN: Yes. I'm not sure, Mr Fortune, how far we're  
2 going to get on that. That's a suggestion that there  
3 would have been, in November 1996, a mortality meeting.  
4 I'm not sure how far we're going to get on that, partly  
5 because there are no records at the time and I'm not  
6 sure whether in November 1996, which would be  
7 pre-autopsy report, what would have been known, apart  
8 from laying down a marker perhaps -- well, there are  
9 some issues we should look at, but laying down a marker:  
10 when the autopsy report comes in, let's look at Claire's  
11 case again.  
12 MR FORTUNE: Sir, that was the only meeting to get anywhere  
13 near a discussion.  
14 THE CHAIRMAN: Yes, thank you.  
15 MR STEWART: Just following on from the chairman's comments,  
16 did you at any time express the view that you didn't  
17 think any particular lessons could be learned from this  
18 case?  
19 A. Sorry, I don't understand that question.  
20 Q. Have you ever expressed the view that, in your opinion,  
21 there were no particular lessons to be learned from this  
22 particular case, from Claire Roberts?  
23 A. Have I ever said there were no lessons to be learned  
24 from this case? I don't believe so, no.  
25 Q. No particular lessons. Can I refer you to 140-041-004.

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1 moment we accept that it might reflect something that I  
2 said, what could I have meant? I think the only context  
3 in which I might even have said anything like that would  
4 have been in the context of 2004, whether there were any  
5 further lessons to be learnt in the relation to the  
6 management and prevention of hyponatraemia in children.  
7 And I think that, in 2004, my view then would have been  
8 that because of all of the efforts which had been made  
9 and the new guidelines which had been implemented in the  
10 Children's Hospital, that probably, at that point in  
11 2004, there would not have been any further lessons to  
12 have been learnt in relation to management of  
13 hyponatraemia from Claire's case. In 1996, that would  
14 have been a completely different matter.  
15 THE CHAIRMAN: Well, I think we can -- when we get that  
16 reference, I'll take your explanation of how it might be  
17 that you are recorded as saying something along those  
18 lines, but the context you're putting it into is 2004.  
19 But in 1996, it was a completely different matter and  
20 there were lessons to be learned in 1996?  
21 A. Yes.  
22 THE CHAIRMAN: Thank you.  
23 MR STEWART: I wonder if we could go back to those two pages  
24 on the screen side by side. The first is 089-003-007  
25 and the second, alongside it, please, is 089-006-014.

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1 This is a note taken by the trust solicitor at the  
2 inquest. It doesn't seem to be showing up. (Pause).  
3 Can you try 140-043-004?  
4 THE CHAIRMAN: No, we don't have that, I think.  
5 MR STEWART: There are two separate paginations on this  
6 page. This is a note taken by Brangam Bagnall & Co  
7 solicitors on behalf of the Trust of the hearing at  
8 inquest. You were asked:  
9 "Should this case have been reported in 1996?  
10 "Dr Young: Perhaps not back in 1996.  
11 "Re the inquiry?"  
12 In other words, should be reported to this inquiry.  
13 And your answer:  
14 "This should be left to the inquiry, and not for  
15 [you], but doesn't personally think there are any  
16 particular lessons to be learned from this case. This  
17 should be left to Mr O'Hara."  
18 Do you remember now giving that as your opinion?  
19 A. I don't remember giving that as my opinion, no. I'm not  
20 sure I've seen that document. And obviously, I can't  
21 comment on the likely accuracy of the minute or note  
22 since I did sign off on some minutes and notes at the  
23 inquest, which I did record as accurate --  
24 Q. Yes.  
25 A. However, if -- and I really can't remember -- for the

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1 I was going to ask you about question 8 because I'm not  
2 sure that the answer given is clear and not misleading.  
3 Paragraph 8:  
4 "Follow-up meetings in January 1997 with consultants  
5 and doctors at the Royal Hospital and the post-mortem  
6 report (our condensed version) ..."  
7 That's a letter written by Dr Webb, I think,  
8 explaining the content of the report:  
9 "... dated 21 March 1997 defined the cause of death  
10 as cerebral oedema linked to a viral infection. No  
11 statements were made about hyponatraemia. Given that  
12 Claire's sodium levels dropped so suddenly within  
13 a 27-hour period, that is to say acute hyponatraemia,  
14 why was this condition not defined?"  
15 The answer given at 8(a) is:  
16 "Hyponatraemia was not thought at the time to be  
17 a major contributor to Claire's condition."  
18 Might I stop there? Would you agree that  
19 hyponatraemia is noted in the chart? It's part of the  
20 diagnosis on discharge, it's noted as a diagnosis by  
21 Dr Webb in PICU, and indeed it appears, as we saw  
22 earlier, under the hand of Dr Stewart in Allen Ward.  
23 Would it therefore, in the light of that, be correct to  
24 say that:  
25 "Hyponatraemia was not thought at the time to be

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1 a major contributor"?

2 A. I think the inquiry has heard from almost all of the  
3 doctors who were looking after Claire at the time. And  
4 certainly whenever I reviewed the notes, despite the  
5 fact that hyponatraemia was recorded, my opinion was  
6 that hyponatraemia was not thought to be a major  
7 contributor to her condition. I think I've covered that  
8 at some length. If indeed the doctors had felt  
9 hyponatraemia was a major contributor to her condition  
10 and had not taken appropriate action, more appropriate  
11 action to address that, then I would have been very  
12 concerned. So certainly my view and reading of her  
13 notes -- and indeed I think it fits with the evidence  
14 that many of the doctors have given here -- is that they  
15 didn't recognise hyponatraemia at the time as being  
16 a major contributor to her condition. They were  
17 attributing most of the symptoms to status epilepticus  
18 and encephalitis, rightly or wrongly.

19 Q. In other words, you were saying, having read the chart,  
20 that you appreciate that the doctors at the time didn't  
21 really think of it in those terms, but I'm suggesting to  
22 you that perhaps, on a slightly different question, it  
23 should have been obvious to them that it was  
24 a contributor.

25 A. I think that's a more difficult question for me to

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1 the sodium level of 121.

2 A. Which is hyponatraemia and the pathologists, I'm sure,  
3 fully understood that there was hyponatraemia.

4 Q. But this answer is going to Mr and Mrs Roberts. They  
5 ask why was this condition not defined. And then it  
6 goes on -- it's slightly -- perhaps the wrong word is  
7 "slippery" -- but it's not really straightforward in its  
8 answer is what I'm suggesting to you.

9 A. I'm sorry, I don't myself accept that. I think that  
10 telling a pathologist that the sodium is 121 millimoles  
11 per litre is telling the pathologist that the patient  
12 has hyponatraemia. Whenever somebody phones me up from  
13 the ward, they don't say, "We have a patient with  
14 hyponatraemia", they say, "The sodium is 115".

15 Q. Yes, but you're telling the Roberts, who are not  
16 neuropathologists, that the post-mortem report notes  
17 that hyponatraemia was indicated. And I have to say, it  
18 doesn't.

19 A. Well, no, it does note that hyponatraemia was indicated.  
20 It does not use the word "hyponatraemia". I think that  
21 the answer to that was given to the Roberts family is  
22 correct, even though the word "hyponatraemia" is not  
23 used in the post-mortem report. And we didn't say -- or  
24 the letter doesn't say that the word hyponatraemia is  
25 used in the post-mortem report. It says that

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1 answer. But certainly, whenever I looked at the chart  
2 in 2004, I identified it very quickly as a significant  
3 contributor. But the questions of awareness of  
4 hyponatraemia and its significance and likely  
5 contribution in the Children's Hospital medical staff  
6 and more widely in 1996 is one that's been discussed  
7 quite intensively.

8 Q. That's the answer given to the Roberts' request for  
9 information about why it was not really defined at the  
10 time. Then it goes on to say in paragraph 8(a):  
11 "It is noted from the post-mortem report that the  
12 presence of hyponatraemia was indicated in the clinical  
13 summary provided to the neuropathologists conducting the  
14 post-mortem."  
15 Is that clear and straightforward? The post-mortem  
16 report, of course, doesn't mention the word  
17 "hyponatraemia".

18 A. I would have to go back and call that up and I'm  
19 speaking from memory, but I think it gives the serum  
20 sodium level. Does it?

21 Q. Yes, indeed it does, it does. But:  
22 "It is noted from the post-mortem report that the  
23 presence of hyponatraemia was indicated in the clinical  
24 summary provided to the neuropathologist."  
25 What was indeed provided in the clinical summary was

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1 hyponatraemia is indicated, which indeed it is.

2 Q. And you think that's an open, transparent, helpful  
3 response to Mr and Mrs Roberts?

4 A. I felt at the time, as I still do, looking at it, that  
5 it's an accurate answer to the question. And if it's  
6 considered to lack transparency, if we should have said  
7 instead of that wording that it's noted on the  
8 post-mortem report that the sodium was 121 millimoles  
9 per litre, then I apologise for that.

10 Q. The paragraph goes on to say:  
11 "The subsequent neuropathology report commented only  
12 on the low-grade sub-acute meningoencephalitis and  
13 neuronal migrational defect."  
14 That's not quite right, is it? It comments on  
15 a number of things.

16 A. I think, as I indicated earlier, I am not even sure that  
17 I had seen the post-mortem report, rightly or wrongly.  
18 I certainly wouldn't have had it in front of me and that  
19 definitely would have been a section that Dr Steen would  
20 have completed.

21 Q. It brings me back to that observation. You are this  
22 highly-qualified individual, who considers himself  
23 independent to this process, to help bring information  
24 to the Roberts. You're not even checking the answers  
25 being given by Dr Steen herself to the Roberts.

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1 A. I think I accept that. I've been very clear about what  
2 I consider to be the purpose of my review and its  
3 objective and its limitations, and Dr McBride I'm sure  
4 will speak to that as well. It was to review the  
5 contribution which hyponatraemia and fluid management  
6 may have made to Claire's death and to make  
7 a recommendation on whether the case should be referred  
8 on to the coroner or not. My subsequent involvement was  
9 doing my best at the time to give the relevant  
10 information to Claire's parents. If I've done that  
11 inadequately, it was an honest effort, then I can only  
12 apologise.  
13 Q. Do you remember how much time you spent on this work?  
14 A. What do you mean by this work?  
15 Q. In checking the chart, checking the responses, making  
16 suggestions, amending.  
17 A. I think there are a number of different phases. I've  
18 indicated that my initial chart review, based on which  
19 I reached my conclusions, was about one hour.  
20 Obviously, there were e-mails doing the rounds  
21 subsequently. I would imagine that the more likely  
22 process was that I was receiving the e-mails and  
23 probably not working from the charts at that stage, but  
24 working perhaps from the note of the meeting and also my  
25 memory and knowledge of the area to provide answers.

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1 "Death certificate issued: cerebral oedema secondary  
2 to status epilepticus."  
3 That indeed is what went on the medical certificate  
4 for the cause of death and what was then translated on  
5 to the death certificate issued to the Roberts family.  
6 Seeing that, how could you allow the Roberts to be  
7 informed by this letter that it was believed at the time  
8 the cause was something not on the death certificate?  
9 A. I think I've described previously fairly carefully how  
10 I carried out my review and its focus. I have explained  
11 that I was very much focused on the events related to  
12 fluid balance and sodium. I suspect -- and I paid very  
13 little attention to events after Claire suffered the  
14 respiratory arrest. So I may not even have read that  
15 at the time, certainly didn't pay it any attention, and  
16 I'm certain that that part of the letter would have been  
17 relying on information coming from Heather Steen.  
18 THE CHAIRMAN: Do you accept that it doesn't sit easily?  
19 A. Yes, absolutely, and I do accept that, yes.  
20 THE CHAIRMAN: I think the problem we keep coming back to on  
21 is that the Roberts, they have a daughter who died  
22 unexpectedly. There are various other circumstances  
23 between 21 and 23 October, which are unsatisfactory.  
24 They never really quite understand or have explained to  
25 them in a way which makes sense to them why she died,

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1 I can't tell you how long that would have taken me. As  
2 you will appreciate, like everyone else, I have a very,  
3 very busy job and a lot of pressures. So I would not,  
4 in practice, have sat down with the note for several  
5 hours to check every detail. Absolutely not.  
6 Q. No. Can we move on to paragraph 10? On the right, can  
7 we have 089-006-015? Question 10 towards the bottom on  
8 the left-hand side, Mr and Mrs Roberts ask:  
9 "Given that Claire's death was sudden, unexpected  
10 and without a clear diagnosis, why was the coroner not  
11 informed or an inquest held?"  
12 The answer is:  
13 "The coroner had not been informed at the time as it  
14 was believed that the cause of Claire's death was viral  
15 encephalitis."  
16 If you'd looked at the chart, you'd have seen that  
17 the medical certificate of cause of death completed by  
18 Dr Steen did not include viral encephalitis as a cause  
19 of death.  
20 A. I'm certain that I didn't see the death certificate. It  
21 may or may not have been in the chart.  
22 Q. The chart itself contains Dr Steen's entry of what she  
23 wrote on that certificate. It's at 090-022-061. There  
24 we are. At 18.45, on the left hand corner, "McKaigue".  
25 And then in Dr Steen's handwriting, she's entered:

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1 and when they go back to the Royal after the UTV  
2 documentary is broadcast, they have a meeting and then  
3 a response to queries which they raise, which are  
4 imperfect, if I can put it that way. Do you understand  
5 how Mr and Mrs Roberts might feel that this isn't just  
6 a bit shoddy in various aspects, but it also makes them  
7 think, "Is there something more sinister going on?"  
8 That would be an entirely natural reaction for the  
9 Roberts to have, wouldn't it?  
10 A. Certainly, chairman. I accept the mistakes and errors,  
11 and I regret that. I think I've tried to outline the  
12 parts I would have highlighted and, in general, the  
13 parts I would have dealt with, I would have thought  
14 might have been apparent from the drafts. The bits  
15 you've highlighted in general are often information  
16 that's not being provided by me, but I accept I had  
17 a contribution into the overall process. I do  
18 understand a little bit the pain which the Roberts  
19 family have felt and their dissatisfaction with the  
20 whole process which has taken place, but certainly if  
21 there have been errors or mistakes made, then I'm  
22 certain that that's what they are. This idea or  
23 suggestion that there has been some form of cover-up --  
24 in all of my involvement in this case, I've never ever  
25 even had any possible sense of that. I think what we're

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1 talking about are mistakes, which have been, as far as  
2 I'm concerned, honestly made.  
3 THE CHAIRMAN: At the very least, you understand why we have  
4 to raise these issues?  
5 A. I understand.  
6 MR STEWART: Would you agree if a proper and systematic  
7 review of the case had been conducted at that time,  
8 those mistakes probably would not have been made?  
9 A. "I'm not sure" is the answer to that because we had two  
10 independent experts at the coroner's inquest, which is  
11 what I believed was going to happen: Dr Bingham, a very  
12 eminent paediatric anaesthetist from Great Ormond  
13 Street, and Dr Maconochie. I believed that that should  
14 give confidence that there was a robust external  
15 assessment of Claire's management and condition.  
16 Despite that, and indeed the subsequent police  
17 investigation, two more experts, then there were clearly  
18 significant issues which were not picked up. The type  
19 of investigation which you describe might or might not  
20 have addressed the issues. It may be that it's taken  
21 something like this inquiry to do it and the very large  
22 number of experts involved.  
23 Q. Isn't the point that all those experts were really  
24 focusing on a given question in the case and not  
25 reviewing the case in a more holistic case?

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1 30 April. I'm sure you were very busy. And then at  
2 139-118-001, a note is taken in a litigation management  
3 office, I think, or a telephone call from you on  
4 10 May 2005, to say:  
5 "Professor Young rang. Has completed statement and  
6 has been approved by medical defence organisation."  
7 So you took it off and had it approved by your  
8 professional indemnity insurers; is that right?  
9 A. Actually, I have no recollection of this at all, I have  
10 to admit. This is the only time in my entire career  
11 when I've been involved with a coroner's inquest and  
12 I would have had no real knowledge of the processes  
13 which would have been involved in it. With Mr Walby  
14 having written to me and suggesting that I should  
15 perhaps have the statement checked by my organisation,  
16 the Medical Protection Society, then I think it's quite  
17 likely that I would have followed his advice. But I've  
18 absolutely no recollection of it.  
19 Q. Very well. Moving on to 139-114-001, this is a week  
20 later. You e-mail, I think, Walby's office to say:  
21 "Please find attached my report on Claire. You may  
22 need to put this in the correct format for me to sign.  
23 I'm happy to make any changes."  
24 What did you mean when you said to Mr Walby, "I'm  
25 happy to make any changes"?

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1 A. I don't believe that's the case.  
2 THE CHAIRMAN: To a degree, in the same way as you've been  
3 focusing on specific aspects rather than an overall  
4 view?  
5 A. Yes, what I'm not sure about is the role of Dr Bingham  
6 and Dr Maconochie at the inquest. Certainly, I would  
7 have understood that they were focused on the whole  
8 management of Claire and events leading up to her death,  
9 not the specific thing that I was focused on.  
10 MR STEWART: Moving on to another part of the process with  
11 which you had a role, and that's providing a statement  
12 for the coroner and your appearance at the inquest.  
13 Mr Walby of the litigation management office wrote  
14 to you on 31 March 2005 asking for a statement at  
15 139-124-001.  
16 He says:  
17 "I would be grateful if you would provide a draft  
18 statement outlining your analysis of the situation,  
19 which led to the discussion of the child's death with  
20 the parents."  
21 He tells you:  
22 "This will be a legally significant statement and  
23 you may wish to consult your professional body or legal  
24 adviser before submitting your draft to this office."  
25 Further at 139-120-001, he sends you a reminder on

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1 A. I think it's fairly straightforward: you may need to put  
2 this in the correct format for me to sign. So I think  
3 I was referring to changes around the formatting of my  
4 report.  
5 Q. Thank you. And page 139-113-001. It's the following  
6 day. This note is taken at the litigation management  
7 office:  
8 "I talked with Professor Young. He has not  
9 discussed the statement with anyone other than the  
10 Medical Protection Society. He agrees not based purely  
11 on notes, also from e-mails passed from Dr N Rooney, as  
12 they did meet with family."  
13 Can you remember that, can you explain that?  
14 A. I'm not sure what needs explained. I think it's  
15 relatively clear.  
16 Q. Okay. Then the note continues:  
17 "Re 'comments from other staff' said this sentence  
18 was suggested by MPS."  
19 This would look like a phrase contained in your  
20 statement. And seemingly you discussed it and you told  
21 Mr Walby this sentence was suggested by the MPS.  
22 A. Are you suggesting there was something wrong in me  
23 contacting the MPS?  
24 Q. No, I'm not. Mr Walby suggested that you might like to  
25 do that and I'm not saying that you did anything wrong

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1 at all. What I am asking about is this discussion that  
2 you and Mr Walby had about a phrase, "comments from  
3 other staff", and it seems that you were explaining that  
4 to Mr Walby and saying, "Yes, that phrase came from the  
5 MPS". It was perhaps inserted by you into the statement  
6 in response to a suggestion from the MPS.  
7 A. Possibly so. I would have to go to the statement.  
8 I would have to look --  
9 Q. We'll have difficulty finding the first version. Then  
10 do you see immediately above that phrase --  
11 A. Sorry, I'm not sure what that means either. Was there  
12 a first version, which is what you're referring to?  
13 Q. I don't have a first version, as submitted by you, with  
14 a phrase "comments from other staff", in it.  
15 A. Is there a version of my inquest statement that contains  
16 that "comments from other staff" which --  
17 Q. No, there's not. If you look above, do you see the  
18 annotation in a distinctive spidery handwriting?  
19 A. Yes.  
20 Q. It says:  
21 "Asked Professor Young to remove these."  
22 Do you remember a discussion with Mr Walby where  
23 a phrase in your statement was discussed, you said it  
24 had come from the Medical Protection Society, and he  
25 said, right, well, it might be better if you just took

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1 something apparently -- according to this, they've  
2 suggested a particular reference -- and at one point,  
3 Mr Walby raises that with you and then asks you to  
4 remove it. And so far as we can glean from the  
5 statement put before the coroner, it was removed.  
6 A. All I can say about this, because I've no recollection  
7 of it at all -- firstly, it looks like I wrote  
8 a statement without this phrase in and sent it to the  
9 Medical Protection Society --  
10 THE CHAIRMAN: Yes.  
11 A. -- it looks as if they recommended inserting it --  
12 THE CHAIRMAN: Yes.  
13 A. -- it looks as if Mr Walby, who I understood to be  
14 assisting the coroner, then suggested that the phrase  
15 should come out. I didn't originally intend the phrase  
16 to be in, obviously, before I sent it to the MPS. It  
17 had not been in my original version of the statement.  
18 That, I think, is the implication of that: I had written  
19 a statement without it, the MPS had asked for it to go  
20 in, so then Mr Walby asked for it to go out again.  
21 Since I had initially written the statement with the  
22 words out and that had been my statement, then very  
23 possibly at the time, if he had suggested it, then I  
24 wouldn't have given it much of a second thought if my  
25 original statement hadn't contained that phrase.

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1 it out?  
2 A. No, I've absolutely no recollection of that at all.  
3 Q. Okay. Because then we move on to 139 --  
4 THE CHAIRMAN: Just to make it simple, the point is, as you  
5 explained a few minutes ago, when you said to Mr Walby  
6 that you were content to make any changes, what you  
7 meant was make any changes in format.  
8 A. Yes, absolutely, I would believe so.  
9 THE CHAIRMAN: That does not appear, insofar as we can gauge  
10 it from this note, to be a change in format. That's  
11 a change to a substantive line or sentence in your  
12 statement.  
13 A. I honestly have no recollection whatsoever of this.  
14 THE CHAIRMAN: We know from Dr Webb's evidence that his  
15 statement, his draft statement, was changed at  
16 Mr Walby's suggestion in a substantive way -- perhaps  
17 not in a fundamental way -- where he said: I think [he]  
18 made an a mistake about not raising Claire with the PICU  
19 anaesthetists at about 5 o'clock. Mr Walby encouraged  
20 him -- let's put it neutrally -- to change that line.  
21 So Mr Walby did not restrict himself -- this may be  
22 perfectly legitimate: it's an issue we'll explore  
23 tomorrow -- to suggesting changes in format. So what  
24 you have here is you have a statement, you run it  
25 through your Medical Protection Society, they suggest

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1 THE CHAIRMAN: I'm making no comment at all at this stage,  
2 and it might turn out to be the most innocuous phrase  
3 that you could insert or delete, but it's not a change  
4 to format.  
5 A. I accept that. I honestly have no recollection of this.  
6 It's the only time in my career -- what I know  
7 I certainly would not have allowed to happen is any  
8 significant change to a statement that distorted the  
9 intention of my meaning. And since the original  
10 statement I wrote didn't have it in, then certainly  
11 whenever I --  
12 THE CHAIRMAN: Thank you.  
13 MR STEWART: There may be no net gain or loss to the  
14 essential meaning of your statement, but it was your  
15 willingness to go along with the idea -- to put  
16 something in, take something out -- when what you're  
17 doing is providing a statement for Her Majesty's  
18 Coroner. That's the issue we're exploring.  
19 A. And my understanding at the time was that Mr Walby was  
20 assisting the coroner, was effectively acting as his  
21 agent, certainly that he was advising me on the correct  
22 way to submit the statement, but the content of the  
23 statement had to be mine in the sense of it.  
24 Q. Did you have a sense that Mr Walby was acting as an  
25 agent to the coroner?

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1 A. Acting on behalf of the coroner in some way or assisting  
2 the coroner. I may be using the wrong phrase there.  
3 I'm not a legal person and it may be that "assisting  
4 the coroner" is a more correct phrase.  
5 Q. I take it you too were assisting the coroner.  
6 A. I hope so, I hope I've assisted the correspond, the  
7 family, and indeed this inquiry, throughout. Certainly  
8 I have done so to the best of my ability.  
9 Q. Let's move on to 139-111-001. This is the next email in  
10 this chain where you send then to Mr Walby:  
11 "Please find a modified version attached. Please  
12 let me know if you would like any further changes."  
13 Are you happy really to go along with Mr Walby's  
14 intentions in really to your statement for the coroner?  
15 A. Not certainly in terms of the substantive content. I've  
16 already indicated that. I've already explained that  
17 I had absolutely no experience whatsoever of dealing  
18 with the coroner and that I viewed Mr Walby as the  
19 expert in doing so.  
20 Q. Then at 139-111-002, we find a copy of the statement,  
21 which doesn't have the phrase "comments from other  
22 staff" within it. That's then sent by you to Mr Walby.  
23 At 139-110-001, Mr Walby writes to you:  
24 "Further to previous correspondence regarding the  
25 above named, please now find enclosed your statement,

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1 it was something Mr Walby was very used to.  
2 Q. Fair enough. You didn't date it. That's presumably an  
3 error. At the top left-hand side, on a blank line, it  
4 says, "Signature of member by whom statement was  
5 recorded or received". I think the idea is that this is  
6 something which you give to a police officer. It's  
7 a member of the police force, a policeman, who receives  
8 it. Didn't that strike you as being odd?  
9 A. You know, I really don't think this is something I can  
10 comment on or help you with at all. It didn't strike me  
11 as being odd at the time. I had the impression it was  
12 very much part of a routine process within the Trust and  
13 now, when I read through the evidence and files, I do  
14 understand that it was routine process. So my guess is  
15 anybody dealing with me around it would just have  
16 treated it as a normal part of business and probably  
17 I accepted it as such.  
18 Q. Very well. You then proceed to --  
19 MR FORTUNE: Sir, before my learned friend goes on, isn't  
20 the important point about this particular format -- and  
21 it applies to other witnesses, including Dr Steen --  
22 that it is the declaration at the top that is being  
23 drawn to the attention of the maker? And it's the  
24 declaration that is to be signed so that it drives home  
25 to the maker the importance of telling the truth. Does

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1 which has been redrafted onto a witness statement form.  
2 Please re-read the statement and, if you are in  
3 agreement with its contents, please sign and date and  
4 return to these offices."  
5 If we go to 090-052-159, this is the redrafted  
6 statement that you were asked to date and sign. It has  
7 been put on to a police witness statement paper. Did  
8 that surprise you?  
9 A. I remember being asked about this in my initial list of  
10 questions, and I think I commented on it in my initial  
11 witness statement to say that I had really no idea how  
12 it was getting on to this paper. And it's now clear to  
13 me. So if I can summarise my understanding just to  
14 check I've got it right because you're obviously  
15 bringing things back to me here. I wrote an original  
16 statement that went to the MPS who inserted a phrase.  
17 Then Mr Walby recommended the phrase come back out.  
18 I agreed to do that. So it was back really to my  
19 original statement that I had drafted myself. And then,  
20 with Mr Walby's assistance, it went on to police headed  
21 paper.  
22 I have dealt with the police on a number of  
23 occasions in a professional capacity and I don't think  
24 this -- I have no recollection of it striking me as  
25 particularly unusual, obviously I guess because clearly

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1 it matter whether it's on a form supplied by the PSNI in  
2 this particular case?  
3 MR STEWART: It might be more important if the initial  
4 statement before modification, editing and possible  
5 correction were put on the police paper, yes.  
6 MR FORTUNE: Sir, it's quite normal for doctors to submit  
7 draft statements or reports to their protection bodies  
8 seeking advice. As Professor Young has said, he was new  
9 to making a statement of report.  
10 THE CHAIRMAN: Yes. If this point needs a bit more  
11 development, we can do it with Mr Walby tomorrow.  
12 Thank you.  
13 MR STEWART: Moving on, so you're preparing for the inquest,  
14 it's the first inquest you've been engaged in, and you  
15 then have sent to you the statements of the other people  
16 involved: Dr Steen, Dr Webb, Dr Sands. If we go to  
17 139-042-001, you see at the bottom there's "To  
18 Ian Young":  
19 "Please find attached the following documents for  
20 your information."  
21 And you were sent those statements and indeed the  
22 post-mortem report, and you read them and at the top of  
23 the page your response then to the litigation management  
24 office is:  
25 "Peter. Thank you for the additional report, which

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1 I've looked at. I would like to mention the following  
2 relevant issues. Dr Webb states on page 14:  
3 "Claire's hyponatraemia led to her developing  
4 cerebral oedema (brain herniation). The swollen brain  
5 will herniate downwards results in brainstem compression  
6 and cardiorespiratory arrest.'  
7 "This seems to me a clear statement that Dr Webb  
8 believes that hyponatraemia played a significant part in  
9 Claire's death. Dr Webb indicates elsewhere in his  
10 statement that he believes that responsibility for  
11 Claire's fluid management lay with the medical team.  
12 Dr Webb also draws attention to the failure to take an  
13 electrolyte sample on the morning following Claire's  
14 admission, which he states was routine practice.  
15 In addition, he states that he believed, at the time,  
16 that such a sample had been taken and that if he had  
17 been aware that the sodium of 132 had been taken the  
18 previous evening, he would have requested an urgent  
19 repeat. These are substantial issues which were not  
20 fully discussed during our meeting this morning, and  
21 which could certainly become significant at the  
22 inquest."  
23 What in particular were you drawing Mr Walby's  
24 attention to apart from the obvious in that?  
25 A. My understanding at the time was that my role was to

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1 an electrolyte sample in the morning following Claire's  
2 admission. That's been discussed quite extensively.  
3 THE CHAIRMAN: It has.  
4 A. And at the time, that was not the information that had  
5 been given to me from other sources. And since I wasn't  
6 working in the Children's Hospital, I wasn't really in  
7 a position to comment on that. The second issue there,  
8 if such a sample had been taken and he would have  
9 requested an urgent repeat, I absolutely do accept that,  
10 the second half.  
11 THE CHAIRMAN: Right. Let's go to the paragraph above:  
12 "This seems to me a clear statement that Dr Webb  
13 believes that hyponatraemia played a significant part in  
14 Claire's death."  
15 When you discussed, towards the start of your  
16 evidence, the three contributors, rightly or wrongly,  
17 then he's closer to your line of thinking than Dr Steen  
18 was in terms of emphasis?  
19 A. Absolutely, at this point. And I hadn't, I think, been  
20 aware of that before, which is why I was highlighting  
21 it, because I thought the coroner's case was going to be  
22 looking at the three slices of the pie and Dr Webb did  
23 seem to me to be closer to my position, and indeed the  
24 eventual formulation which I suggested when asked by the  
25 coroner.

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1 assist on the key issues being drawn out at the inquest.  
2 So in highlighting those issues and believing Mr Walby  
3 to be assisting the coroner, then that was my intention.  
4 Q. Was it perhaps that you can see that there was a gap  
5 opening up between Dr Steen and Dr Webb and that Dr Webb  
6 was essentially saying, "Not me, it's the medical team",  
7 and there was going to be a difficulty at the inquest if  
8 the witnesses were going to start giving conflicting  
9 evidence and blaming each other?  
10 A. Not at all. That would not have been a matter of  
11 concern for me. The purpose of the inquest was to try  
12 to find the reason for Claire's death. I'll say in  
13 passing that whenever I reviewed the notes, and  
14 subsequently, it never occurred to me for a moment that  
15 anyone other than Dr Steen was the responsible  
16 consultant in Claire's case.  
17 THE CHAIRMAN: Do you have an issue with what you summarised  
18 Dr Webb as having said there?  
19 A. That was certainly clearly the interpretation I took  
20 from his statement in terms of key issues which I felt  
21 hadn't been drawn out previously.  
22 THE CHAIRMAN: Yes. But what you have done is summarise  
23 Dr Webb's position; do you think that position is right?  
24 A. There were two questions. The first -- so I think it's  
25 clearly his position. So first was the issue of drawing

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1 THE CHAIRMAN: Then the paragraph that you did take me to  
2 a moment ago, when it really draws attention to the  
3 failure to take a sample in the morning, that's an  
4 indication that Dr Webb has realised that he has  
5 misunderstood the notes because his evidence to the  
6 inquiry was that, when he saw the notes, he thought the  
7 sample had been taken that morning.  
8 A. Absolutely, and I think that indicates, before  
9 the coroner's inquest, that Dr Webb's position certainly  
10 was that he had misunderstood the timing of the sample.  
11 Otherwise, he would have requested another one urgently.  
12 THE CHAIRMAN: And you agree with him on that?  
13 A. That there should have been? Absolutely, yes.  
14 THE CHAIRMAN: So the sample which was taken on Claire's  
15 admission the previous evening should have been updated  
16 on the Tuesday morning.  
17 A. I think as you have said yourself before, and I agree  
18 completely, if that had happened, very probably this all  
19 could have been avoided -- in terms of the hyponatraemia  
20 contribution, at least.  
21 THE CHAIRMAN: We'll never know, but there's a very good  
22 chance it would have shown some reduction in the sodium  
23 level?  
24 A. I'm pretty certain. Based on my long experience with  
25 this, I'm pretty certain it would have been between 125

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1 and 130.  
2 THE CHAIRMAN: At which point you do begin to worry?  
3 A. Below 130 would have been a trigger to anyone, I think,  
4 in that period, that it was more significant.  
5 THE CHAIRMAN: Yes, thank you.  
6 MR STEWART: Do you think it important that Dr Steen should  
7 learn of your discovery of what Dr Webb had said?  
8 A. I don't think there was any discovery. My understanding  
9 or my impression at the time was that it was better for  
10 everybody going to the coroner's inquest to see the  
11 statements from everyone else, and certainly I remember  
12 that I had access, I think, to all of the statements  
13 before I went.  
14 Q. So why was it important for everyone to know each  
15 other's points of view?  
16 A. From my perspective, clearly there were issues which  
17 needed to be teased out for the coroner and with the  
18 independent experts who were looking at the case. There  
19 were clearly always going to be differences in clinical  
20 opinion, I think, in terms of the contribution of what  
21 I've called the three slices of the pie. I think it's  
22 very helpful to know what others think when you're going  
23 to engage in that sort of discussion.  
24 Q. Yes. But let's say those others didn't share the same  
25 view as you or you knew that two of the other members of

1 Mrs Roberts on 17 December. At the top of the second  
2 paragraph, you'll see he said to them:  
3 "As you have been informed by Professor Ian Young of  
4 the Queen's University Belfast, our medical case note  
5 review has suggested that there may have been  
6 a care-management problem in relation to hyponatraemia  
7 and that this may have significantly contributed to  
8 Claire's deterioration and death."  
9 Do you know what "a care-management problem" meant  
10 at that time? Do you understand the terminology,  
11 care-management problem?  
12 A. I must admit, no, it was not terminology that had any  
13 special significance for me at all at the time. I have  
14 seen subsequently, from the inquiry's website, although  
15 I wouldn't pretend to fully -- I saw it in passing that  
16 it was in fact a phrase that had some special  
17 significance, but it didn't have any special  
18 significance to me.  
19 Q. It's the acts and omissions of clinicians in relation to  
20 the care of a patient, and indeed you were asked about  
21 this -- you are quite right -- at WS178/1, page 7. This  
22 is your witness statement request, paragraph 4(a).  
23 Arising from that letter you were then asked:  
24 "What was the care-management problem of which you  
25 informed Mr and Mrs Roberts? The care management

1 the team giving evidence were actually going to disagree  
2 one with the other. It'd be pretty important to make  
3 sure you got your lines squared.  
4 A. I think that is certainly very helpful information for  
5 somebody to know. I think, for any doctor who's  
6 reflective, what it makes you do is make you think about  
7 your position and your justification for it and have you  
8 really got it correct. It helps you to marshal your  
9 arguments. There was space here for differences of  
10 opinion -- that was my view -- because it was  
11 a difficult case; it wasn't a straightforward wrong or  
12 right in some of its aspects.  
13 Q. Would you want those differences of opinion explored at  
14 the hearing or other not?  
15 A. That's what I thought would be happening, that everyone  
16 would have a chance, and the coroner would consider it  
17 all in light of the independent external opinions.  
18 Q. And you'd have been happy if everyone had gone along and  
19 disagreed?  
20 A. I'd have been happy for that to happen, yes, because  
21 I think that's the best way you can assist the coroner.  
22 Q. In terms of assisting the coroner, I have just a couple  
23 more questions. It's in relation to something that  
24 arose indeed in your evidence to the inquest. At  
25 139-145-001, it's a copy of a letter written to Mr and

1 problem which I referred to was the possible role of  
2 hyponatraemia in Claire's deterioration and subsequent  
3 death, and the way in which the management of her fluid  
4 balance and monitoring of serum electrolytes contributed  
5 to the development of the hyponatraemia."  
6 That's the position that you would hold to, that was  
7 what you meant by the care-management problem, was it?  
8 A. I myself didn't use the phrase "care-management  
9 problem", I don't think, at any stage.  
10 Q. No. What you meant by that phrase would have been --  
11 A. I didn't mean anything because I haven't used the  
12 phrase.  
13 Q. Right. I think you know what I am asking you: had you  
14 used that phrase, whatever phrase you did use, the  
15 import of your message to Dr McBride was, "the possible  
16 role of hyponatraemia in Claire's deterioration", and so  
17 forth.  
18 A. Absolutely. That's what I said to Dr McBride: that on  
19 that basis, I believed the case should be further  
20 forwarded to the coroner.  
21 Q. You were asked about this letter at the inquest -- and,  
22 sadly, this is again at the same page that we tried to  
23 bring up on the screen earlier. It's given two separate  
24 pagination numbers: either 140-041-004 or 140-043-004.  
25 This is the solicitor, Brangam Bagnall's note. We've

1 got it this time.

2 We have cross-examination by Mr McCrea, and the  
3 letter, 17 December, Mr McBride, that's the letter  
4 I referred you to a moment ago, was read. The second  
5 paragraph:

6 "Mr Lavery objects, unfair to confront the witness  
7 with a letter he's not seen before. Dr Young was  
8 allowed to read the letter, as is Michael Lavery and  
9 the coroner. The letter is then received by the coroner  
10 pursuant to rule 17. This paragraph relates to a  
11 'care-management problem'. Dr Young asked to explain  
12 this comment. He did not use this term to Dr McBride,  
13 he is fairly sure of this. He merely discussed with  
14 Dr McBride whether this case should have been referred  
15 to the coroner."

16 That's not quite the same answer as the witness  
17 statement to the inquiry, is it?

18 A. Well, I'm ... So I have no, again, no recollection of  
19 this, nor can I comment on the accuracy of the minute or  
20 what exactly was asked to me. But I think --

21 THE CHAIRMAN: Sorry, but professor, that response which is  
22 noted from the inquest seems to be along the lines of  
23 the evidence that you've been giving today.

24 A. Yes.

25 THE CHAIRMAN: Right. So that is consistent with what

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1 said to us is that:

2 "The care-management problem that you were referring  
3 to was the way in which the management of her fluid  
4 balance and monitoring of electrolytes contributed to  
5 the development of hyponatraemia."

6 Which is going further.

7 A. I think in the meeting with the Roberts, if we go back  
8 to it, there were two key issues which I talked about as  
9 having changed and which I thought would have made  
10 a difference to Claire. One was the choice of type of  
11 fluids and then I also talked about the frequency of  
12 electrolyte monitoring and how that would have changed.  
13 So those, I felt, were the two issues which I discussed  
14 in the context of fluid management and what had changed.

15 THE CHAIRMAN: Okay.

16 MR STEWART: What I would suggest is that the note of the  
17 evidence given to the inquest might indicate that, so  
18 far from you welcoming an open debate about the  
19 questions arising in this case, you weren't actually  
20 giving very much away to the coroner, "No lessons to be  
21 learned from this case", and you simply told Dr McBride  
22 that this matter should be referred to the coroner.

23 A. Let me say that I think that's a complete distortion of  
24 what actually happened and what I said. We covered  
25 earlier the issue of whether lessons could be learnt and

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1 you have been saying today: what you were engaged to do  
2 by Dr McBride. I think the point that's being raised  
3 with you is, if we go back to 139-145-001, when the --  
4 sorry, I have got the wrong ...

5 MR STEWART: WS178/1, page 7.

6 THE CHAIRMAN: Thank you. When you were asked about this at  
7 4(a), what you informed the inquiry was that:

8 "The care-management problem was the possible role  
9 of hyponatraemia in Claire's deterioration and death  
10 ..."

11 That's fine because that's the emphasis question:  
12 "... and the way in which the management of her  
13 fluid balance and the monitoring of electrolytes  
14 contributed to the development of the hyponatraemia."

15 A. This, I think, relates to the information given to  
16 Mr and Mrs Roberts.

17 THE CHAIRMAN: Given to Mr and Mrs Roberts by Dr McBride on  
18 foot of the information which you provided Dr McBride  
19 with. You were given the notes, you did --

20 A. Right, okay.

21 THE CHAIRMAN: -- a case note review. You informed  
22 Dr McBride that you believed Claire's case should be  
23 referred to the coroner. You've indicated to us that  
24 you believed that that's what he thought already, so you  
25 were confirming his view. In this answer, what you have

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1 I indicated clearly the very specific context in which  
2 I might possibly have said that about 2004 and about the  
3 management of children with hyponatraemia. And the  
4 context of that was all of the changes which had taken  
5 place in relation to hyponatraemia and fluid management  
6 in children, the new Northern Ireland guidance and how  
7 that had been implemented within the Children's  
8 Hospital.

9 MR STEWART: Thank you. I have no further questions, sir,  
10 unless there are any from the floor.

11 THE CHAIRMAN: Okay.

12 MR MCCREA: A few minutes, please.

13 THE CHAIRMAN: Mr McAlinden, do you want a few minutes?

14 I think, professor, we have virtually reached the  
15 end of your evidence, unless there are any particular  
16 points. I'm going to rise for a few minutes.

17 Mr McAlinden, I've received a letter this afternoon,  
18 which you may not have seen yourself yet. It's from  
19 your solicitors about privilege being waived for  
20 a single letter that had been previously claimed and  
21 a desire for it to be circulated so that Mr Walby can  
22 refer to it tomorrow.

23 I am concerned -- Mr McCrea, wait one moment,  
24 because you may have something to say about this. I'm  
25 not going to make a decision about it tonight. You will

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1 know that privilege was claimed by DLS by the Trust for  
2 exchanges and letters. We've received notification this  
3 afternoon that Mr Walby wants to refer tomorrow to  
4 a letter for which privilege had previously been  
5 claimed, so that privilege is now waived for that  
6 letter, but only for that letter, so that Mr Walby can  
7 refer to it in his evidence tomorrow. And Mr McAlinden,  
8 I will need to look at this tonight, but I'm not sure if  
9 you can pick and choose among your privileged letters  
10 and correspondence documents and decide "I'm going to  
11 waive privilege for this single document, but retain  
12 privilege for the remainder". So I'm going to circulate  
13 your covering letter tonight and we can pick up the  
14 issue tomorrow morning. Okay?

15 MR McALINDEN: Yes.

16 THE CHAIRMAN: I'll rise for a few minutes to see if there  
17 are any outstanding issues.

18 (5.22 pm)

19 (A short break)

20 (5.35 pm)

21 MR STEWART: Thank you, sir.

22 If I may, for the sake of completeness, just mention  
23 one matter, please, to Professor Young. That's  
24 in relation to the amendment made to your statement for  
25 the coroner at the suggestion of Mr Walby, and indeed

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1 from all of the other medical practitioners".  
2 MR McALINDEN: I think the point is this: that there was no  
3 initial statement with a phrase "all the other staff".  
4 That is simply just someone's interpretation of what  
5 appeared in the statement as opposed to there being  
6 another draft with the words within inverted commas  
7 in that draft. It's always been the case that the draft  
8 statement provided by Professor Young contained the  
9 phrase:

10 "However, I did not have access to comments from all  
11 of the other medical practitioners involved in Claire's  
12 care."

13 THE CHAIRMAN: I am not sure that was quite the point that  
14 was being raised earlier. The point that was raised  
15 earlier -- and it's a question of how much, if any,  
16 significance is attached to it -- is that the professor  
17 had drafted a statement, it had gone to MPS, who had  
18 added a reference, which Mr Walby then suggested he  
19 should take out, and he agreed to take it out but it  
20 wasn't really your phrase in the first place --

21 A. Yes.

22 THE CHAIRMAN: -- and therefore you're quite happy to remove  
23 it. But that's not the one, is it?

24 MR McALINDEN: Yes.

25 MR STEWART: There was clearly a modification because the

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1 Mr McAlinden has now provided me with a copy of the  
2 first draft of your statement, which was in file 139.  
3 It's at 139-172-001. At the end of the second  
4 paragraph, the phrase appears:

5 "I did not have access to comments from all of the  
6 other medical practitioners involved in Claire's care."

7 I wonder, is that the phrase that was removed?  
8 Because the version I have is the same. It may be the  
9 same statement, but a different reference. Because  
10 if we look at 139-111-002, there it appears again:

11 "I did not have access to comments from all of the  
12 other medical practitioners involved in Claire's care."

13 So it doesn't seem as though it has been amended at  
14 all. That is a different copy of the same document  
15 because Mr Walby's handwriting has been removed from  
16 that. I'm not sure if Mr McAlinden can cast any further  
17 light on this.

18 THE CHAIRMAN: If I've understood it correctly, what you're  
19 trying to do is tidy up the point about how the  
20 professor's draft statement goes to MPS, they suggest  
21 that a phrase is included and the professor's happy to  
22 put it in, and then it comes back from Mr Walby with  
23 a suggestion that it's excluded; is that the point?

24 MR STEWART: Yes. The phrase "comments from other staff"  
25 has been removed, and it turns into, I think, "comments

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1 e-mail at 139-111-001 says so.

2 MR McALINDEN: If you look at 139-172-001, you may see the  
3 thought process that went into that:

4 "This needs to be more specific ... MPS  
5 [et cetera]."

6 There is a bit cut off. We'll have to provide you  
7 with a full copy of that, but Mr Walby will be able to  
8 explain what the discussion was with Professor Young in  
9 relation to that issue. It's just to draw to the  
10 inquiry's attention, at the very earliest stage, that  
11 the draft statement was provided to the inquiry.

12 THE CHAIRMAN: Thank you very much. Was there anything  
13 further? Mr Stewart?

14 MR STEWART: No, sir, thank you.

15 THE CHAIRMAN: Mr McAlinden or anybody else? Sorry, you are  
16 last. No other questions? Mr McAlinden? Sorry.

17 MR McALINDEN: If I could take Professor Young to his  
18 inquest statement at 091-010-064. It's number 5.  
19 I would like Professor Young to comment on the content  
20 of that, bearing in mind the suggestion that he was  
21 somehow or other involved in some form of cover-up.

22 A. Yes, thank you. That was a comment from Dr Bingham, who  
23 was one of the independent external experts at the  
24 coroner's inquiry, who raised the possibility in his  
25 statement that the sodium result of 121 millimoles per

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1 litre was a laboratory error and, in fact, that Claire  
2 might not have been suffering from such severe  
3 hyponatraemia. As Mr McAlinden points out, I intervened  
4 to essentially challenge that and to say that it was not  
5 possible that the 121 would represent laboratory error  
6 and that it was a genuine result.

7 I guess it goes back to the suggestion that somehow  
8 I was trying to be unhelpful to the coroner or to hide  
9 anything. I conducted the original chart review within  
10 the Trust, I recommended to Dr McBride that  
11 hyponatraemia was likely to be involved in Claire's  
12 death and that the case should go to the coroner.  
13 At the coroner's inquest, I intervened again when  
14 perhaps there would have been a possibility of the  
15 hyponatraemia being downplayed to correct what I felt  
16 was a mistaken opinion from Dr Bingham.

17 THE CHAIRMAN: Yes. Thank you very much.

18 Professor, that's the end of your evidence. Is  
19 there anything further that you wanted to say?

20 A. There was a couple of other issues that I expected to be  
21 asked about because they related to me, and wasn't.

22 THE CHAIRMAN: Okay. If we can get through them now,  
23 we will. We haven't, with any witness, to the inquiry  
24 despite the way it may seem, gone through every single  
25 point with every single witness, but if there's anything

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1 whether I had had any contact to the inquiry. I don't  
2 know if we can get that up.

3 THE CHAIRMAN: This will be your first witness statement?

4 A. Yes.

5 THE CHAIRMAN: We'll see what we can do. Sorry, the  
6 question you were asked was ... (Pause). The statement  
7 is witness statement 178/1, I'm just looking for a ...  
8 This is about contact with Dr Webb.

9 A. Yes.

10 THE CHAIRMAN: It's page 4, paragraph (f):

11 "Did you attempt to interview Doctors Webb, McKaigue  
12 or members of the nursing staff?"

13 Was this part of your engagement through Dr McBride?

14 A. Yes. I just wanted to be absolutely clear about this  
15 because there's an e-mail indicating I had e-mailed  
16 doctors -- there's an e-mail exchange, first of all,  
17 saying that Dr Steen raised the fact that Dr Webb ought  
18 to be contacted, and then an exchange between Dr McBride  
19 and myself about who should do it. Dr McBride asked me  
20 to do it. I do have a clear recollection -- although  
21 Dr Webb, I think, didn't -- of speaking to Dr Webb on  
22 the phone. I wanted to be absolutely clear that the  
23 purpose of that was to inform him that the case was  
24 being referred to the coroner so that he would have  
25 knowledge of that and that, indeed, I think I let him

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1 that you feel particularly that you want to say to  
2 emphasise something which is already before us, I'm  
3 quite prepared to hear you.

4 A. One was the suggestion -- and it came in the opening  
5 statement of governance from counsel to the inquiry --  
6 that my review, in some way, touched upon communication  
7 and that I considered communication with the family as  
8 part of my review.

9 THE CHAIRMAN: I understand. Your response was that you had  
10 a clearly-defined role, which was a case note review.

11 A. Yes.

12 THE CHAIRMAN: And rather than a review of the general  
13 communications between the doctors and nurses on the one  
14 hand and the Roberts family on the other, is that your  
15 point?

16 A. Yes, I definitely was not conducting such a review or  
17 even considered the issues.

18 THE CHAIRMAN: Yes. Okay.

19 A. The second point relates to the telephone contact I had  
20 with Dr Webb -- and I appreciate this came up in  
21 particularly the Roberts family governance opening.  
22 I think a slightly sinister connotation was placed on it  
23 potentially. I completely understand the reasons for  
24 that, but I just wanted to address it and highlight the  
25 fact that I was asked in my witness statement about

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1 know that the Roberts family had written to the hospital  
2 after the television programme, that I had reviewed the  
3 case and had recommended it should be referred to the  
4 coroner, and that was the nature of that exchange.

5 THE CHAIRMAN: Okay. Was there any further point?

6 A. No, I would just like to say a general thing, first of  
7 all, to the Roberts family. I appreciate absolutely  
8 at the core of this are the tragic deaths of several  
9 children, and Claire Roberts was one of those, and just  
10 to expression my enormous sympathy and indeed my  
11 admiration to them for their persistence in trying to  
12 fully understand what happened.

13 Secondly, to say if I have made any mistakes during  
14 my involvement in it, then I apologise for them, but  
15 they've been honest ones and I've done my very best  
16 throughout, I think, to assist the entire process and  
17 everyone involved.

18 Certainly I have never, ever encountered any  
19 suggestion or even hint of a desire on the part of the  
20 Trust or anyone I've interacted with to cover up what  
21 has happened in this case. That's all I wanted to add.

22 THE CHAIRMAN: Thank you very much, professor. It has been  
23 a long day and I'm grateful to you for staying with us  
24 to complete your evidence.

25 (The witness withdrew)

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1 As the professor leaves, we'll pick up the evidence  
2 tomorrow morning at 10 o'clock. Is it Dr Hicks first?  
3 MR STEWART: Yes. Then Dr Taylor and Mr Walby.  
4 THE CHAIRMAN: Okay. Shall we deal first of all at 9.45  
5 with this issue about the document?  
6 MR McALINDEN: If you would give me a very short while,  
7 I would hope to have an answer for you in the next five  
8 or 10 minutes in relation to that issue, so that if the  
9 documentation can be disclosed, it can be -- well,  
10 attempts can be made to make sure you have it later on  
11 this evening rather than tomorrow morning. So if you  
12 can just bear with us for a short while --  
13 THE CHAIRMAN: Of course we'll wait.  
14 (5.47 pm)  
15 (The hearing adjourned until 10.00 am the following day)  
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1 I N D E X  
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3 MISS ELIZABETH DUFFIN (called) .....1  
4 Questions from MR STEWART .....1  
5 PROFESSOR IAN YOUNG (called) .....36  
6 Questions from MR STEWART .....36  
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