CHRONOLOGY OF HOSPITAL MANAGEMENT & GOVERNANCE CLAIRE

SCHEDULE 1: Position as at Claire's admission on 21st October 1996

Date	Protocols, Guidance, Circulars & Practices in force	Source/ Reference	Papers & Publications
October 1983		London: HMSO	NHS Management Inquiry (1983) Report (the Griffiths Report)
4th June 1984		Press Release no.84/173, 4 June Department of Health & Social Security (1984)	Griffiths Report: Health Authorities to Identify Managers
1990		Department of Health, London	A Guide to Consent for Examination or Treatment
1991		HMSO ((1991) (Department of Health)	Welfare of Children and Young People in Hospital – Referred to children with disabilities being *"doubly disadvantaged"* (p.20)
1991/1992			Report of the National Confidential Enquiry into Peri-operative Deaths (1991/1992)
March 1992	Northern Ireland Health and Personal Social Services: A Charter for Patients and Clients	Ref: 080-003-080	
October 1993	Letter from John Hunter (Office of Chief Executive of Health & Personal Social Services Northern Ireland) to inter alia the Chief Executives of Trusts & Boards setting out the: *"framework of accountability which will exist between the Management Executive (ME) and HSS trusts in the future"*	Ref: 079-013-306	
21st December 1993		NHS Management Executive	Improving Clinical Effectiveness

		EL(95)115	
December 1994		No.8, Nuffield Institute for Health	Bulleting on the Effectiveness of Health Service Interventions for Decision-makers: Implementing Clinical Practice Guidelines: Can guidelines be used to improve clinical practice?
March 1995		Ref: 080-004-098	Letter from Chief Executive of Health & Personal Social Services Northern Ireland to inter alia Chief Executives of Trusts & Boards enclosing: Explanatory Booklet setting out the Management Executives response to 'Being Heard' – Wilson Review Committee's Report on NHS complaints procedures
6th October 1995		Ref: INQ-0379-11, p.2 HSS(GHS)2/95, pgs. 4 -23	A Guide to Consent for Examination or Treatment, circulated by the Management Executive of the Chief Executive
1995	Management of Formal & Informal Complaints[1]	TP6/95	
1995		Ref: 080-013-299	HPSS Management Plan 1995/96 to 1997/98 including the following under 'Best Practice' it states: *"Providers need to continue to focus on improvement in standards of practice"* and *"Specifically units should ensure that there is a clear policy on: clinical audit as part of a programme to improve all aspects of service quality, not just clinical outcomes"*.

[1] This was the Trust's policy for complaints at the relevant time

SCHEDULE 2: From Claire's death until the notification of the results of the Limited Autopsy on 21st March 1997

Date	Events in relation to children	Reference	Other Developments
23rd October 1996	Staff Nurse Margaret Wilkinson[2] recorded in Claire's medical notes and records that a second brainstem test was carried out between 2.00pm and 6.15pm	Ref: 090-027-085	
	Dr. Heather Steen (Consultant Paediatrician) [3] records in Claire's notes that: *"Discussed …parents – agree that ventilation should be withdrawn Consent for limited pm [post-mortem] given"*	Ref: 090-022-061	
	Diagnosis of Brain Death form completed by Dr. David Webb (Consultant Paediatric Neurologist) [4] as doctor (1) and Dr. Heather Steen as doctor (2). It stated that the time of the second brain stem test was taken at 6.25pm and recorded: *"Is this a Coroner's case? No"*	Ref: 090-045-148	
	Staff Nurse Margaret Wilkinson recorded in Claire's medical notes and records that: *"Deceased 6.15pm Death certificate issued For PM in am. Consent signed"*	Ref: 090-027-085	
	Case Note Discharge Summary is signed by Dr. Mannam (SHO, Royal),[5] which records that ventilation was withdrawn from Claire *"after discussion with parents at 18.45"* and: *"Principal diagnosis: Cerebral Oedema Other diagnosis: Staus epilepticus Other diagnosis: Hyponatraemia"*	Ref: 090-009-011	

[2] SN Margaret Wilkinson: See Schedule of Persons for details
[3] Dr. Heather Steen (Consultant Paediatrician, RBHSC): See Schedule of Persons for details
[4] Dr. David Webb (Consultant Paediatrician Neurologist, RBHSC): See Schedule of Persons for details
[5] Dr. S Mannam (Senior House Officer, Royal): See Schedule of Persons for details

	Mr. Alan Roberts[6] states that Dr. Heather Steen stated to him "*on 23 October 1996 at approximately 19:00 that there would be 'no need' for an inquest.*"	Ref: 091-004-007	
	Limited (brain only) post-mortem examination by Dr. Brian Herron (Pathologist).[7] The provisional anatomical summary of which was: "*History of acute encephalopathy, brain to be examined after fixation*"	Ref: 090-005-007	
1st November 1996	ICU Discharge Summary signed by Dr. Mannan, recording a diagnosis of "*respiratory arrest*"	Ref: 090-006-008	
8th November 1996	Monthly Paediatric Directorate Audit at which Claire's case was presented along with 3 others	Letters from DLS: 24.11.2010 & 10.01.2011	
11th November 1996	Dr. Andrew Sands[8] meets with Mr. and Mrs. Roberts[9] on the ward to explain "*as far as [he] was able, the course of events…*"	Ref: 090-022-061, Ref: 091-009-056	
18th November 1996	Letter from Dr. Heather Steen to Mr. and Mrs. Roberts informing them that she would be happy to meet with them and discuss any queries that they might have. She also informed them that the post-mortem results would not be available until after Christmas and warned them that they may not enable her to answer all their queries.	Ref: 090-004-006	
10th December 1996	Anaesthetic record keeping in Adam's case reviewed at an Audit meeting	Ref: 078-015-098	
10th January 1997		Ref: 080-009-232 HSS(MD)3/97	Letter from the Dr. Henrietta Campbell (CMO) to Chief Executives of Trusts and Medical Directors asking them to put into effect the

[6] Mr. Alan Roberts: See Schedule of Persons for details
[7] Dr. Brian Herron (Pathologist, State Pathology Department): See Schedule of Persons for details
[8] Dr. Andrew Sands (Paediatric Registrar, RBHSC): See Schedule of Persons for details
[9] Mrs.Margaret Roberts: See Schedule of Persons for details

			agreement in the letter of 13th November 1996 to Sir Kenneth Calman
11th February 1997	The Autopsy Report by Dr. Brian Herron stated that the fixed brain weighed 1606g, that there was *"symmetrical brain swelling with effacement of gyi"* and that on *"sectioning of the brain the presence of diffuse brain swelling is confirmed". (Emphasis added)* The Report commented that the features of Claire's brain were: *"those of cerebral oedema with neuronal migrational defect and a low grade subacute meninoencephalitis … the reaction in the meninges and cortex is suggestive of a viral aetiology, though some viral studies were negative during life and on post mortem CSF [central spinal fluid]. With the clinical history of diarrhoea and vomiting, this is a possibility though a metabolic cause cannot be entirely excluded"*	Ref: 090-003-003 Ref: 090-003-005	
6th March 1997	Letter from Dr. Heather Steen to Dr. McMillin (Claire's GP)[10] advising of Claire's post-mortem results: *"The cerebral tissue showed abnormal neuronal migration, a problem which occurs usually during the second trimester of pregnancy and would explain Claire's learning difficulties. Other changes were in keeping with a viral encephalomyelitis meningitis"* The letter also advised that she and Dr. David Webb had seen Mr. and Mrs. Roberts and discussed the post-mortem findings with them.	Ref: 090-002-002	
19th March 1997	Letter from Brangam Bagnall & Co to Dr George Murnaghan (Medical Director)[11] stating in relation to Adam that: *"I believe from a liability point of view,*	Ref: 060-016-031	

[10] Dr..McMillin (Claire's GP): See Schedule of Persons for details
[11] Dr. George Murnaghan (Medical Director, Royal): See Schedule of Persons for details

	this case [Adam's] cannot be defended"		
21st March 1997	Letter from Dr. David Webb to Mr. and Mrs. Roberts providing a summary of the post-mortem findings: *"… the findings were of swelling of the brain with evidence of developmental brain abnormality (neuronal migration defect) and a low grade infection (meningoencephalitis). The reaction in the covering of the brain (meninges) and the brain itself (cortex) is suggestive of a viral cause. The clinical history of diarrhoea and vomiting would be in keeping with that. As this was a brain only autopsy it is not possible to comment on other abnormalities in the generals organs."*[12]	Ref: 089-001-001	

SCHEDULE 3: Main events in the period between the notification of the results of the Limited Autopsy on 21st March 1997 and the UTV broadcast on 21st October 2004

Date	Events in relation to the children	Reference	Other Developments
8th April 1997	Litigation brought by Adam's mother in respect of his death is settled without admission of liability and with the inclusion of a confidentiality clause	Ref: 060-015-028	
May 1997		INQ0485-11	Paediatric Medical Guidelines: RBHSC (1st edition), with contributions from: Drs. Bartholome[13] (Claire), Hicks[14] (Adam, Claire & Conor), O'Connor[15] (Adam), Savage [16] (Adam), Steen (Claire), Webb (Adam & Claire)

[12] Note: Claire's parents do not accept that Claire was suffering with diarrhoea when she was taken to hospital – she had one loose motion.
[13] Dr. Brigette Bartholome (Paediatric Registrar, RBHSC): See Schedule of Persons for details
[14] Dr. Elaine Hicks (Consultant Paediatric Neurologist, RBHSC): See Schedule of Persons for details
[15] Dr. Mary O'Connor (Consultant Paediatric Nephrologist, RBHSC)
[16] Dr. Maurice Savage (Consultant Paediatric Nephrologist, RBHSC)

			The topics include: 'Vomiting' (under General), 'Headache' (under Neurology), 'Acute renal failure' (under Renal). There is no specific reference to hyponatraemia but under 'Vomiting' there is reference to raised intracranial pressure as a possible cause (p.13) and to U+E as investigations to consider. Whilst under management of renal failure there is reference to the restriction of fluids and to cerebral oedema in relation to indications for dialysis (p.116)
9th May 1997	Memorandum of Dr George Murnaghan to Drs. Savage, Webb and Taylor[17] and Messrs. Keane[18] and Brown[19] advising them that Adam's case had settled but that: *"From a liability position the case could not be defended"*	Ref: 060-010-015	
May 1997		Ref: WS-012/1, p.8	Alison Armour's[20] article is published in the BMJ: 'Dilutional hyponatraemia: a cause of massive fatal intraoperative cerebral oedema in a child undergoing renal transplantation' [ie Adam]
December 1998		Ref: 078-001-004 (IWS of Clive Gowdy[21])	The Department commissions Healthcare Risk Resources International consultants to undertake a survey of risk management in all HPSS organisation. The terms of reference for the survey were to determine the level of application of

[17] Dr. Robert Taylor (Consultant Paediatric Anaesthetist, RBHSC): See Schedule of Persons for details
[18] Mr. Patrick Keane (Consultant Urologist, Belfast City Hospital): See Schedule of Persons for details
[19] Mr. Stephen Brown (Consultant Paediatric Surgeon, RBHSC): See Schedule of Persons for details
[20] Dr. Alison Armour (Senior Registrar, State Pathology Department)
[21] Clive Gowdy (Permanent Secretary, DHSSPS(NI))

			RM practices within these organisations. Incident reporting was one of the items included in the survey.
1999		Ref: 078-001-004 (IWS of Clive Gowdy)	Risk management report – good level of awareness of the need to develop rigorous systems for risk management ("RM") and a good level of compliance with the requirements for RM. However, there was a general perception that there might have been a significant level of under-reporting of adverse incidents. The survey provided each of the organisations with an assessment of their position against the average performance on each of the factors covered in the survey. Department initiated work on the development of a regional RM strategy.
February 1999		Effective Health Care Bulletin Vol.5, No.1	NHS Centre for Reviews & Dissemination: 'Getting Evidence into Practice', which summarises the results of systematic reviews of different dissemination and implementation interventions
9th February 1999		Ref: 093-035 (appended to PSNI interview)	Dr. Robert Taylor invites a number of colleagues (including Consultant Anaesthetists and Consultant Paediatricians) to convene meetings regarding the Clinical Implications and implementation of the recent "*Framework for the Future*" document for Paediatric ICU – in particular he wished to consult widely on agreed

			guidelines for admission, initial management and transfer of critically ill infants and children
1st April 1999			National Institute for Clinical Excellence (NICE) established for England & Wales
17th November 1999		NCEPOD	The 1999 Report of the National Confidentiality Enquiry into Perioperative Deaths is published compiled from data from 1st April 1997 – 31st March 1998, with the following findings in relation to fluid management: *"•Fluid imbalance can contribute to serious postoperative morbidity and mortality.* *•Fluid imbalance is more likely in the elderly who may have renal impairment or other comorbidity.* *•Accurate monitoring, early recognition and appropriate treatment of fluid balance are essential.* *•Fluid management should be accorded the same status as drug prescription.* *•Training in fluid management, for medical and nursing staff, is required to increase awareness and spread good practice.* *•There is a fundamental need for improved postoperative care facilities"* *('Key Points, p.68, emphasis added)* See also: *"• The documentation on fluid charts was often poor.* *• Doctors and nurses of all grades need to understand the clinical importance, and ensure the accurate recording, of fluid intake and*

			output. • *Multidisciplinary review of the problem and development of good local working practices is required.* • *Fluid charts are important documents that need to be retained and appropriately filed for future reference."* *('Key Points, p.84, emphasis added)*
14th April 2000	Lucy dies		
October 2000			'Confidence in the Future – for Patients and for Doctors'
April 2001		DHSSPS(NI) Consultation paper	'Best Practice Best Care: A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS', which identified that the: *"absence of a single focus for the production and dissemination of clear consistent guidelines for the HPSS is already leading to uncertainty"* (p.22)
19th June 2001	Raychel dies		
26th June 2001		Ref: 093-035 (appended to summary of PSNI taped interview)	Meeting of Sick Children Liaison Group at Antrim Area Hospital, the minutes of which record: *"Hyponatraemia; BT [Dr. Robert Taylor] presented several papers which indicated the potential problems with the use of hypotonic fluids in children. Work to take place on agreed guidelines from the Department of Health on this subject"*
July 2001		Bristol Royal Infirmary Inquiry	Report of the Public Inquiry into Paediatric

			Cardiac Surgery Services at Bristol Royal Infirmary (established in October 1998), the forward by the Chairman Ian Kennedy stated in relation to section 2 of the Report: *"We offer our view of the way forward for the NHS: an NHS fit for the 21st century. The scale of the enterprise is considerable. So are the time and resources which will be needed to achieve the necessary changes. We make close to 200 recommendations. They are the recommendations of all of us. This is a unanimous Report. Our job is done. It is up to others to decide how to take things forward."*
August 2001			DHSS & NPSA, 'Doing Less Harm; Improving the Safety and Quality of Care through Reporting, Analysing and Learning from Adverse Incidents'
25th September 2001		Ref: 093-035 (appended to summary of PSNI taped interview)	Dr. Taylor sent a suspected 'adverse drug reaction report' to the Medicines Control Agency in relation to Raychel noting: *"Post op appendectomy – Urea + electrolytes not measured for 48 hours – symptomatic – seizures Na+118"*
26th September 2001		Ref: 007-048-094	Dr. Miriam McCarthy (Senior Medical Officer DHSSPS (NI)) convenes the first meeting of the Hyponatraemia Working Group attended by Dr. Robert Taylor; Dr Lowry[22]; Dr Nesbitt[23]; Mr

[22] Dr. Darrell Lowry (Consultant Paediatric Anaesthetist, Craigavon Area Hospital)
[23] Dr. Geoff Nesbitt (Consultant Anaesthetist and Medical Director, Altnagelvin Hospital)

			Marshall[24]; Mr McCallion[25]; Dr Kennedy[26]; Dr Loughrey[27]; Dr Crean[28]; Dr Mark[29] and Ms. McElkerney[30]
25th March 2002		DHSSPS(NI)	Publication of the: 'Guidance on the prevention of hyponatraemia'
21st June 2002		HSS (PPM) 3/2002 Ref: 079-008-012	'Corporate Governance: Statement of Internal Control', issued to all Chief Executives of HSS Boards & HSS Trusts
January 2003		INQ0485-11	Managing Medical Problems in Children: RBHSC (3rd edition[31]), with contributions from: Drs. Bartholome (Claire); Hanrahan (Raychel); O'Connor (Adam); Sands; Steen (Claire); Taylor (Adam & Claire); Webb (Adam & Claire) Topics include: 'Dehydration' and 'Fluids - Prescribing' (under General), which refers explicitly to 'hyponatraemia' and advices: *"In most cases this implies a minimum sodium concentration of 130mmol/L. Seek senior advice for management of hypernatraemic dehydration"* (p.9)
13th January 2003		HSS (PPM) 10/2002 Ref: 079-009-037	DHSSPS(NI) publishes guidelines 'Governance in the HPSS – Clinical and Social Care Governance:

[24] Mr. Glen Marshall (Consultant Surgeon, Erne Hospital)
[25] Mr. William McCallion (Consultant Paediatric Surgeon, RBHSC)
[26] Dr. Fiona Kennedy (Consultant in Public Health Medicine, NHSSB)
[27] Dr. Clodagh Loughrey (Consultant Chemical Pathologist, Belfast City Hospital)
[28] Dr. Peter Crean (Consultant Paediatric Anaesthetist, RBHSC)
[29] Dr. Margaret Mark (Medical Officer, DHSSPS(NI))
[30] Ms. Elizabeth McElkerney (Directorate Manager, Woman & Child Health Directorate, Ulster Hospital)
[31] Previous editions were known as: 'Paediatric Medical Guidelines'

			Guidelines for Implementation' in the context of 'Best Practice – Best Care'. It includes reference to: *"identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance"* (p.6) *"This culture needs to be one of openness, transparency, listening to the views of users, staff and local communities, learning, sharing information and developing partnerships"* (p.7) *"… there are some core arrangements which should always be put in place. These are establishing and maintaining … an open, honest and proactive system where people can report poor performance, near-misses and adverse events to allow them to be appropriately dealt with, <u>lessons learned and shared within and where appropriate outwith the organisation</u>"* (emphasis added, p.8) *"The Chief Executive of each organisation … will designate a senior professional at board level [by 28th February 2003] to support him or her in the discharge of his or her role as an accountable officer for the delivery of quality care and treatment (para.25) … The senior professional will also develop local systems for engaging the views of users and staff and mechanisms that will support the dissemination of clinical and social care standards, best practice and innovation (para.27, p.10)"*

February 2003			'Implementation of Clinical and Social Care Governance'
8th February 2003	Raychel's Inquest		
April 2003			The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 comes into force in April 2003 placing a statutory duty of quality on all HPPS providers
28th April 2003			Luce Report submitted to the Minister of an Investigation in England, Wales & Northern Ireland: The Report of a Fundamental Review into Death Certification and Investigation'. It provided at para.34: *"Coroners should send promptly to any public or other body a clear and succinct account of any inquest or investigation finding relevant to the body's services, activities or products and to the safety of its users, customers or staff."*
12th May 2003	Conor dies		
19th September 2003		Ref: 079-010-055	Deliotte publish their Final Report: 'Evaluation of HPSS Baseline Assessment and Action Plan – Clinical and Social Care Governance'
November 2003			Statement published by the Royal College of Paediatricians and the Royal College of Anaesthetists: 'Possibility of water overload with

			severe hyponatraemia developing after the infusion of 4% dextrose/ 0.18% saline'
17th February 2004	Lucy's Inquest starts		
19th February 2004	Lucy's Inquest concludes		
March 2004			Deloitte's Report on: 'Adverse Incident & Near Miss Reporting in Northern Ireland'
April 2004			National Patient Safety Agency publishes: 'Seven Steps to Patient Safety; An overview guide for NHS staff'
9th June 2004	Conor's Inquest		
7th July 2004		HSS (PPM) 06/04 Ref: WS-061/1, p.4 Ref: 079-012-299	DHSSPS issues: 'Reporting and Follow up on Serious Adverse Incidents – Interim Guidance'

SCHEDULE 4: From the UTV broadcast on 21st October 2004 to the inclusion of Claire's case in the work of the Inquiry on 30th May 2008

Date	Events in relation to the children	Reference	Other Developments
21st October 2004	UTV broadcast the 'Insight' programme: 'When Hospitals Kill'		
Date unknown	Claire's parents contact the Royal afterwards as they had continuing concerns over Claire's death		
Date unknown	Professor Young states in his deposition to the Coroner[32] that:	Ref: 091-010-063	

[32] Note: Professor Young states in his Deposition (Ref: 091-010-062) that he spoke to Drs. Steen, Sands, Rooney and to Claire's parents.

	"I was asked to review the medical records of this 9-year old girl by Dr Michael McBride, Medical Director of the Royal Group of Hospitals "… I informed Dr Michael McBride, the Medical Director of the Trust that in my opinion hyponatraemia may have made a contribution to the development of cerebral oedema in Claire's case. I advised that it would be appropriate to consider discussing the case with the coroner for an independent external opinion with access to statements from all of the staff involved in Claire's case		
1st November 2004			Angela Smith MP, Minister with responsibility for Health Social Services and Public Safety, announces she had appointed Mr John O'Hara QC to conduct an inquiry into the issues raised by the recent UTV Insight programme 'When Hospitals Kill'
18th November 2004			Angela Smith MP announces the Terms of Reference for the Inquiry into the deaths of Adam, Lucy and Raychel. The press release states that the Minister said: *"I believe it is of the highest importance that the general public has confidence in the quality and standards of care provided by our health and social services … The death of any child is tragic and it is essential that the investigation into these deaths is independent, comprehensive and rigorous. The Terms of Reference I have set for the Inquiry and the powers available to it are wide-ranging and should ensure that the Inquiry deals with all the issues of concern."*
6th	A meeting took place between	INQ 0241/11	

December 2004	Professor Young,[33] Dr. Michael McBride[34] and Dr. Heather Steen, which *"was not formally minuted"*. Professor Young stated that Dr Steen "*has definite views about the significance of the fluid management, which are not quite the same as mine."* Dr. McBride decided at that meeting that Claire's case should be referred to the Coroner, and later that evening agreed that Dr Webb should be informed.	INQ-0558-11	
7th December 2004	Meeting between Claire's parents and medical staff from the Royal (Drs. Rooney, Steen, Sands and Professor Young) Drs. Steen and Sands stated they believed Claire was very unwell. Professor Young stated that a drop in sodium levels can cause swelling of the brain which may have contributed to the swelling of Claire's brain and therefore ultimately her death. He also stated that: *"At the Royal Hospitals, lessons have been learnt regarding management of sodium levels in children – which is still not the case in many UK hospitals"* Professor Young advised Claire's parents to consider giving permission to refer the case to the Coroner. They were given time to think about the matter. The Trust would not contact the Coroner until they heard from Claire's parents.	Ref: 089-002-002 Ref: 089-002-004	
8th December 2004	Mr. Roberts writes to the Royal requesting answers to questions and referral to the Coroner	Ref: 089-003-006	
14th December 2006	Dr Rooney suggests postponing a further meeting until early January, in light of the questions posed by Mr. Roberts, with a referral to the Coroner in the meantime. Mr. Roberts was happy with this.	INQ-0558-11	
15th	Dr McBride e-mails Dr. Walby	INQ-0558-11	

[33] Professor Ian Young (Consultant in Clinical Biochemistry, RBHSC): See Schedule of Persons for details
[34] Dr. Michael McBride (Medical Director, Royal): See Schedule of Persons for details

December 2004	(Associate Medical Director of the Royal)[35] to ask him to take the lead in informing the Coroner of Claire's case		
16th December 2004	At the request of the family Dr. Walby reports Claire's case to the Coroner for investigation.	Ref: 089-004-008	
17th December 2004	Dr. McBride writes to Claire's parents to inform them of the report to the Coroner	Ref: 089-005-010	
7th January 2005	Claire's parents meet Mr. Leckey, Coroner to discuss their concerns relating to hyponatraemia and Claire's treatment	Ref: 089-007-016	
12th January 2005	Letter from the Royal (Dr. Rooney[36]) to Claire's parents, responding to questions arising in Mr. Roberts' letter of 8th December 2004. Answers provided by Dr. Steen and Professor Young. Indicates that: 'The Coroner had not been informed at the time as it was believed that the cause of Claire's death was viral encephalitis'	Ref: 089-006-012	
17th January 2005	Mr. Roberts writes to the Inquiry Chairman to inform him of Claire's case and upcoming inquest		
25th January 2005	Letter from Dr. Walby to the Coroner – Dr. Walby mentions that in a letter of 16th December 2004 he: *"referred to the provisional diagnosis as simply being that of a viral illness whereas the admitting Registrar had gone further and considered it to be possibly encephalitis"*	Ref: 097-005-006	
3rd February 2005	Letter from Dr. Herron to John Leckey (Coroner)[37] in which she states that: *The central oedema that was present may have many causes, one of which is hyponatraemia. The autopsy did not exclude this as a cause of brain swelling nor did it show any specific findings*	Ref: 097-003-004	

[35] Dr. A P Walby (Associate Medical Director, Royal): See Schedule of Persons for details
[36] Dr Nichola Rooney (Consultant Clinical Psychologist, RBHSC): See Schedule of Persons for details
[37] Mr. John Leckey (HM Coroner for Greater Belfast): See Schedule of Persons for details

	(structural changes) to make the diagnosis of hyponatraemia. I am unclear from the letter as to whether it is thought that the hyponatraemia was a primary factor in this case, i.e. caused the brain swelling, or was secondary to the brain swelling.		
16th March 2005	Dr. Heather Steen gives statement	Ref: 096-004-021	
14th April 2005	Dr. Bingham[38] prepares report on Claire	Ref: 091-006-023	
6th July 2005	Dr. Andrew Sands gives statement	Ref: 096-002-013	
22nd September 2005	Claire's parents meet Mr. Leckey, Coroner. They express their wish that he hold an Inquest and Coroner agreed to do so	Ref: 089-010-029 & Ref: 089-011-034	
25th April 2006	Depositions given at Inquest of: Mr. Roberts, Dr. Sands, Dr. Steen, Dr. Herron, Professor Young and Dr. Webb, Dr. Bingham and Dr. Maconochie[39]	Respectively: Ref: 096-001-001, Ref: 096-003-015), Ref: 096-005-025, Ref: 096-006-032, Ref: 096-008-041, Ref: 096-010-065, Ref: 096-11-070 & Ref: 096-012-079	
4th May 2006	Verdict on Inquest delivered: Cerebral oedema due to meningo-encephalitis, hyponatraemia due to excess ADH production and status epilepticus	Ref: 091-002-002	
30th May 2008	It is announced at a public progress meeting of the Inquiry that Claire's death is to be included in its work		

[38] Dr Robert Bingham (Consultant Paediatric Anaesthetist, Great Ormond Street Hospital for Sick Children, London): See Schedule of Persons for details
[39] Dr Ian Maconochie, (Consultant in Paediatric A&E Medicine, St Mary's Hospital, London): See Schedule of Persons for details