CLAIRE ROBERTS: THE ROBERTS FAMILY

GOVERNANCE OPENING

THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

BANBRIDGE COURTHOUSE DECEMBER 2012

Governance Opening

The Inquiry has a very detailed and comprehensive Opening on the Governance issues prepared by Ms Anyadike-Danes Q.C. and her team. This sets out the evidence received relating to Governance and lists the Governance issues that the Inquiry Team feel relevant and important. It also quotes and highlights some of the clinical evidence and how it is related to the Governance. The Roberts family fully support the Governance Opening prepared by the Inquiry Team. However, they want me to deal with the Governance issues on a more personal level and examine how they affect Claire and her family and examine their relevance, particularly in relation to the safekeeping of children who are treated in the Royal Belfast Hospital for Sick Children in the future. Of course, the family want the full list of Governance issues investigated and support that investigation but they see some of those issues as more pertinent to them and hopefully these are issues upon which they can comment and provide some useful input that may assist this Inquiry. Having listened to the evidence relating to the clinical issues the family are aware that the Inquiry has already identified numerous errors, oversights and shortcomings in Claire's diagnosis, treatment and management. Of course, the

family want to know why the Treating Clinicians responsible for her care in 1996 repeatedly failed to identify the errors and still deny them to this day.

The family acknowledge that mistakes are made in every walk of life and it is doubtful that anyone sitting in this room today has not made a mistake in their professional career. Some of those mistakes have very little impact on our lives and careers; some of those mistakes may have led to embarrassment, or even worse, professional criticism and admonishment. However, in this case, a catalogue of errors led to the death of a child. Tragic incidents occur in every walk of life. Children are lost in boating accidents when on family holidays; they are killed in the back of their parents' cars when a serious crash occurs; we have heard of numerous farming accidents where an unfortunate father tragically crushes his child in a tractor accident. Those mistakes are open to investigation and criticism but in Claire's case nothing seems to have been properly investigated, there has been little or no criticism levelled at anyone and most tragically, it would seem that for a number of years after the death of Claire nothing changed at the Children's Hospital.

There are a number of points that appear in the Table of Contents in the Opening document that Mr and Mrs Roberts feel are more relevant to users of the hospital and their contact with medical staff and the hospital administration. They feel that they can, perhaps, help the Inquiry with the evidence on those issues. Those include:

1. Communication with parents.
2. Children with learning disabilities.

3. Medical records and general record keeping.
4. Drug administration and keeping parents informed about the administration of drugs.
5. Post-death events.
6. Post-mortem request procedure.
7. Conduct of the autopsy, in particular why the autopsy was limited to "*brain only*".
8. The Autopsy Request form.
9. The Autopsy Report and informing parents about the contents of the report in plain and simple language.
10. The adverse incident reporting.
11. The investigations into Claire's death immediately after her death in 1996 and thereafter the investigations that arose out of the UTV documentary in 2004 and the investigations leading up to the Inquest in 2006.

THE PARENTS' APPROACH

Fundamental to how the parents approach this case is their belief that the Doctors who were treating Claire did not realise how ill she really was. Once you accept this basic premise, then everything else falls into place.

The parents believe that they were misled throughout the course of events from around the time of Claire's death to the start of this Inquiry. They were never given a proper and adequate explanation of what happened to Claire, what treatments she received and what caused her death. She was admitted to the Children's Hospital with a tummy bug at 8pm on Monday the 21st October. By 4am on the 23rd October, she was beyond

help. The shocking fact is that just over 30 hours post-admission she was dead. The cause of death has been a matter of debate and dispute.

But, what one can never dispute is that Mr and Mrs Roberts have been waiting 16 years to discover what actually happened to Claire.

Alan and Jennifer Roberts, like the other parents in this Inquiry, have no medical expertise. However, like all parents in the Inquiry they have a good firm grounding in common sense and they have an excellent memory of what went on because we are dealing with a child of their family and that memory is pertinent to that child. So when Dr Bartholome, when in hindsight agreed, and Dr Sands told the Inquiry that undoubtedly Claire was the "*sickest child on the ward*" this came as a complete shock to them. Dr Sands has gone so far as to say that Claire had a major neurological problem and that she was very neurologically unwell. The parents are now more than a little confused as they have heard, in the last few days, that Dr Webb may not fully agree with that assessment of Claire's condition. We also know the nurses didn't seem to be very concerned and though Dr Sands maintains that he did tell the staff that she was very unwell that view does not seem to have been transmitted to the parents by either Dr Sands or the staff.

To set the scene for what happened later in relation to the Governance issues any neutral observer with a fair amount of common sense would have to ask the following questions:

- If she was the sickest child on the ward then why did Dr Steen not see her first thing on the morning of the 22nd October? Why did she not see her after the ward round, if Dr Sands assessed her as very seriously ill, or perhaps just before she went to her clinic? Why did she not come back after her clinic at around 5pm when she was fully aware, or should have been aware, that Dr Webb was seeing her patient? Of course, all of that makes sense when you take into account Dr Steen's comment that it was disgraceful that her parents were not told how ill Claire really was. The answer and the fundamental truth, is that the parents were not told how ill Claire was because most of the Doctors didn't realise how ill she was. In fact, it is probably the case that no one realised how ill she was and if they did they certainly didn't transmit that to the parents.

- Why did Dr Webb leave at 5pm if Claire was the sickest child on the ward? His treatment plan had not been implemented so he did not know what results it would produce yet he left "*the sickest child in the ward"* and went home without arranging for any other cover.

- Why did Dr Webb not inform the parents that Claire was very sick? The parents went home at 9.15 and the Inquiry has seen what effect that has had upon the parents. They would never have left the hospital had they been properly informed. The communication process between Doctors and Nurses and between the staff and hospital users should be examined by this Inquiry.

- Why did Dr Webb not advise the parents that they shouldn't go home until Claire showed some improvement?

- Why did the nurses let Mr and Mrs Roberts leave the hospital at around 9.15pm? In fact, the evidence would suggest that the nursing staff were quite nonchalant about them leaving and gave them no cause for concern. The answer may be that the nurses weren't told, weren't aware and did not appreciate that Claire was very neurologically ill.

- Why did the Doctors act as they did if in fact they did realise that Claire was ill, was very neurologically ill and could be described as the "*sickest child on the ward"*.

- Why did Dr Barthlolme not engage with the Consultant on call when they got the blood results at around 11.30pm on the 22nd October?

- Why were the parents not called back to the ward at that point? Even the most Junior Doctor on the ward, Dr Stewart was aware that they had a serious problem on their hands. We have a Registrar who is run off her feet and yet no one calls for assistance from more Senior Clinicians and no one informs the parents. It is on these fundamental issues of common sense that the parents want an answer. The system for dealing with such emergencies should be fully reviewed by this Inquiry.

Let's put the parents' evidence into the framework of the events on the 21st, 22nd and 23rd October 1996. They say that Dr Sands never told them that Claire had a major neurological problem, that he was going to get an opinion from a Neurologist and that she may require investigations such as EEG and CT scan. If he had, this would have immediately raised serious concern, the alarm bells would have been ringing and Mr and Mrs Roberts definitely would never have left the hospital.

Once again, you can see how this fits with the fundamental point that Mr and Mrs Roberts make and I repeat on their behalf:
They don't believe that the Doctors realised how ill Claire really was.

WHAT EXPLANATION WERE THEY GIVEN ABOUT THEIR DAUGHTER'S SUDDEN AND TOTALLY UNEXPECTED DEATH?

They had a meeting with Drs Steen and Webb in relation to the brain coning and the brain stem tests. They are adamant that they were told that Claire died of a viral illness and that no other specific information was given. Hyponatraemia or fluid management was never mentioned. Quite justifiably the parents are angry that a simple procedure like a blood test was not carried out. The Chairman of this Inquiry has repeatedly made the point that something as simple as a blood test could have turned this case around. The witnesses are still disputing responsibility over the blood test but it would seem to be an undisputed fact that had the bloods been done at an earlier stage and the sodium level discovered then Claire would have been alive today. Even at 11:30pm on the 22nd October, when the SHO Dr Stewart realised that the patient may be suffering from

Hyponatraemia, no one with any experience had the time to examine Claire. We have heard from the experts that even at that late stage there was some chance of saving Claire. It would seem that it was only at this point that the SHO appreciated that Claire was very ill. If it was appreciated by other staff then why was there no emergency procedures put in place when Dr Stewart contacted Dr Bartholome? There is a question mark as to whether or not she may have been beyond help at that stage but unfortunately her condition was not fully appreciated and even though the notes suggest that the fluids were restricted the mathematical calculation of the fluids shows that in fact, when one takes into account the intravenous drug infusions, the fluids were actually increased. Further, there should have been more discussion about whether sodium should have been added to the fluids. The bottom line is that she was failed by the system as there does not seem to be any clear guidelines on what should have happened in this type of case and a review of the system may save lives in the future.

The problems with staffing levels, the skill and experience of the Doctors diagnosing and advising the treatment and the information that the parents are given on the ward are individual to each case and all families are aware that in busy hospitals there are always risks and that children fall between the gaps in the care regime and do not get the correct treatment quickly enough. Mr and Mrs Roberts and their extended family know that there are risks when children go into hospital. They may have been able to deal with Claire's death had a proper investigation been carried out and a full and frank explanation given to them in late 1996 or in early 1997. However, in this case Alan and Jennifer Roberts were misled. They believe they were misled in relation to the explanation given for Claire's death, or at least, they didn't get the whole truth. In the

beginning they were given a limited version of what happened in Claire's treatment but as things went on they make the case that they were actually misled on certain issues that fall within Governance.

SHOULD THE CORONER HAVE BEEN INVOLVED IN 1996?

This leads us into the question about why Claire's death was not referred to the Coroner. We have heard evidence from Dr Scott-Jupp, an expert Paediatrician, who seems to have no doubt that because of an uncertain diagnosis, i.e. not a firm diagnosis that this was an indicator for reporting the case to the Coroner (transcript of the 04/12/12, page 119). The parents will say in evidence that they feel that a Doctor has a statutory and ethical duty to inform the Coroner of the sudden death of a child; they want to make the point that when a child's death is sudden, unexpected and without clear diagnosis, then it should be referred to the Coroner. If the Clinicians were in any doubt whatsoever they should have referred it to the Coroner. The family want to know why it wasn't referred given the uncertainty in the diagnosis.

AUTOPSY REQUEST FORM

They are now aware that the Autopsy Request form was full of misleading information. I opened the family's case on the Clinical Issues highlighting several errors on the form; errors that the family say should not have been on the form because the information was never given by them. They acknowledge the work done by the Inquiry on this issue. They find it ironic that the clinical notes are brief but that the Autopsy Report form is full of information, albeit, mostly wrong. They have now heard Dr Herron

agreeing with the proposition that if the information provided on the form was factually incorrect it would influence the way that he would approach his pathology investigations. Simply stated, if the clinical summary is wrong then this is probably repeated throughout the investigation and the mistake is compounded.

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

BRAIN ONLY AUTOPSY

Was a "*brain only"* autopsy appropriate? One thing that sticks with the parents is that Dr Herron, the Pathologist, stated that "*brain only"* was underlined and he had "*never seen that before"*. We now have Dr Scott-Jupp's evidence on this and he is of the opinion that if the parents consent then a full autopsy is more appropriate as it may provide more information that would assist in reaching a conclusion about the child's death. They also find it very interesting that the pathology evidence is that the level of inflammation found is low grade, sub-acute and on a scale of 1/10 it rates as a 1 or 2. Experts such as Professor Harding and Dr Squier state that there is no evidence of acquired infection. Further, Dr Squier's evidence (05/12/12 at page 21/22) is clear on this point relating to brain only autopsy. In 1996 she would always expect to do a full autopsy unless the parents do not consent. However, at a meeting on the 3rd March

1997 Mr and Mrs Roberts were told by Dr Steen and Dr Webb that the post mortem had concluded that a viral infection was responsible for the brain swelling though the virus itself could not be identified.

AFTER THE 2004 UTV DOCUMENTARY

(A) In her witness statement WS143-1, page 71 (Para 44h). Dr Steen states that she has no recollection of the events other than that Claire's parents were aware of low sodium being implicated as this is what jogged their memory and resulted in them contacting the Trust to discuss Claire's death. The Roberts will say that this statement is incorrect. They were never aware of Hyponatraemia or Claire's low sodium level until after the meeting with the Clinicians and Professor Young on the 7th December 2004 at the Children's Hospital. They contacted the hospital because the TV programme had highlighted that the wrong type of fluid had been administered to children featured in the programme. Their first enquiry with the hospital was in relation to Claire's fluid management, fluid type and amount of fluid given. You will hear details of this when they give their evidence before this Inquiry on the 13th December.

(B) The meeting of the 7th December 2004:

When they attended the meeting the parents were told that Professor Young was going to conduct an independent investigation into the events surrounding Claire's death. They now challenge Professor Young's independence. It became clear after reading the files, examining the correspondence and e-mails that

Professor Young was in contact with the various Clinicians who had charge of Claire's care during her admission to hospital on the 21st / 22nd and 23rd October 1996. Of particular relevance is the contents of file 139 which could loosely be described as the Coroner's Investigation file relating to the Royal Victoria Hospital. There are a number of issues relating to the correspondence in that file. The parents want the full file investigated and the letter of the 5th October 2012 (attached to this Opening statement) from their Solicitors, Ferguson & Company, to the Inquiry Solicitor sets out in detail, the issues raised by the family. They want to make the following points in this Opening:

- Document 139-153-001 is an e-mail from Professor Young to Michael McBride dated the 6th December 2004. This is the day before the meeting with Mr and Mrs Roberts when he was put forward as an independent investigator.

- When you look at the contents of the e-mail you can see that he met with Heather Steen on the afternoon of the 6th December and that they had a discussion about Hyponatraemia. They reached an agreement in that she wants to present the "*clinical journey"* while he deals with the fluid issues. Then he comments "*hopefully this will work".* What will work? What is he trying to work? The parents want to know what this means.

- They also want to know who else was at the meeting when the email opens with "*We met with Heather Steen this afternoon"*.

- At the end of the e-mail Dr Steen recommends someone should speak to David Webb in Dublin so that he is informed "*about what is happening"*.

What was happening? Why should Dr Webb be informed about what's happening? Why would Professor Young contact Dr Webb to tell him what is happening when he is carrying out an independent investigation? If he was contacting him for information that would be a different matter, but why is he contacting him about what is happening?

- Referring to the note of the meeting of the 7th December (089-002-005) Professor Young added that, at the time of Claire's treatment, there was a lack of awareness regarding low sodium. However, Dr MacFaul will say that from 1984 onwards there was awareness of fluid management, Hyponatraemia and encephalopathy.

- It was during this meeting that the parents first heard that on admission to hospital Claire's sodium level was 132 but had later fallen to 121. It was at this meeting that they were first advised that she had received No 0.18 fluids.

- This was the first time they were advised that a blood check to test the sodium level had not been carried out between admission and approximately 24 hours later. However, they were not advised of the implications of this.

- Further, Professor Young made no comment about the mistakes in treating Claire, the absence of appropriate tests, the poor record keeping or the overdose of drugs,

(C) The Letter of the 12th January 2005 [096-018-113], from Dr Nicola Rooney who chaired the meeting on the 7th December 2004: This letter deals with the parents' questions arising from the meeting on the 7th December 2004.

Mr and Mrs Roberts are critical of this meeting of the 7th December 2004 and this letter of explanation arising out of it. It should be noted that Dr Steen and Professor Young rely on the medical charts (paragraph 3 of the letter) and therefore we must assume that they have read them, checked the notes and reviewed the treatment and drug therapy. They want to draw attention to:

- Reference 5(a) "*It is not possible to say whether a change in the amount and type of fluids would have made any difference in Claire's case as she was very ill for other reasons."* The parents were never told about any other reasons, they were never told that she was very ill and that a Neurologist was summoned or that a CT scan was organised for her the day after. What evidence, tests or results did Dr Steen have, other than the sudden fall in the sodium level within 23 hours. It seems some Clinicians are still in denial and perhaps a proper review could have come up with some answers.
- Reference 6 (b) .... "*Her hourly CNS observations remain stable for a period of time and no clinical signs of further deterioration were noted*". However, it must be pointed out that Claire's Glasgow Coma Scale reading fell from 9 to 6 during this period. There was no improvement in Claire's condition due to an incorrect diagnosis, medication overdoses and an incorrect fluid plan. Why would the Doctors not act when the GCS dropped to 6? We now know that Dr Webb changed his statement, at Mr

Walby's request, where it relates to dealing with the issue of PICU referral.

- Reference 7(b) "*The correct action was taken"*. In fact, correct action was not taken and this statement is incorrect. Her fluids were actually increased when one adds in the intravenous fluid. Dr Bartholome failed to turn up and examine Claire at 11.30, no Consultant was informed and Claire was unattended for a further 3 hours before her respiratory arrest at 2.30am. No decision was taken on whether to increase sodium levels in fluids though it was considered by Dr Stewart. The last section of paragraph 9 of the letter sets out the practice at the time but was this done? The practice at the time, as appears in the letter seems to have been:

  (i) Restrict fluids

  (ii) Consider administering fluid with a higher sodium content.

  We now know neither was done yet there seems to be an assumption in the letter that they were done.

  If a comprehensive review or audit had been done it would have had to arrive at the conclusion that there were mistakes and system failures.

- When you look at paragraph 10 of the letter you can see that another review of the case notes has been carried out. The parents cannot understand why the mistakes were not detected.

- By way of papers served yesterday, we now know that Mr Walby also had some input amending this letter that was sent in draft to him by Dr

Rooney. The parents want the Inquiry to fully investigate Dr Walby's input into this letter.

THE INQUEST IN 2006:

There are a number of points the parents will raise in their evidence but one of the main issues is that the parents find it absolutely incredible, I can use no other term to describe their feeling about this, that despite Professor Young's review the analysis of the papers leading up to the Inquest (by Dr Steen, Dr Webb and others) and the public examination during the Inquest, that no one realised that Claire had two substantial overdoses of drugs. Dr Steen reviewed the clinical notes when making her statement for the Coroner and again, when making her Police statement, as did Dr Webb. Claire had an overdose of Midazolam of more than 300% and an overdose of Phenytoin but that was not picked up by any of the witnesses or experts and in particular it was never mentioned by Dr Steen, Dr Webb or Professor Young.

Did the Inquest clear things up for Mr and Mrs Roberts: absolutely not. Not one expert spotted any of the mistakes that were in the notes. No one criticised the notes for content and structure, lack of timing, dating and signing and we must question how that would fit with any audit or review of the notes. Inquiry Counsel have highlighted this aspect of the case in the Opening Statement but I feel that I must repeat Dr Steen's concession:

> "*I can in no way defend the quality of my documentation or anyone else's"* [Page 37 of the transcript 03/10/12) .... "*our documentation is poor and we know its poor*" [Page 80 of transcript 15/10/12].

Why did the witnesses not point this out to the Coroner? A number of witnesses reviewed the notes for the Coroner's case and they discuss various references in the notes and in fact, you will see that at reference number 139-156-005 Dr Steen discusses various elements of the notes in her Police statement. She reviews the drugs but fails to mention the overdoses and also misses that the prescription records show a massive overdose of 120mgs of Midazolam. It may also be very relevant that Dr Sands added to the note the entry "*Encephalitis / Encephalopathy*" that his entry was undated, unsigned and obviously in a different hand and pen as that which appears to have written the note at the ward round. Why was there no criticism of this entry? In relation to this entry made by Dr Sands "*Encephalitis / Encephalopathy"* the parents have a genuine doubt as to why this entry was made as it does not fit with the nursing notes. In fact, they will say that it fits with nothing at all in the case.

The family want the issues that were tested in the Inquest to be reviewed by this Inquiry. They want those issues raised again in light of the expert evidence and the further statements that have been made. For example, there is a letter from Dr Walby, to the Coroner, (139-149-001) where in paragraph 3 it states:

> "*She was examined by a Paediatric Neurologist Dr Webb and he considered her to have a postictal acute encephalopathy and was treated as such. She developed Hyponatraemia and consideration was given to whether this was from fluid overload with low sodium fluids or a stress induced anti-diuretic hormone effect, and her fluid management was altered."*

Did Drs Steen, Sands or Webb give consideration to fluid overload with low sodium fluids in 1996? The parents were told it was a virus. Was Claire's fluid management considered / reviewed in 1996 or at any time before the parents started asking questions in 2004? The parents will say that there was no discussion about fluid overload or low sodium fluids in 1996.

Why were the parents not told about Hyponatraemia in 1996?

Hyponatraemia appears in the clinical records, it was entered by Doctor Stewart and then it appeared in the Intensive Care notes. Why wasn't this raised with the parents?

The clinical mistakes, errors, oversights, lack of audit / review, limited autopsy etc., meant that Claire slipped through a gaping hole in the safety net provided by the National Health Service. Once she was through that hole, she was dead.

The family believe that the cover up began after Claire was transferred to PICU and it was recognised there was no hope of recovery. If the family are not correct about a cover up then what happened in 1996? How would a neutral observer interpret the evidence? What is the explanation for the events surrounding investigations and information given to the family? They have already raised issues of concern on file 139 and want to highlight the following as a further small example of what any member of the public, with an ounce of common sense, would want reviewed and investigated:

(i) In file 139 at reference 139-096-001. This is an email from Mr Walby to Dr Webb dated the 31st July 2005. Mr Walby suggested a change to Dr Webb's statement and we can see his draft statement at 139-198-021. This has already been highlighted in Dr Webb's evidence in Monday of this week but it is something that the parents are particularly concerned about as it looks as though there is a hand steering the evidence behind the scenes.

(ii) At 139-106-110 we have another piece of correspondence from Mr Walby, this time to Dr Sands dated 6th June 2005 suggesting that he should leave out a section of his statement. This discusses fluid therapy and concludes paragraph 1 stating "*All in all it sounds very defensive and at this stage if you leave your comments out it is probably better*".

(iii) At 139-148-001 we have correspondence from Mr Walby to Dr Steen dated 22nd December 2004. It is worth reading the handwritten note at the bottom and I refer to this document. What errors did Dr Steen identify and what impact did those errors have? What did Mr Walby do in relation to Dr Steen's input and why was she adding any input at all?

(iv) We have already highlighted the e-mail from Professor Young to Dr McBride on the 6th December 2004 but we would also like to refer to the e-mail passing between Professor Young and Mr Walby on the 10th April 2006 (139-038-001) when Professor Young states that Drs Sands and Steen should be appraised of Dr Webb's comments. Bear in mind, that the Inquest into Claire's case was held

on the 4th May 2006. Why was Professor Young, as an independent Investigator, ensuring that the witnesses be appraised of each other's comments? A neutral observer would conclude that his independence was compromised. A parent would jump to only one conclusion.

(v) Further additional papers have been served in file 139. We have already raised the issue in relation to Mr Walby's advice to Dr Rooney in relation to the letter of the 12th January 2005. The parents also want the Inquiry to investigate Professor Young's e-mail to Mr Walby dated 7th April 2006 (139-170-001) when he discusses various issues that have been raised in Claire's case. Why was Professor Young corresponding with Peter Walby in the "*Litigation Management Office"* if he was conducting an independent review? What is the meaning of the e-mail of the 5th May 2006 (139-161-001) from Peter Walby to Pauline Webb and I quote the third paragraph:

> "*I spoke to Mr Roberts at the end of the Inquest and advised him that if he still has concerns he should write to the Chief Executive. The Clinicians would be happy to meet with the family if that would assist however I wish to warn you that there were questions raised which will properly be answered by the O'Hara Inquiry in due course and you need to be aware of their interest in discussing policy changes etc., arising out of the death of Adam Strain in 1995. I would counsel you against allowing the Roberts to run their own mini O'Hara Inquiry themselves."*

Claire's parents would like those comments to be fully investigated.

There are dozens of issues that have been highlighted in the opening statement prepared by the Inquiry Team but Mr and Mrs Roberts want to put a personal slant on this Opening and want to make the following points:

- Nothing was done after the death of Adam Strain. In fact, the Inquest into Adam's death came only a matter of months before Claire's death. What lessons were learnt?

- Nothing was done after Claire's death. There is no hard evidence or records of any meetings or review procedures, staff or nursing reviews or the review of any element of supervision or staffing on the wards. Not one part of the system that was in place at the time was reviewed or overhauled. Not one member of staff was criticised in any way whatsoever.

- Why was nothing done after the Inquest? The Medical Director, Dr Murnaghan, was asked by the Coroner to address the problems and he undertook to do something. When he was asked why he didn't do what the Coroner requested him to do. He replied: "*Mea culpa".* A fitting answer for a man who failed to do anything.

Alan and Jennifer Roberts have reached the inevitable conclusion that no one did anything because no one wanted to raise any ripples on an otherwise quite smooth pond. What hurts the parents most is that Claire seems to have died for nothing. The hospital learnt nothing; they did nothing and therefore what else can reasonable thinking parents make of this other than that there was a general cover up going on.

Why did Claire's parents have to wait 16 years to get to the truth?

It is absolutely incredible, and the parents have instructed me to use those words, that the public now have to hear that after the death of two children, Adam and Claire, that nothing was done. In fact, hopefully Dr Murnaghan speaks on behalf of the Children's Hospital when he says "*mea culpa".* Will the Clinicians and Administrators of the Children's Hospital fall in behind Dr Murnaghan and also acknowledge the blame that falls on them?