

1

Friday, 19 October 2012

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(9.30 am)

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THE CHAIRMAN: Good morning. Just before Dr Sands starts:

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Mr Sephton, after Tuesday afternoon's exchange about

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Dr Stevenson, we haven't heard anything from your end

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about any more points; is that correct?

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MR SEPHTON: That's correct. We have been in contact with

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our client, Dr Webb. We have impressed upon him the

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urgency of the situation. He has e-mailed us, late last

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night, something which is a start, but I'm afraid it's

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not yet in a position where I'm able to disclose it.

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I'm very conscious that the inquiry wants a document

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as soon as possible and I have impressed that upon

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Dr Webb. I hope by the end of today I will have such

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a document, but I can't put one before the panel now.

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THE CHAIRMAN: More importantly for Dr Sands giving

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evidence, I don't want any surprises today coming from

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Dr Webb like we had for Dr Stevenson on Tuesday

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afternoon when Dr Stevenson was giving evidence.

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MR SEPHTON: I can tell the inquiry that my concern with

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Dr Webb is around the issues of who was the consultant

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responsible. I don't think there are going to be any

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surprises there.

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THE CHAIRMAN: That's an issue which has already been

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developed, I think, substantially. Okay. Dr Sands

1 knows the lines of questioning which are going to come
2 from the inquiry, he has his representatives here.

3 MR SEPHTON: There are no factual matters I intend to raise
4 with Dr Sands of which he hasn't had notice.

5 THE CHAIRMAN: Thank you. Dr Sands, please.

6 DR ANDREW SANDS (called)

7 Questions from MS ANYADIKE-DANES

8 MS ANYADIKE-DANES: Good morning, Dr Sands. Do you have
9 a copy of your curriculum vitae there?

10 A. I do.

11 Q. You've made two statements for the inquiry, that's
12 correct, isn't it?

13 A. Three now, I think.

14 Q. Sorry, two in relation to clinical issues, I should say.

15 A. That's correct.

16 Q. And did you make any previous statements for anyone else
17 in relation to this case?

18 A. To the coroner for the inquest.

19 Q. Yes. You didn't make any in terms of any inquiry that
20 there might have been in relation to the hospital?

21 A. No, I didn't.

22 Q. So if I ask you about your inquiry witness statements --
23 for the record, they're at 137/1, and that is dated
24 23 December 2011, and 137/2, and that's dated
25 18 June 2012.

1 A. That's correct.

2 Q. Do you adopt those witness statements as your evidence
3 subject to anything that you might say to the inquiry
4 during your evidence here?

5 A. Yes, I do. Maybe I should just point out one thing that
6 has come to light quite recently, I suppose. The rota
7 has been made available to me, the on-call rota for
8 junior doctors from the evening and night of the 22nd
9 into 23 October 1996. That probably affects, to some
10 degree, my -- clarifies some of my answers in relation
11 to who was on call and what the roles were on the
12 evening of the 22nd, the night of the 23rd.

13 Q. At this stage, are you able to assist with how that
14 clarifies what you might have said?

15 A. Just in terms of the personnel and their individual
16 roles at that time, because I didn't have the rota,
17 which I've now seen in the last 10 days or so.

18 Q. Does that mean that you're now aware of the individuals'
19 names where before you would only have been aware that
20 there would have been a registrar or there would have
21 been an SHO, now you know the actual persons that you're
22 talking about?

23 A. And perhaps actually the number of SHOs.

24 Q. I understand.

25 MR GREEN: I can give Ms Anyadike-Danes a reference now, or

1 if she wishes to have it later she can have it then.

2 MS ANYADIKE-DANES: Perhaps now would be convenient.

3 MR GREEN: 302-031-004.

4 MS ANYADIKE-DANES: Thank you very much indeed.

5 While I was questioning you before about your

6 inquiry witness statements, you said you had made

7 a statement at the inquest. So that we're clear, you

8 had made a statement which was to be provided to the

9 coroner; that's correct, isn't it? And I think that

10 we have that, 6 July 2005. That's a fairly short,

11 two-page statement.

12 A. That's correct.

13 Q. In fact, the reference for that, for the record, is

14 090-051-157. Then there is your actual deposition --

15 A. That's correct.

16 Q. -- which, at the bottom of it, will be some manuscript

17 writing, some further things that were added while you

18 were actually giving evidence to the coroner; that's

19 correct, isn't it?

20 A. That's correct.

21 Q. And that is dated 4 May 2006. The reference for that is

22 091-009-055. The new part, because your earlier

23 statement is in fact just incorporated into that, starts

24 at 091-009-059. And those are all the statements that

25 you've made in relation to Claire's case; would that be

1 correct?

2 A. That's correct. If I could mention maybe while we're on
3 the subject, in my deposition to the coroner, I think
4 there's a transcription error, as I read my statement
5 out to the coroner, in terms of my position at the time.
6 I think I'm recorded as being a paediatric cardiology
7 registrar. I think that appears in the deposition to
8 the coroner.

9 THE CHAIRMAN: Yes, you said:

10 "I had commenced my first substantive post as
11 a paediatric registrar in paediatric cardiology."

12 A. Which is actually slightly different, Mr Chairman, from
13 my statement to the coroner. So I think that was just
14 a transcription error taken as I read out my statement
15 to the inquest.

16 MS ANYADIKE-DANES: So what should it be?

17 A. It should have been that my first substantive post was
18 as a paediatric registrar in Allen Ward on
19 7 August 1996. Prior to that I had been a locum
20 registrar in paediatric cardiology for four months.

21 Q. In fact, that --

22 THE CHAIRMAN: Sorry, just for the record, we're looking at
23 091-009-055. Just to make sure, doctor, that we're
24 looking at the right thing. This will be brought up in
25 a moment. There we are. Ten lines down:

1 "I had commenced my first substantive post as
2 a paediatric registrar in paediatric cardiology."
3 A. Which is not quite correct, and that's not as in my
4 statement to the coroner.
5 MS ANYADIKE-DANES: If we pull up your CV, which I can take
6 you to, it's at 311-001-001, but for these purposes, if
7 we could pull up 004 of that document. Does that more
8 accurately set out your previous engagements?
9 A. It does.
10 Q. So then I think the point you were making is that you
11 can see that you were the locum registrar in paediatric
12 cardiology and that's what you were from 1 April to
13 6 August of 1996.
14 A. That's correct.
15 Q. And then you were the registrar, specialist registrar in
16 paediatrics, and that's where you were from
17 7 August 1996 to 5 August 1997. And that's what you
18 were actually when Claire was admitted; is that correct?
19 A. That's correct.
20 Q. So just while we're at that, does that mean that was
21 really your first substantive registrar posting?
22 A. That's correct.
23 Q. And you'd been about two-and-a-half months into that or
24 thereabouts?
25 A. That's also right, yes.

1 Q. It was only something like about six months earlier when
2 you were an SHO yourself?

3 A. That's true.

4 Q. Just so that we have it correctly, the hierarchy of
5 clinicians, because the terminology has changed, and
6 we have a document that seeks to assist us with that.
7 But from your point of view, was it JHO, SHO, registrar
8 and then consultant in 1996?

9 A. I think there would have been a distinction made between
10 registrar and senior registrar. That largely
11 disappeared with the adoption of the specialist
12 registrar terminology, in which case you would be
13 a specialist registrar in year 1, 2, 3, 4 or 5, rather
14 than be a senior registrar in perhaps four or five of
15 your training.

16 Q. In fact, I think when we were looking at that file 150,
17 and we saw a letter between Dr Livingstone at
18 Cupar Street and Dr Bartholome, Dr Livingstone was
19 a specialist registrar.

20 A. I think she may have been a senior registrar.

21 Q. I beg your pardon, senior registrar, yes. That's to be
22 distinguished from your position, as you weren't
23 a senior rather at the time of Claire's admission.

24 A. That's right.

25 Q. I would now like to ask you just in general terms about

1 your knowledge of the Adam Strain case. As you may be
2 aware, Adam Strain was admitted for paediatric renal
3 transplant in 1995 and died in November 1995. Then he
4 had an inquest into his death in the summer of 1996. So
5 just a few months really before Claire was admitted and,
6 in fact, just before you would have started your
7 position as registrar. You would have been at the
8 hospital at the time when that inquest happened and, in
9 fact, I don't think you were at the hospital when he was
10 actually admitted for his surgery. Just from looking at
11 this, you would have been there when the inquest took
12 place.

13 Dr Bartholome yesterday said that she -- it's at
14 page 4 of yesterday's transcript, line 9, but not to be
15 pulled up. This is what she said about it:

16 "I cannot definitely say whether in October 1996
17 I had read the full result [that's the full result of
18 the inquest], but the whole events surrounding this
19 inquest have been known to me and to most of the doctors
20 in the Children's Hospital."

21 Would you agree with that?

22 A. I don't think I would, but that's based on my lack of
23 knowledge about the Adam Strain case.

24 Q. Were you aware of it at all?

25 A. To the very best of my recollection, no.

1 Q. Can you recall when you became aware of it?

2 A. I don't think I became aware of the Adam Strain case
3 until after, in fact, the television documentary was
4 shown. The name in fact would have meant, I think, very
5 little to me. Perhaps nothing at all until somebody
6 told me about it after that television programme was
7 aired. So I wasn't aware, knew nothing about the case.

8 Q. So if there was general discussion about it, it's not
9 a discussion that would have moved so widely as to have
10 included those perhaps not involved on the nephrology
11 programme, not involved on Musgrave Ward and not you?

12 A. I think that's probably correct. I did move then into
13 cardiology and away from the general paediatric side of
14 things and indeed away from, I suppose, much of what
15 went on in Musgrave Ward and so on, and indeed they may
16 well have had a good background of Adam and his history,
17 whereas I wouldn't have.

18 Q. Did cardiology involve surgery in those days?

19 A. Yes, the cardiology ward is a mixed medical and surgical
20 ward, although the patients don't actually have their
21 surgery within the Children's Hospital. They have their
22 cardiac surgery over in the adult hospital, the Royal
23 Victoria Hospital.

24 Q. What about the anaesthetist for any paediatric
25 cardiology surgery, would those anaesthetists be from

1 the Children's Hospital?

2 A. No, at that time they were a separate group. Currently
3 there's quite a bit of crossover, but at that time and
4 indeed until very recently, the cardiac anaesthetists
5 were a separate group working on a separate site, that
6 is in the Royal Victoria Hospital rather than the
7 Children's Hospital.

8 Q. So although the paediatric anaesthetists who worked on
9 the renal transplants came from the Children's Hospital,
10 the anaesthetist who worked in cardiac surgery did not,
11 they came from the main hospital, the adult hospital?

12 A. That's correct.

13 Q. When you moved into that, did you have any exchanges,
14 did you have much communication with your colleagues at
15 the main hospital, if I can put it that way, when you
16 moved into cardiology?

17 A. I would have been over visiting patients in the cardiac
18 surgical intensive care unit.

19 Q. The reason I'm asking you this is because one of the
20 things to have come out of Adam's inquest was
21 a recognition that, for children going into major
22 surgery with the potential for electrolyte imbalance,
23 particular care needed to be taken of their fluid
24 management, in particular, the testing. And that went
25 on into ensuring that there was ready access to

1 laboratory results because there was such a concern that
2 that was an area which had been deficient in Adam's
3 surgery, if I can put it that way.

4 So there would be an issue if major surgery was
5 identified as the area of concern. Obviously, cardiac
6 surgery in children is major surgery. I say
7 "obviously"; is that correct?

8 A. That's correct.

9 Q. Yes. So if there was going to be that sort of concern
10 and people ought to be alive to that, what I'm trying to
11 explore with you is whether that had, in any way,
12 transmitted itself to the paediatricians dealing with
13 the cardiac matters for children in 1996.

14 A. I think that's very difficult for me to say. I'm not
15 aware that Adam's case did cause a change of care
16 amongst the anaesthetists, particularly who were looking
17 after the cardiac theatres and the post-operative
18 cardiac surgical intensive care. It may have done, but
19 I don't believe it was discussed with me or was
20 something that was discussed generally within our team.

21 Q. So if I understand you rightly, although that might be
22 something that the paediatric anaesthetists in relation
23 to renal transplant may have been alive to -- because he
24 obviously was a renal transplant case -- you're not
25 aware of that message having got to the adult

1 anaesthetists who are providing anaesthetic care to
2 paediatric cardiology patients?

3 A. I'm not aware of that.

4 Q. If it had transmitted itself, that message, in that way,
5 is that something that you would expect to have at some
6 stage become alive to?

7 A. I would have expected my senior colleagues to be aware
8 of it, perhaps first of all, and to transmit that to the
9 whole team as we were all -- I mean, as a trainee, as
10 a specialist registrar in paediatric cardiology, I would
11 have expected to hear about it from other colleagues.

12 Q. Is it something you would have wanted to know about?

13 A. Yes.

14 Q. Thank you. Just if we stay there, what was your own
15 awareness of hyponatraemia at that time? Leaving aside
16 anything that may have or should have filtered down to
17 you in relation to Adam's case, what was your own
18 awareness of hyponatraemia?

19 A. In 1996?

20 Q. Yes. Round about the time of Claire's admission, if you
21 can put it in that way.

22 A. I think amongst clinicians at the time, including me,
23 I think we would have first and foremost regarded
24 hyponatraemia as a descriptive term of a low serum
25 sodium, not so much as a diagnosis or an entity of

1 itself.

2 Q. Well, would you have been aware of how a child might
3 reach such a condition or situation, if I can put it
4 that way?

5 A. I would have had theoretical knowledge, at least, of
6 that. I had studied for my MRCP examination and passed
7 that in 1995, the summer of 1995. I'm not sure I would
8 have had the appreciation of acute, that is sudden,
9 hyponatraemia versus more chronic hyponatraemia, which
10 I do remember seeing in adult patients as a houseman.
11 I can recall adult patients coming in with low serum
12 sodiums maybe before having surgery, and been aware that
13 they were clearly hyponatraemic, perhaps because of drug
14 therapy or other causes. As to whether I'd seen it
15 particularly in the paediatric setting, perhaps not much
16 at that stage.

17 Q. Well, were you aware of what we have called rather
18 loosely the Arieff article in 1992?

19 A. I don't think I was.

20 Q. In terms of how it might develop, if I can put it that
21 way, I wonder if I could -- it's slightly out of turn,
22 but now that we are talking about hyponatraemia and your
23 state of knowledge, it might help to do it now.

24 090-022-056. This is part of Claire's clinical notes
25 and records, which I'm sure you have seen. If you look

1 at the second paragraph starting "hyponatraemia". So
2 that is hyponatraemia and, as you've described it,
3 hyponatraemia is effectively to say that the serum
4 sodium is low. Would you agree that the 121 falls into
5 that classification of hyponatraemia?

6 A. Certainly.

7 Q. 135 to 145 being the sort of normal range, so 121 is
8 pretty low.

9 A. Certainly.

10 Q. And sufficiently low to be of concern?

11 A. Yes.

12 Q. And therefore classified, not just technically as
13 hyponatraemic, but hyponatraemia that you have to do
14 something about?

15 A. Yes.

16 Q. So this is Dr Stewart's note, and this is a note that
17 he's making at 11.30, so he has those results and he has
18 hyponatraemia, so he has that as how to classify it.
19 Then he's querying the causes. One is fluid overloads
20 and low-sodium fluids. That's one pathway, if I can put
21 it that way, towards hyponatraemia. The other is SIADH.
22 Would you have been aware of that yourself in 1996?

23 A. Of those as causes of hyponatraemia?

24 Q. Yes.

25 A. I would have certainly been aware of this syndrome of

1 inappropriate ADH, again probably more from
2 a theoretical point of view rather than having
3 practically dealt with it on a frequent basis. In terms
4 of fluid overload with low-sodium fluids, I think at the
5 time I would have been aware of that as a potential
6 problem.

7 Q. So although you may not have seen many instances of it
8 yourself in your paediatric career at that stage, you
9 certainly were aware that that was a means by which
10 hyponatraemia could develop?

11 A. Yes.

12 Q. And they might have different ways of addressing them,
13 depending on which cause it was?

14 A. Yes.

15 Q. We had prepared a little flow chart to see how these
16 things might interact with one or other of your
17 differential diagnoses, but since we're talking about it
18 now, it might be as well to have it. I think it's
19 310-014-001.

20 There we are. It's a simplistic graphic
21 representation of what I'm quite sure is a complex
22 situation. But this is just to try and see where the
23 interrelationships might be. Would you say, broadly,
24 that, leaving aside the three at the bottom, you can get
25 a sort of cyclical relationship, as is described above,

1 with the greens feeding into the cerebral oedema, the
2 cerebral oedema feeding into the SIADH, and an
3 alternative route to getting to the retention of free
4 water and the hyponatraemia being the one that you've
5 just identified, which is the hypotonic fluids? So
6 overadministration or too rapid a rate of administration
7 of the low sodium fluids could lead to a retention of
8 free water or an excessive retention of free water, that
9 lowering the serum sodium level could produce
10 hyponatraemia, which could lead to cerebral oedema, and
11 the cerebral oedema could produce the SIADH in and of
12 itself and you could just get into that awful cycle.

13 Although you might not have stood on the ward and
14 drawn that out yourself, but if you had been asked,
15 would you have appreciated that there were those
16 interrelationships?

17 A. I'm not sure in 1996 whether I would have understood it
18 in those quite clear terms as they're laid out there,
19 because I think this does reflect the understanding now
20 that, if you have even some elevation in ADH levels and
21 you provide a source of free water, that you can then
22 retain free water, that you can then see hyponatraemia.
23 So I don't think I would have understood it in this sort
24 of clarity at that stage.

25 Q. But from what you had said before and looking at

1 Dr Stewart's own note, you would have understood, would
2 you not, that an overadministration of low sodium fluid
3 could lead to a retention, an excessive retention, of
4 essentially free water, and that would necessarily
5 produce a low serum sodium, which is hyponatraemia;
6 you'd have understood that?

7 A. Yes, but probably just in those fairly simple terms, and
8 had you asked me to draw this diagram in 1996,
9 I probably wouldn't have been able to.

10 Q. But if we stick with that fairly simple relationship,
11 and once you'd got to hyponatraemia, might you have
12 appreciated that hyponatraemia, left unchecked, could
13 produce cerebral oedema?

14 A. Yes.

15 Q. Thank you. And that's one of the reasons you would have
16 appreciated then why it is dangerous and it needs to be
17 addressed.

18 A. Hyponatraemia, yes.

19 Q. Thank you. Before we go into the day and work our way
20 through the day, which I'm going to try and do with you,
21 because it's less confusing than jumping about the
22 issues, I wonder if you could help with this: what were
23 your teaching responsibilities at that time?

24 A. Again, I'd have to say that my recollection is not
25 complete on that matter, but typically during the

1 university terms, we would have had medical students to
2 teach and would have taught them on a regular basis.
3 That would have probably involved consultants and
4 registrars taking them in tutorial groups for fixed
5 sessions. We probably had some teaching responsibility
6 as well towards SHOs within a ward group meeting
7 setting, and that probably occurred on a weekly basis.

8 Q. If we stick with the SHO element of it, apart from
9 a sort of more formal teaching session, is that
10 something that was really ongoing, that you would use
11 ward rounds, if you were conducting them, as a learning
12 point, if I can put it that way, particular conditions
13 of patients as a learning point or outcomes of their
14 treatment; is that something that you were expected to
15 carry on through the day with your SHOs?

16 A. I think that is the model that was usually employed.
17 I have to say that is somewhat time dependent and
18 depends just on what else is happening and whether
19 there's time to do that. I think that in a teaching
20 hospital particularly, that's how things ought to be and
21 that's what you would aim for.

22 Q. And the Children's Hospital was a teaching hospital?

23 A. Yes.

24 Q. So that was the intention, not exactly mentoring, but
25 you would be bringing along these SHOs and taking the

1 opportunity to teach them. What do they call it,
2 ward-based learning perhaps?

3 A. Yes, and I think a lot of learning was ward based.

4 I think if one was taking a ward round, one would feel
5 the onus was on the registrar, me as an individual, to
6 firstly and foremost try and address the patient's
7 needs. Teaching would probably have been of secondary
8 importance and would have been subject to having time to
9 maybe take people aside and talk to them and explain why
10 you were doing something and why a particular course of
11 action might be appropriate.

12 Q. Is it part of your role to, apart from inculcating good
13 practices, which you're trying to do there, but also try
14 and prevent or avoid poor practices developing amongst
15 the SHOs?

16 A. Yes, as a general rule, and I think if one had a concern
17 about poor practice, one would have felt obliged at that
18 stage to tell a senior doctor, that maybe there was --
19 if it was a small problem, if it was something that
20 could be corrected or if you could encourage somebody to
21 do something a slightly different way, I think one would
22 have tried to do that. If there was a major issue, then
23 I think one would have tried to talk to a senior doctor
24 about it.

25 Q. Leaving aside the major issues, just making sure that

1 they're coming along in the way you would wish them to
2 because these are going to be the future doctors
3 standing in your shoes at some point, you hope. For
4 example, record keeping. You're presumably looking at
5 the medical notes of patients all the time as you go
6 through your working day, and if you identify poor
7 record keeping, is that something that you think --
8 leaving aside what the consultant might do -- that you
9 might have a word with whichever was the SHO involved to
10 draw that to their attention?

11 A. Yes.

12 Q. And you would consider that part of your responsibility?

13 A. Yes.

14 Q. And did you do that sort of thing in 1996?

15 A. I think we did. I seem to remember that we did have
16 discussions of that sort. I don't remember exactly
17 in relation to record keeping, but other things, about
18 how a ward should be run and how things should be done.
19 It partly depends. Obviously, you take a lead from your
20 consultant, you also provide a lead by thinking what is,
21 in your own mind, best practice and then you try and
22 encourage others to try and follow both of those
23 examples, and I think we did have discussions of that
24 sort as a team. As well, when we came to Allen Ward, we
25 received some instruction from consultants about these

1 matters as well.

2 Q. I understand that it's quite difficult to go back
3 16 years and tease out what you think you were told then
4 and what you might have developed along the way, but
5 given that you had perhaps not been in Allen Ward that
6 long yourself, were you aware of having any sort of
7 discussions to assist you in what the relevant
8 consultants' expectations were of you, what their own
9 standards were, how they wanted to have things done, if
10 I can put it that way?

11 A. I don't have very many direct recollections. I can tell
12 you of one though that I do remember.

13 Q. Yes.

14 A. I assume it was actually quite early after starting at
15 the Children's Hospital -- it was possible it was my
16 very first attachment to the Children's Hospital, so it
17 may have been a little before I was a reg in Allen Ward.
18 I remember Dr Steen sitting some of us down and telling
19 us how we should avoid doing blood tests out of hours if
20 possible, do them within hours, try and avoid doing a
21 so-called full admission profile on admission just for
22 the sake of it, that tests should be focused,
23 well-organised and done within lab hours if possible.
24 And that's just something that has stuck in my mind from
25 way back. As I say, it may pre-date October 1996 by

1 a little bit, in fact it may relate to my very first
2 attachment to the Children's Hospital.

3 Q. And that was why? That was because out-of-hours put
4 a burden on the laboratory and the other resources to do
5 it?

6 A. I believe so, and also, I think it was to make people
7 think exactly what they were asking for, why they were
8 asking for it, what they hoped to find from it.

9 Q. To be more focused in your thinking about what might be
10 the diagnosis that would require any given test being
11 carried out?

12 A. Yes. I think other individual consultants, I'm quite
13 sure, had their specific things that they were concerned
14 about. For example, Dr Redmond would have had very
15 definite views about what she did or didn't want done
16 with other her cystic fibrosis patients as a more
17 specialist doctor. And I feel Dr Hill as well would
18 have had probably particular things about her own group
19 of patients with neurodevelopmental disorder, that she
20 felt should be done or how things should be done and she
21 would have emphasised those points I believe as well.

22 Q. Without getting to actual specifics, but in the way that
23 you have given that generally for those two consultants,
24 were you aware of anything like that in relation to
25 Dr Steen?

1 A. Other than what I've mentioned, because I do believe it
2 was Dr Steen who did discuss about the investigations,
3 I have no other specific recollection about how she
4 particularly wanted things done.

5 Q. Do you recall any discussion as to the circumstances in
6 which any of those consultants, but obviously
7 specifically Dr Steen, would have wanted to be contacted
8 by you in relation to any of their patients? Did you
9 have those sorts of discussions?

10 A. I'm not sure how explicit that would have been. I think
11 we would have all been aware of what the consultants'
12 expectations were, but it may not have been explicit.
13 I would say that as a junior doctor, time and time
14 again -- and I still repeat this today -- we were told
15 that if we were in any doubt about a patient that we
16 should seek senior advice and not hesitate, not delay,
17 in doing that.

18 The other thing that was emphasised is that we
19 should encourage people to be able to spot the sick
20 child because we see lots of children, many of whom can
21 appear quite sick, but sometimes when their temperature
22 comes down, miraculously, they look so much better
23 straightaway. But being able to spot a sick child and
24 to seek senior advice, get senior advice and don't be
25 afraid to ask for that.

1 Q. Speaking of getting senior advice, were you -- I think
2 you probably were here when Dr Steen was giving her
3 evidence, and she indicated that she was contactable in
4 a variety of ways. She had a bleeper, like many I'm
5 sure, she had a mobile phone, not so much like many, she
6 had a secretary who maintained her diary and, at any
7 given time, the clinicians would have known how to reach
8 her; would you accept that?

9 A. I'm not sure I would have known of all of those routes
10 of contact with Dr Steen.

11 Q. Which do you think you wouldn't have known about?

12 A. I can't say. I think, though, I would have usually
13 known her whereabouts and --

14 THE CHAIRMAN: Did you have a bleeper?

15 A. I had a pager, yes.

16 THE CHAIRMAN: Did all the doctors have pagers?

17 A. I'm not sure that all the doctors had pagers and carried
18 them all the time. Within the hospital, I think all of
19 the junior doctors had pagers. I'm not sure all of the
20 consultants had pagers all the time. I'm not sure all
21 the consultants had mobile phones all the time.

22 MS ANYADIKE-DANES: You just added a bit to it: even if they
23 had them, you're not sure they had them with them all
24 the time?

25 A. That's right.

1 Q. Thank you. Just finally on this general part of what
2 I'm asking you, I've asked you about your teaching
3 responsibilities and you went through what you did
4 during term time with the medical students and then what
5 you tried to do on the ward with the junior doctors.
6 Did you have clinics yourself?

7 A. As in a registrar-run clinic?

8 Q. Yes.

9 A. I think there was probably one registrar-run clinic.

10 Q. Can you help us with when that might have been?

11 A. I have asked a lot of people about this. I think there
12 was a registrar-run clinic, which was a review clinic,
13 I think on a Thursday morning. That's the best advice
14 I can get, having asked people about it.

15 Q. The reason I'm asking you this is because Dr Stevenson
16 is not clear in his own mind exactly where you were on
17 the afternoon of Tuesday. Well, where you were in the
18 hospital. And he did wonder whether you might have been
19 attending a clinic or a lecture or something of that
20 sort. Can you assist?

21 A. This has been an issue for me too in trying to recall
22 this, trying to find out about where I was during that
23 afternoon. Because my own recollection of it is that
24 I was out of the ward for much of that afternoon for
25 what seems like a finite period. That's my own

1 independent recollection of it.

2 When I first asked people about it, they said, no,
3 there wasn't a clinic on the Tuesday afternoon. So
4 I thought, well, maybe I was teaching or doing other
5 clinic duties, maybe I was still seeing patients in
6 other parts of the hospital. More recently, when
7 I asked again about it, because it still bothered me
8 that I couldn't pin it down, I asked Dr Anne Armstrong,
9 who currently does a clinic on Tuesday afternoon on the
10 fourth Tuesday afternoon of the month, which is
11 a medical review clinic.

12 I asked her then, was that inherited from Nan Hill,
13 whom she had taken over part of the responsibilities
14 from, when Nan Hill had retired. She said, yes, it was.
15 I phoned Nan Hill and I asked her because I still wasn't
16 sure. I asked her: did you do a medical review clinic
17 on that Tuesday afternoon, the fourth Tuesday afternoon
18 of the month? She said she did. And I asked her,
19 I said, "Please don't let me put words into your mouth,
20 but would you have expected a registrar from Allen Ward
21 to be with you doing that clinic or even instead of you
22 doing that clinic?", and she said she would have
23 expected registrar help at that clinic.

24 Q. So that's where you could have been?

25 A. That's where I could have been. I don't remember,

1 I don't have a clear recollection of where exactly I was
2 on the afternoon, but my independent recollection
3 is that I was out of the ward for a period of time,
4 a finite period of time, during that afternoon. I may
5 have been able to briefly call back into the ward at
6 some stage, but ...

7 Q. If you were attending that clinic, do you know where
8 that would have taken place?

9 A. As I understand it, in the surgical outpatient area of
10 the old part of the Children's Hospital, because the
11 rest of the Tuesday afternoons -- as I understand it,
12 Dr Hill did a joint surgical clinic with, I think, maybe
13 Mr Boston, initially and then, maybe more recently,
14 Mr Bailey. That really related to patients with spina
15 bifida.

16 Q. And I'm going to try and see if I can pull up one of the
17 site maps. Let's try 300-003-003. There. It's
18 actually on the hospital complex, do you think?

19 A. Yes.

20 Q. If we perhaps blow that up then. Can you help us with
21 where you think it might have been if you orientate
22 yourself?

23 A. It was actually -- it was adjacent to the old A&E
24 department, which faced on to the Falls Road.

25 Q. Can you point the pointer? Are we going to the right of

1 where that is?

2 A. Yes, just to the right and down a little bit.

3 Q. Just about there?

4 A. Yes. Perhaps slightly to the left, because as far as

5 I'm aware, the surgical outpatients occupied just two or

6 three rooms down from the casualty cubicles.

7 Q. Somewhere roughly where that is marked?

8 A. I think so.

9 Q. And if you were going to get there from where Allen Ward

10 is, which we can see identified there, roughly how long

11 would that take you?

12 A. Five minutes. Less. Maybe four minutes.

13 Q. If you were going to do something like this, I know you

14 say you can't remember if you were doing it, but if you

15 were going to do something like that, is that something

16 that you would know in advance that you were going to do

17 that?

18 A. Well, usually, although if a consultant perhaps said

19 that they couldn't do all of the clinic, couldn't maybe

20 do any of the clinic, then you might have found yourself

21 doing rather more than you'd anticipated.

22 Q. If that's the fourth Tuesday in every month, that might

23 have been only the second or so one you'd done; would

24 that be right? But it would be, I understood you to

25 say, an established practice, not necessarily that the

1 registrar is doing it, but certainly that there is
2 a clinic like that?

3 A. That's my understanding. I wouldn't have known that had
4 I not gone through that process, and I did ask the Trust
5 recently to see if they could clarify that at all.

6 Q. But that would be known on the ward that there was
7 a clinic like that that registrars may, from time to
8 time, have to attend and may, from time to time, have to
9 take?

10 A. I believe so.

11 Q. And if that's established and known in that way, what
12 sort of arrangements are made for cover for you?

13 A. Well, I would still have been contactable with my pager.
14 People would have known where I was. I don't think
15 I would have had direct registrar cover for my absence
16 if I was doing a clinic such as that, insofar as I think
17 then the ward staff, senior house officers, really would
18 have been working away without my presence actually
19 there and then.

20 Q. And so in terms of senior house officer cover for Claire
21 on that day, that is Dr Stevenson certainly and
22 Dr Stewart; is that right?

23 A. I think I think so, yes.

24 Q. So that would just be the two of them?

25 A. Yes.

1 Q. And if you had been attending that clinic, what time
2 would it start, or more particularly, when would you be
3 expected to turn up for it?

4 A. At a guess, perhaps around 1.30, quarter to two.

5 Q. I'm just trying to establish your whereabouts. I hadn't
6 entirely realised we would go down this direction, but
7 let's pursue it seeing as we are talking about your
8 whereabouts. Dr Webb thinks that some time, lunchtime,
9 you and he had perhaps attended some sort of lecture and
10 that that is when you and he had the conversation about
11 Claire. Do you remember anything like that at all?

12 A. I don't think I met Dr Webb to speak with Claire at that
13 lunchtime meeting. I am aware that there is and was
14 a Tuesday lunchtime meeting in the Children's Hospital
15 that ran most Tuesday lunchtimes from 1 to 2 o'clock.

16 Q. What is it for, the Tuesday lunchtime meeting?

17 A. It's usually a senior doctor and his or her team will
18 present a case or cases, and then -- so it gives some
19 clinical information followed by some discussion about
20 a particularly interesting aspect of patient care.

21 Q. Is it something that you would normally attend?

22 A. Yes. As far as I was able to, yes.

23 Q. I am just trying to see if we can pull up that reference
24 from Dr Webb for you. WS138/1, page 5. I think it's
25 2(a) and (b).

1 THE CHAIRMAN: It's the bottom two lines.

2 MS ANYADIKE-DANES: Yes:

3 "I cannot recall when Dr Sands contacted me about
4 Claire, but I believe this was in the corridor at
5 lunchtime on 22 October. I cannot recall the exact
6 details ..."

7 I was am trying to place where you were. That comes
8 in (b):

9 "I believe Dr Sands contacted me in person at
10 lunchtime on 22 October. This may have been after
11 a hospital clinical meeting that we had both attended."

12 So as I understand it, there probably was a hospital
13 clinical meeting, you're just not sure whether you
14 attended it?

15 A. I think it would have been finished at 2 o'clock, so
16 that would have suggested that I talked to Dr Webb after
17 2 o'clock. And I don't think that's how I contacted
18 Dr Webb.

19 Q. Do you have any actual recollection? You do? We'll
20 come to in that a minute then. That would have meant,
21 if you had attended that, you would have been at the
22 lunchtime meeting, and if you had gone on to the clinic,
23 you're pretty much going directly to the clinic if that
24 had happened?

25 A. Yes.

1 Q. Which, absent being contacted through your pager to
2 attend back at Allen Ward, would have had you away for
3 most of the afternoon if that had happened.

4 A. Yes.

5 Q. Okay. And I think you were saying that if you were
6 going to a clinic like that, it would be known ahead of
7 time that you were and it would be known that you could
8 be contacted, at least, through your pager.

9 A. Yes.

10 Q. And if for any reason that didn't work, did people
11 actually know where that clinic was being conducted to
12 physically ask somebody to go and get you?

13 A. I think they would. I think nursing staff and,
14 I believe, junior medical staff would have known, yes.

15 THE CHAIRMAN: Why do you think that it's not likely that
16 Dr Webb is right that you spoke to him at about
17 2 o'clock?

18 A. My memory is that I left the ward round after we'd seen
19 Claire and that I went to find Dr Webb at that point.
20 I would have probably gone first to Paul Ward because
21 that's where Dr Webb's ward base was. I don't think
22 that's where I found him; I think I found him elsewhere
23 in the hospital at that stage. So I think it took me
24 a little time to find him, but not so very long.
25 I think while there, my memory is that I described

1 briefly Claire's findings to him and asked him if it was
2 okay that we give a dose of rectal diazepam because
3 that's what we had suggested on the ward round. But
4 I think it wasn't actually given or prescribed until
5 12.15. So I believe I checked with him that he was
6 comfortable with that before it was given and it was
7 given around about or shortly after 12.15.

8 THE CHAIRMAN: So if that recollection is correct and it
9 fits, then you spoke to him some time perhaps between
10 11.30 and 12?

11 A. Perhaps around 12-ish, yes.

12 THE CHAIRMAN: Thank you.

13 MS ANYADIKE-DANES: I think we can see the reference for
14 when the rectal diazepam is given. I think it's
15 090-026-075. If one goes right down to the bottom, just
16 so that we understand how this works, this is the
17 once-only prescription and the rectal diazepam,
18 5 milligrams, was once only. Time of administration,
19 12.15, and whose signature is that?

20 A. I think it's --

21 Q. It looks like Dr Stewart's signature prescribing it.
22 And Nurse Linsky, it looks like her signature signing
23 off as having actually given it?

24 A. That's my impression too.

25 Q. So what you're saying is -- in fairness to you, I think

1 that's what you said in your witness statement at 137/1,
2 page 11. Right down at the bottom in relation to (i):

3 "I left the ward round to speak to Dr Webb and asked
4 for his advice, and raised the question of an urgent CT
5 scan. The ward round discussion had suggested a trial
6 of rectal diazepam."

7 And we can see that from the notes:

8 "I believe that I checked that Dr Webb was in
9 agreement with this before administration."

10 So if you piece the plan, if I can put it that way,
11 in her medical notes and records following the ward
12 round, with the administration of the rectal diazepam
13 in the prescription sheet, and you saying that you
14 didn't do that before you confirmed that with Dr Webb,
15 then that assists in placing when you were discussing
16 with Dr Webb. Is that how you would categorise it?

17 A. That's right.

18 Q. Is there any way that you might have had a further
19 discussion with Dr Webb, slightly later on in accordance
20 with what he recalls in his evidence, that you might
21 have, after all of that, nonetheless gone to the
22 lunchtime meeting and nonetheless raised the case of
23 Claire, about whom you might have had concerns? Is that
24 possible?

25 A. It's possible, but I don't remember that.

1 Q. But it could have happened?

2 THE CHAIRMAN: It's possible.

3 MS ANYADIKE-DANES: Thank you.

4 If you'd been concerned about a patient's condition,
5 would you have gone to the clinic?

6 A. I think I still would have felt an obligation to go to
7 the clinic, but I wouldn't have gone there without
8 having tried to put in place a plan or at least feel
9 that somebody was going to be looking at the patient
10 whom we're concerned about, somebody who was going to
11 try and help manage things. I would have felt uneasy
12 about doing that unless I felt that was going to happen.

13 Q. And who would that person be if you're starting the
14 clinic at 2?

15 A. I think in this case I felt that Dr Webb was going to
16 come and see Claire quite soon. Perhaps I felt he would
17 see her even maybe sooner than he did. I suppose I went
18 to him feeling that he might even be able to come right
19 away.

20 Q. Staying as we have with that part of your witness
21 statement there, are you saying that when you had raised
22 Claire with him, whenever it was, before 12.15, it was
23 your impression, understanding, hope, that he would
24 actually come quite soon to see Claire?

25 A. That's right.

1 Q. And certainly before you had to leave to go to that
2 clinic?

3 A. That was my hope.

4 Q. Can you recall whether he had actually come to see
5 Claire before you left for the clinic?

6 A. My recollection is that I wasn't there when he came to
7 see Claire, so I wasn't actually in Allen Ward when he
8 came to see Claire. I remember being, I suppose,
9 frustrated at having asked Dr Webb to come, that I had
10 been unable to be there when he was there.

11 Q. So did that mean, then, that you left for the clinic
12 without actually being sure when Dr Webb was going to
13 see Claire?

14 A. Yes, I knew he was coming, he assured me he was coming.
15 I would have anticipated his arrival soon, but I may
16 have had to go before he came to Allen Ward.

17 Q. So if you were speaking to Dr Webb, let's say 12-ish, to
18 enable you to have had that conversation, got back, told
19 them, "Yes, administer the rectal diazepam", and that's
20 all signed up for 12.15. So let's say you were speaking
21 to him at about 12-ish, would that be a reasonable time?

22 A. Yes.

23 Q. So in two hours, you haven't seen him, and you're
24 sufficiently concerned to have gone to see him in the
25 first place and had wanted him to see her earlier. Did

1 it not trouble you that you were leaving Claire, a
2 patient who you had been concerned about, to go to this
3 clinic when you weren't entirely sure when Dr Webb was
4 going to come and see her?

5 A. I think that would have caused me concern. I don't
6 remember exactly how I felt at the time, but indeed that
7 may have the time when I also tried to contact Dr Steen
8 to let her know that I'd spoken to Dr Webb. So when
9 I say I had spoken to Dr Steen in the afternoon, it may
10 have been in the early afternoon.

11 Q. I understand. I will come to that in a minute. I'm
12 sorry to be taking you out of turn, but it is just that
13 we were talking about where you were and what you were
14 doing in more general terms so I thought I'd take the
15 opportunity to do that. Just so we close that off, not
16 entirely being sure when Dr Webb is coming but believing
17 he will come, those then in charge of any deterioration
18 in her condition or managing her until Dr Webb finally
19 does come and making any decisions that might need to be
20 made, should he delay even further coming, that was left
21 to Dr Stevenson and Dr Stewart?

22 A. Yes. Again, I would hope that if they had additional
23 worries over and above those that had been voiced at the
24 ward round or thought there's still no sign of Dr Webb,
25 that they would have called me and told me that perhaps

1 there's no sign of Dr Webb yet, what do you want us to
2 do, are there other things we should be doing.

3 Q. Because they wouldn't have been present, either of them,
4 would they, when you had your conversation with Dr Webb?

5 A. That's right.

6 Q. Could it have been in some way that they thought that,
7 registrar to consultant, it had been sorted out and
8 we're just holding the fort, as it were, until Dr Webb
9 turns up?

10 A. I take the point. I still would have hoped that they
11 would have known me well enough to give me a call if
12 they weren't happy and felt able to do so.

13 Q. Just so that we're clear: how ill would Claire have had
14 to appear to you for you not to have gone to that
15 clinic?

16 A. I think she would have needed to appear very unwell and
17 perhaps on a ... My impression of Claire on the ward
18 round really related to her neurology and her being
19 neurologically very unwell. If her other vital signs
20 had been impaired or changing rapidly, I think I would
21 have felt very uneasy about going to that clinic and
22 I would have perhaps had to cancel or pull out of that
23 clinic if possible.

24 Q. Her Glasgow Coma Scale at that stage had fallen.

25 THE CHAIRMAN: At which stage?

1 MS ANYADIKE-DANES: At the stage he's going to the clinic,
2 which is 2 o'clock. The first record taken of her
3 Glasgow Coma Scale is at 1 o'clock. In fact, if we just
4 pull up this compendium document that we have just been
5 looking at, 310-001-001.

6 A. I may have had to be at the clinic rather before
7 2 o'clock, perhaps 1.30 or 1.45.

8 THE CHAIRMAN: Yes, I think you said early it would be about
9 1.30.

10 MS ANYADIKE-DANES: So you would have had to leave at about
11 1.30? So all that you would have known is the first
12 result, which is, I think, 9. You wouldn't have known
13 about anything after that?

14 A. I may not.

15 Q. Can I then ask you to try and take it chronologically in
16 what was going on during your day? When did you
17 actually come on to the ward to take over, as it were?

18 A. Again, I don't remember precisely from the
19 22nd October 1996, but usually just a little before
20 9 o'clock.

21 Q. Dr Steen had said if she was doing a ward round, she
22 would be arriving at about 8.45 or so to have a talk to
23 people, perhaps have a quick look at notes, maybe talk
24 to the nurses, that sort of thing. Would that accord
25 with the sort of time that you'd expect to get there?

1 A. I think, on occasion, Dr Steen would even be there
2 earlier than me.

3 Q. But you would be there at about quarter to or there or
4 thereabouts?

5 A. Thereabouts.

6 Q. Do you have any independent recollection of the 22nd?

7 A. I do.

8 Q. Thank you. As I ask you, will you tell me when we get
9 to a point which is no longer your independent
10 recollection, but is a reconstruction from the
11 documents, if I can put it that way?

12 Dr O'Hare was the doctor who was covering that night
13 on call during the night shift, and we have had her
14 evidence yesterday. I don't know if you heard any of
15 that evidence.

16 A. I've seen the transcript.

17 Q. So you know -- and maybe you have been in that position
18 yourself -- how many beds you're taking care of and you
19 know what the pressures might be. In any event, she
20 writes up her examination, she sees Claire twice.

21 A. Yes.

22 Q. She sees her at 8 o'clock and then again about midnight.
23 Would you have looked at those notes before the ward
24 round?

25 A. Not necessarily, unless they were pointed out to me and

1 said: here, you'd better have a look at this chart or
2 there's something in here that you should read
3 beforehand.

4 Q. Would you have expected to have had any kind of handover
5 at all between you and Dr O'Hare?

6 A. I would have hoped for a handover, albeit a limited,
7 perhaps brief handover. I think that was the practice
8 and was the practice for some lengthy period of time.
9 My impression is that the morning handover may have been
10 somewhat more limited than the evening handover,
11 I suppose, because you're handing over to somebody who's
12 covering a greater number of patients.

13 Q. Mm-hm.

14 A. So the morning handover may have been less formal and
15 more limited.

16 THE CHAIRMAN: You'll have seen her point yesterday that if
17 she was doing a handover to each of the wards that she
18 covered overnight, and it was 10 minutes each, that
19 could be an hour's work. She thought in those days it
20 was less likely that there would have been even an
21 informal handover unless there was a patient of real
22 concern. And the ward that she continued to work on
23 after 9 am was Musgrave, not Allen Ward.

24 A. That's right. I think that's right. It might have to
25 be a patient or patients whom one was particularly

1 concerned about in order to prompt a handover.

2 THE CHAIRMAN: Yes. Okay. In any event, you don't remember

3 a handover from 22 October?

4 A. I don't remember specifically that morning, no.

5 MS ANYADIKE-DANES: But I think you said that you might have

6 been expected to have been told something, however

7 briefly and informally?

8 A. That I'm constructing really from looking back at

9 Claire's admission note and thinking, you know, that

10 Claire, as she appeared in A&E, and to Dr O'Hare,

11 that ...

12 Q. Let's pull that up and see if that helps. If we start

13 at 090-011-013. That's the actual referral. If we put

14 next to that the note that I think Dr Puthuchearny takes

15 at 012-014. There we are. That's the admission. So

16 you see the description there.

17 If we then move on to the note or at least the

18 beginning of the note that Dr O'Hare takes at

19 090-022-050, we'll just run through these and you can

20 help us with what, in this, would you have thought

21 should really have guided Dr O'Hare to have had some

22 word with you, however briefly. That's the first page

23 of her note. We see it starts at 8 pm and she takes

24 a history. If we go on to the next page, 051.

25 THE CHAIRMAN: Well, you've seen these notes, I presume,

1 doctor?

2 A. I have, yes.

3 THE CHAIRMAN: Can you tell us, what is it about what is
4 contained in these notes which makes you say that you
5 would have been expected to have been told something at
6 about 9 am?

7 A. Again this, is with hindsight having reviewed the notes,
8 and I appreciate I wasn't there when Dr O'Hare saw
9 Claire at that time. But it's the level of
10 consciousness, it's the concern over the level of
11 consciousness both in the A&E department and when
12 Dr O'Hare writes:

13 "Not responding to parents' voice/intermittently
14 responding to deep pain."

15 MS ANYADIKE-DANES: In fairness, if we pull up the next
16 note, 052, then you have the two pages of her
17 examination, which may be the most useful things for you
18 to help us with.

19 So that's her examination and the results. It also
20 captures midnight, so that's helpful. You have talked
21 about the level of consciousness and the reflexes, did
22 you say?

23 A. Well, the neurology generally, the abnormal neurology,
24 which I think the casualty doctor noticed as well, and
25 was in the GP referral too, all of which raised

1 concerns. I think what makes the difference, though,
2 is that Claire seems a bit more responsive at
3 12 midnight when Dr O'Hare reviews her. I also think
4 what probably makes a difference is that, according to
5 the nursing notes, Claire seemed brighter.

6 Q. Yes. But you wouldn't have seen those nursing notes
7 at the time?

8 A. Absolutely, no, I'm just reconstructing this from having
9 looked at the notes.

10 Q. And it may be that Dr O'Hare wouldn't have seen them
11 just before she left.

12 A. Quite.

13 Q. So if you're saying why you would have expected
14 Dr O'Hare to have had even a brief exchange with you,
15 it's based on, essentially, these two pages --

16 A. Yes.

17 Q. -- and also the page from A&E and, to some extent, the
18 reason for admitting her in the first place?

19 A. Quite.

20 Q. And it's all the neurological concerns so far as you've
21 told us so far?

22 A. Yes.

23 Q. Is there anything else that you would have thought she
24 should have maybe just drawn to your attention?

25 A. Those would have been the main things, I think.

1 THE CHAIRMAN: And just to get this clear: you're saying
2 there are issues in these notes which do cause you
3 concern, which make you think that there might have been
4 a handover, but on the other hand you say, for instance,
5 the 12 midnight entry, "Slightly more responsive", maybe
6 that's what makes the difference, maybe that's why there
7 wasn't a handover?

8 A. That, for me, sort of balances a little bit Dr O'Hare's
9 view for me a little bit.

10 THE CHAIRMAN: It suggests that Claire has not got worse
11 overnight, but that she may be a little bit better?

12 A. That's certainly possible, yes.

13 THE CHAIRMAN: Is that what you think might make a
14 difference as to why there wouldn't be a handover.

15 A. Yes.

16 THE CHAIRMAN: Okay, let's move on.

17 MS ANYADIKE-DANES: Yesterday when Dr O'Hare was asked by
18 the chairman -- it's at page 178, line 18 -- she said:
19 "If I were to hand over, I would have said that this
20 is a child that I wasn't 100 per cent clear about her
21 diagnosis and I would like her reviewed on the ward
22 round."

23 And given what you have seen there from those two
24 pages of notes, is that the sort of thing that you might
25 have expected Dr O'Hare to tell you?

1 A. I think she may have told me a little more than that,
2 rather than saying she wasn't 100 per cent sure what was
3 going on. She may have said a little bit about the
4 abnormal neurology or the reduced level of
5 consciousness.

6 Q. And that's notwithstanding the fact that she notes at
7 midnight a slight improvement and that if she'd had an
8 opportunity to note it, she could have said: that's
9 confirmed with the nurses. Leaving aside that, you'd
10 have still expected her to have had some sort of word
11 with you about Claire?

12 A. I think it would have been appropriate, but as I say,
13 it is balanced probably by the fact that she felt Claire
14 to be a little bit better.

15 THE CHAIRMAN: It also must be balanced, doctor, by who else
16 Dr O'Hare was looking after.

17 A. Quite.

18 THE CHAIRMAN: Because we now know she had this ridiculous
19 workload where she is the senior doctor in charge of
20 over 100 children. So it might be that she did have
21 concerns about Claire and she has expressed her level of
22 concern about Claire, but it might also be that there
23 were other children who she was still, for instance,
24 working on at 9 o'clock.

25 A. Yes.

1 THE CHAIRMAN: And let's say hypothetically she's working on
2 a child from 8.30 to 9.30, there won't be any handover
3 to anybody, will there?

4 A. I think that's right, and those sort of contingencies
5 will have happened, do happen, will get in the way of
6 what might be best practice, what one would intend and
7 hope to do.

8 THE CHAIRMAN: It's easy for us to say today there should
9 have been a handover and things are better now,
10 I understand. The major problem seems to me to be that,
11 in 1996, there was a single registrar in charge
12 overnight of the Children's Hospital.

13 A. Yes, and I did that job as well. I would agree with the
14 doctors who have given evidence about that already.
15 That was an onerous job, a big responsibility.

16 MS ANYADIKE-DANES: Thank you. Dr O'Hare does write in her
17 note -- would you agree that's a fairly full note that
18 she writes, those two pages?

19 A. Yes.

20 Q. Whatever the pressures of time on her, that's a fairly
21 full note she writes.

22 A. Yes.

23 Q. And she goes back to see her again at midnight. On both
24 occasions, she says "reassess". So she is regarding
25 Claire as a patient that needs to be reviewed. Had you

1 read it -- and I know that you're not sure that you
2 would have looked at the notes before the ward round.
3 I presume you'd have looked at them at some stage.

4 A. During the ward round, it may have been that the senior
5 house officer had the notes sitting on the trolley and
6 read the notes to me.

7 Q. Assuming that had happened and he had read out the
8 salient features of that, including the "reassess", what
9 would you understand "reassess" to mean?

10 A. I think there are two mentions of "reassess" and
11 Dr O'Hare does the first reassessment herself and then
12 suggests "reassess in the morning". I think Dr O'Hare
13 has probably said she felt that was on the ward round,
14 do that reassessment on the ward round rather than
15 beforehand, if I'm taking that correctly.

16 Q. Yes. Assuming that's the case, she thought that
17 reassessment would take place as part of what would
18 happen during the ward round. What would you have
19 understood that that involved?

20 A. I think on the ward round that really involves starting
21 from the beginning again and going through things in
22 terms of history, examination, investigations,
23 management plan.

24 Q. Yes. It's not up here, but it has been up a few minutes
25 ago and you have obviously seen it and so has everybody

1 else. When Dr O'Hare goes through her examinations, she
2 goes through -- and in fact one had the benefit of her
3 evidence yesterday to understand exactly what all this
4 means and how she went through it. She went through
5 quite a detailed CNS examination, if I can call it that:
6 she was trying to sit her up, she was testing her motor
7 power, her tone and her reflexes, and whether there was
8 any cogwheel rigidity. She has recorded all of that for
9 left and right and so on. If you say that you were
10 effectively going to start from scratch and do your own,
11 would you have done the sort of thing that she has
12 recorded as having done, would you have been doing the
13 same thing yourself?

14 A. Similar, perhaps not in quite so much detail as one
15 would do for a clerk-in, the very first time you see
16 a patient.

17 Q. Why?

18 A. I think a clerk-in is often the most complete record of
19 physical -- sorry, history taking, physical examination,
20 and you will see the clerk-in notes are often the
21 biggest notes in the medical charts.

22 Q. Yes, but given that there was a concern about her
23 neurological condition and there was some suggestion
24 that she might have improved a little bit, although
25 you'll hear in a moment that the parents' view was that

1 she had not, would you not have been wanting to repeat
2 some of that test so that you can compare the results
3 that Dr O'Hare had got at 8 o'clock in the previous
4 evening with the results that you were getting now and
5 form your own view as to what was happening?

6 A. Yes.

7 Q. Does that mean that these tests, if I can put it that
8 way, that Dr O'Hare had carried out, say in relation to
9 her reflexes and so on, you would have carried those out
10 yourself?

11 A. Yes.

12 Q. And do you think you did?

13 A. Yes.

14 Q. The results of those are not recorded in her notes,
15 though, are they?

16 A. I think they are under --

17 Q. Sorry, maybe I have missed that.

18 A. -- "bilateral long tract signs". That's a term used to
19 catch a number of things.

20 Q. Maybe we'll go to that so we see that. If we pull up
21 two pages together, we have the 052. If we pull up 053.
22 Then I think you have it. So the start of it is right
23 down at the bottom, isn't it, "Ward round, Dr Sands"?
24 Where are you referring to now?

25 A. "Pupils sluggish to light." It's under, "CNS

1 examination, difficult to see fundi", that was difficult
2 at that stage to see the back of the eyes with an
3 ophthalmoscope, but clearly we were trying to do that.
4 "Bilateral long tract signs", suggesting bilateral upper
5 motor neurone lesions, suggesting abnormal power in the
6 upper and lower limbs, abnormal reflexes in the upper
7 and lower limbs, and suggesting tone was increased in
8 the upper and lower limbs, and also that the plantar
9 reflexes were abnormal.

10 Q. If anybody was wanting to see what the differences were
11 between when she was clerked in and those tests or
12 examinations being made at 8 pm, and this record here of
13 your examination during the ward round, how would they
14 be able to tell what the change or difference in her
15 condition was?

16 A. I think that note could be expanded somewhat to be a bit
17 more specific, but --

18 Q. It's a bit dense.

19 A. I think it is, yes.

20 THE CHAIRMAN: Let him finish.

21 A. Dense in one way, but condensed in another. Maybe
22 condensed in making it difficult for some people to
23 interpret or to work out.

24 MS ANYADIKE-DANES: If you were coming to that, would you
25 necessarily be able to see what difference there had

1 been in the results that Dr O'Hare had obtained and the
2 results of your examination?

3 A. I think I would, but I might want some more detail.

4 Q. And how would one gauge the difference in her condition
5 between the two from the note that's recorded there? If
6 that's all you had, Dr O'Hare's notes and the note which
7 is made on the ward round which includes that
8 expression, how would you tell the difference?

9 A. I'd probably need to see Dr O'Hare's note again to try
10 and contrast.

11 Q. If one takes off the 052 and puts up 051. 090-022-051.
12 I think that's there.

13 A. So Dr O'Hare has been able to examine more of the
14 cranial nerves, she's ticking off the cranial nerves as
15 being ticked individually, so they seem to be intact and
16 normal. The fact that we haven't been able to assess
17 the cranial nerves, it has been difficult to do that,
18 perhaps suggests that that was technically difficult to
19 do at the time. If there were bilateral long tract
20 signs, it does suggest that the cranial nerves were also
21 affected. Pupils were equal and reactive to light at
22 that stage. Here the pupils are sluggishly reactive to
23 light only. Sorry, equal and reactive to light and
24 accommodation, Dr O'Hare's written "PERLA", suggesting
25 the patient is able to focus and that the pupils are

1 constricting as Claire focuses on something as well as
2 constricting with light, whereas here the pupils are
3 just sluggish to light.

4 Dr O'Hare also got a better look at the fundi, the
5 back of the eye, and suggested the discs were not
6 blurred.

7 Q. Sorry, could I just pause there? When you said the
8 pupils are sluggish to light, is there a difference
9 between that and Claire not liking light?

10 A. I think, yes, I think there is a difference. I think
11 that specifically relates to the pupillary response
12 rather than a patient shying away from the light or
13 closing their eyes to light.

14 Q. Does one develop from the other?

15 A. No, not necessarily.

16 Q. Thank you. So you had noted your conclusions
17 in relation to the reaction to light.

18 A. And I commented just that Dr O'Hare was able to see the
19 fundi, the back of the eye, the retina and the optic
20 discs and she commented that they're not blurred, and
21 I think I find it difficult to see the fundi at that
22 stage. That is my view of the fundi with the
23 ophthalmoscope: it was not clear enough or was impaired.

24 Q. I suppose what I'm trying to ask you about -- and that
25 was very helpful, your explanation there -- but if you

1 take from the "sit up [and so forth] stares vacantly",
2 take that from Dr O'Hare, right down to the tests on the
3 reflexes and so forth: is all of that condition, if I
4 can put it that way, addressed by your bilateral long
5 tract signs? Is that where you are dealing with the
6 sorts of things that are addressed there?

7 A. Yes.

8 Q. And that's actually the point that I was asking you. If
9 you had that information from the "pros" right down to
10 the clonus, if I can put it that way, from Dr O'Hare's
11 report, and you had your bilateral long tract signals,
12 would you be able to tell between those two things as to
13 what was the change in her condition?

14 A. The biggest difference looking at it now is that the
15 reflexes are particularly brisk on the right side,
16 I think, when Dr O'Hare records it. And it seems to be
17 that it's bilateral, it's both sides where the reflexes
18 are abnormal, on the ward round.

19 Q. Yes. And clonus?

20 A. That's not specifically recorded on the ward round.
21 I suppose that's sustained abnormal movement of,
22 typically, the ankles or some of the other joints.

23 Q. Did you want to see whether that had got any worse?

24 A. It may not have been considered as a critical thing at
25 that point, the presence or absence of clonus or whether

1 it was worse or better. The fact that there were
2 bilateral long tract signs suggests that the tone was
3 increased and that often goes along with clonus as well.

4 Q. So if I understand you correctly, you would be able to
5 tell a level of deterioration or, put it this way,
6 a level of change between those two notes, even though
7 the reference that you have got is actually very
8 succinct, nonetheless anybody coming to it and looking
9 at those two notes would be able to see that?

10 A. I think they would see a difference. I have to say,
11 I think it would be helpful to have the same person do
12 both, and that's often the advantage of having
13 continuity, having one person examine the child and then
14 another so that they examine in exactly the same way and
15 their notation is exactly the same.

16 Q. If you had had the note in front of you and seen the way
17 that Dr O'Hare had reflected that information, might you
18 have tried to do it in the same way yourself so that
19 somebody could maybe more easily see the differences?

20 A. Perhaps so.

21 Q. And if you haven't got the note in front of you, is it
22 something that you expect your SHO to either try and see
23 if he can record it in that way, so that somebody can
24 readily see the differences, or point that out to you,
25 or ask you even?

1 A. I think that would be ideal, but it is very individual.

2 Q. I understand. Really what I was trying to get from you

3 is what information you might have had going into the

4 ward round. How unusual was it, if I can put it that

5 way, that it would be you who would be leading a ward

6 round in October 1996, because that might change over

7 time?

8 A. It is certainly something that has changed over time.

9 I don't think it would have been exceptional in 1996.

10 I suppose we may need to draw the distinction between

11 a post-taken ward round, a pick-up ward round, if you

12 like.

13 Q. What does that mean?

14 A. I mean where patients who had been admitted the previous

15 day or previous night are being seen on the ward round.

16 Versus ward rounds that took place on a daily basis

17 whereby if a patient has been in maybe for a day or two,

18 you might find an SHO doing a ward round or a registrar

19 or both.

20 THE CHAIRMAN: But is the difference that it's more

21 important that the pick-up ward round is conducted by

22 somebody more senior?

23 A. Yes.

24 MS ANYADIKE-DANES: Is that because that's really the start

25 of the formulation of the diagnosis, the start of the

1 whole plan of treatment and care, so you want to get
2 that established in the best way possible, if I can put
3 it that way?

4 A. I think that's one of the main reasons, and these
5 patients have perhaps not been seen by too many people
6 as they've come in. And you've got some observations
7 done, you've perhaps got a feel for what's going on. If
8 a patient has been in for several days, that clearly
9 becomes more established, so perhaps it is perceived at
10 least that junior doctors, at this stage, would have
11 been okay doing those subsequent ward rounds or would
12 have been able to cope with those better and manage the
13 patients.

14 Q. You mean following an established plan as opposed to be
15 part of actually establishing the plan?

16 A. Yes.

17 Q. So if we go back to your impression, was it more unusual
18 then not to have, unless there were some very pressing
19 good reason, the consultant do this post-take ward
20 round?

21 A. At the time, I have to say I don't think it was
22 exceptional that a registrar would do this post-take
23 ward round.

24 Q. Did you have any knowledge of Dr Steen's practice about
25 these matters, if I can put it that way?

1 A. I find it very difficult to recollect exactly what
2 Dr Steen's practice was in relation to ward rounds. My
3 understanding is, where she could, she would take them.

4 Q. If she wasn't going to take one, how would you get to
5 learn of that?

6 A. I suppose one of two ways. She may have been able to
7 tell me herself, "Look, I'm not able to take the ward
8 round this morning", or had a senior nurse say,
9 "Dr Steen has been in and has informed us that she can't
10 take the ward round this morning because she has other
11 commitments". I think that might be particularly true
12 of doctors with limited sessional commitments to the
13 Children's Hospital who perhaps did a lot of community
14 commitments, for example.

15 Q. But did you expect to know that she wasn't going to be
16 able to do the ward round in one way or another?

17 A. I think so.

18 Q. And can I then ask you about the ward round on this
19 particular day? Although we talk about it as if it only
20 involved Claire, we now know from having looked at
21 file 150 that it involved actually a number of children
22 that were being seen. Can you recall whether you knew
23 beforehand that Dr Steen wasn't going to be able to take
24 the ward round?

25 THE CHAIRMAN: Sorry, how long beforehand? Because you must

1 have known as you started the ward round. Do you mean
2 did he know the night before or ...

3 MS ANYADIKE-DANES: At any point until you were about to
4 start it and she wasn't there.

5 A. It's difficult to be absolutely certain. I don't think
6 I would have known the night before. I may have done,
7 I suppose, if Dr Steen had said, "Look, I have this
8 important meeting, I've got a case conference that
9 I have to go to". So I might have done. But more
10 likely, perhaps, I would have known on the morning.

11 THE CHAIRMAN: That's part of the job for you, that you --

12 A. Yes.

13 THE CHAIRMAN: Not only are you going to be on the ward
14 round with Dr Steen or whatever other consultant you are
15 due to be with, but also you know it's part of your job
16 to step up to lead the ward round if the consultant is
17 not available?

18 A. Yes. That's right.

19 MS ANYADIKE-DANES: You said that you do remember some
20 aspects of the 22nd. Do you remember whether she was
21 part of the ward round or not?

22 A. My recollection is that Dr Steen wasn't part of the ward
23 round that I did that morning.

24 Q. That's an actual recollection as opposed to
25 a reconstruction?

1 A. Yes.

2 Q. Can you help us with who else would have been involved?

3 We can see that it certainly seems that Dr Stevenson was

4 involved because he signs the note. But do you know who

5 else was involved in the ward round?

6 A. I assume Dr Neil Stewart was as well. I guess that

7 information comes really because he's written up the

8 prescription for diazepam.

9 Q. Although he could have been asked to do that, I suppose,

10 by Dr Stevenson if they were sharing things between

11 them.

12 A. Sure.

13 THE CHAIRMAN: Surely more to the point, he has also written

14 up other ward rounds from file 150.

15 A. That's true too. I think as well there would have been

16 the expectation that if we're doing a ward round, that

17 all available doctors would be there and would be on it

18 together, sharing information, sharing the jobs, as you

19 go. An exception to that might be if something needed

20 done very urgently, a patient needed seeing, and you

21 just had to go on without maybe one of the doctors.

22 THE CHAIRMAN: Dr Stevenson suggested to us on Monday or

23 Tuesday that what would happen would be that he and

24 Dr Stewart would go with you and they would effectively

25 take it in turns to be scribe, as he said, which

1 indicates that they're generally both with you through
2 this ward round; does that make sense?

3 A. That makes sense.

4 MS ANYADIKE-DANES: When Dr Steen was giving evidence -- and
5 I think you were there for most of it -- I read out to
6 her a passage in relation to ward rounds in the report
7 that has just been produced by the Royal College of
8 Physicians and the Royal College of Nursing. I don't
9 propose to go into that except to say that she accepted
10 that that was a fairly accurate reflection of at least
11 the importance that was being placed on ward rounds,
12 even though it didn't, in those days, comprise of the
13 multidisciplinary teams that it might now. Would you
14 accept that a ward round is a fairly important event in
15 the day of the hospital, if I can put it that way, the
16 Children's Hospital?

17 A. I think that's right. I think if I might add, if it's
18 conducted by the registrar, it perhaps would tend to be
19 more functional and maybe not have all of the teaching
20 elements that you might hope for or expect with
21 a consultant sort of grand round with as many people
22 in the multidisciplinary team there as possible.

23 Q. And if you are doing it, or the registrar is doing it,
24 you have with you whichever SHOs are available to you,
25 or available to participate, as I understand it.

1 A. Yes.

2 Q. And you have nurses as well.

3 A. Usually at least one nurse. I'm not sure you'd always

4 have had more than one nurse, although maybe I should

5 qualify that. You may have had a nurse from an

6 individual bay or patient area who would contribute to

7 the ward round as you arrived with them.

8 Q. Yes, because that nurse is the one who's allocated to

9 that bay and those particular patients. Although she

10 might not travel from bay to bay with you, she might

11 contribute to the discussion when you reached her

12 particular bay; is that correct?

13 A. Yes.

14 Q. The nurse that did travel with you, would that be

15 a senior nurse?

16 A. My understanding is that that would usually have been

17 a senior nurse.

18 Q. Is the purpose of that so that senior nurse can in turn

19 impart what has to be done to her own nurses who are

20 going to look after the individual patients?

21 A. I would also say probably as well to keep the junior

22 doctors up to speed and maybe make some notation on

23 their behalf as well.

24 Q. Yes. Do you recall at all whether there was a senior

25 nurse with you on the 22nd?

1 A. I don't recall who the nurse was at that stage. Some of
2 the evidence suggested it might have been Staff
3 Nurse Linsky.

4 Q. That's correct.

5 A. But I have no independent recollection of that.

6 Q. Had you been in Allen Ward sufficiently long to know
7 those nurses individually, to be able to have recognised
8 any of them?

9 A. Oh, I think most of them I would have done, yes.

10 Q. So if the senior nurse had been with you on that ward
11 round, do you think that's something that you might have
12 remembered or not?

13 A. I can't say. I can't say.

14 Q. That's fair enough. You say that your recollection
15 is that Dr Steen wasn't on that ward round with you.
16 I just want to put to you a number of things that
17 Dr Steen has said in and around that issue, just so that
18 we have your view on it, since you actually do have
19 a recollection.

20 She says she believes that she was -- I have taken
21 this from a number of parts of the transcript, which
22 spanned three days, and I don't have a specific day and
23 line, although if I'm asked to do it, we'll find it.
24 I'm giving you a sense of what her evidence was. She
25 believes she was in the hospital before the ward round

1 and that morning. Precisely when, she's unsure, but she
2 believes that she was. And she believes it was her
3 normal practice to carry out the ward round, certainly
4 the one that was on Tuesdays. She could think of
5 nothing that would have prevented her from doing that on
6 the 22nd.

7 She also thinks that the ward round appears to have
8 started late because the practice would be to work
9 geographically, unless for some reason the condition of
10 a child determined otherwise, and if that's what was
11 happening then to have got to Claire around 11 -- which
12 is when her parents recall her being there, and there
13 seems to be some other indication that that's when you
14 arrived at Claire. In her view that was late. She
15 would have expected the ward round to have been
16 completed by then because after then comes the CSF grand
17 round. She also thinks that she may well have popped in
18 and out of the ward round and simply not been recorded
19 as having done that. And that she was in bay 7, which
20 she says is the bay where Claire was, at some point in
21 the morning to examine another child. I think she says
22 there were four beds in that bay. So in her view, she
23 could have seen Claire and she says that, given Claire's
24 condition and her parents not thinking that she was
25 getting any better, she would have wanted to see her.

1 That was the sense of her evidence coming through.

2 Can you comment on any of that?

3 MR GREEN: Sir, perhaps the doctor can, in fact, comment on

4 all of that? I will just have to wait and see.

5 However, a lot of information has been compounded into

6 the preamble to that question. I just raise the point.

7 THE CHAIRMAN: I agree, it runs to a page on the transcript.

8 Let's see.

9 MR QUINN: Mr Chairman, I would raise a point here: it's

10 a very important issue and I have noted down very

11 quickly six main headings on that.

12 MS ANYADIKE-DANES: I can take them separately. That might

13 help.

14 MR QUINN: This is a very important issue for the family.

15 MS ANYADIKE-DANES: That's perfectly fair and I'll take them

16 separately.

17 Firstly, Dr Steen says she believes that she was in

18 the hospital before the ward round and during that

19 morning. What is your sense or recollection?

20 A. My recollection is that Dr Steen didn't come on the ward

21 round with us. She could have been there first thing

22 in the morning, even perhaps before I was there.

23 Q. But apart from that, were you aware of the fact that she

24 was in the hospital that morning?

25 A. I'm not aware of the fact that she was in the hospital

1 that morning and it's to the best of my recollection.

2 It was my understanding that she was out of the hospital
3 at least for part of that ward round and including the
4 time when we were seeing Claire on the ward round.

5 Q. Why is that your understanding?

6 A. That's just my recollection, that that's what

7 I understood at the time. That's my recollection.

8 THE CHAIRMAN: You mean it wasn't just that she wasn't with
9 you on the ward round, that she wasn't physically in the
10 hospital?

11 A. At least for part of that ward round and the part when
12 we were seeing Claire.

13 MS ANYADIKE-DANES: We have looked at the medical notes and
14 records of all of Dr Steen's patients who were on the
15 ward, actually on three wards, on that day. And those
16 ward rounds are primarily -- and I think you were there
17 when I went through them -- taken by yourself with the
18 assistance of one or other of Dr Stevenson or Dr Stewart
19 as scribe. And I think Dr Stevenson himself may have
20 taken one ward round also.

21 None of those notes of ward rounds reflect the
22 presence of Dr Steen at all. And is it your view that
23 that's accurate and that's because she wasn't part of
24 any of those ward rounds, not just Claire?

25 A. I believe that's right. I think if Dr Steen had been on

1 the ward round, it wouldn't have been my ward round.

2 THE CHAIRMAN: So if for instance she was there more for

3 half an hour, she might have come in towards the end of

4 one patient, you move on to the next patient and it's

5 then noted as "Ward round, Dr Steen" rather than "Ward

6 round, Dr Sands"?

7 A. I think if Dr Steen has contributed to it, in

8 a hierarchical system as we have, it would be Dr Steen's

9 ward round. That is my understanding.

10 THE CHAIRMAN: Even if she comes in while you are with

11 a patient?

12 A. Yes, it would be Dr Steen.

13 THE CHAIRMAN: Let's move on to the next point.

14 MS ANYADIKE-DANES: She says it was her normal practice to

15 carry out the ward rounds, certainly the one on

16 Tuesdays.

17 A. I find it difficult to be sure of what Dr Steen's normal

18 practice was. She is in a better position to answer

19 that than me, except to say I think it wouldn't have

20 been exceptional that a registrar would conduct some or

21 all of one of those ward rounds of Dr Steen's.

22 THE CHAIRMAN: And you made the point a few minutes that

23 Dr Steen and some others who have significant community

24 commitments missed more ward rounds than people who had

25 more clinical sessions in the hospital as a result of

1 those commitments.

2 A. That's my recollection.

3 THE CHAIRMAN: Just to make it clear: you weren't making

4 that as a criticism of her --

5 A. No, not at all.

6 THE CHAIRMAN: -- it is just a fact that she and others who

7 work primarily outside the Children's Hospital. Things

8 crop up and they tend to miss, in your view, more ward

9 rounds than others who spent most of their time in the

10 hospital?

11 A. I think particularly around complex child protection

12 issues and case conferences, which were quite lengthy

13 discussions, as I understand it, and often took place,

14 I think, in Cupar Street and other places in relation to

15 complex family issues.

16 MS ANYADIKE-DANES: You did know, didn't you, that Dr Steen

17 had a clinic in Cupar Street in the afternoon on

18 Tuesdays?

19 A. I think I would have known that, yes.

20 Q. So what you're talking about is, yes, you would have

21 known and would have expected that and would factor that

22 into your care of the patient, but this is something

23 over and above. You would have anticipated her to be

24 in the hospital on the Tuesday morning and your

25 recollection is that she wasn't there for some part of

1 the Tuesday morning, including the ward round.

2 A. At least part of the ward round, if not all of it, yes.

3 Q. Certainly including the part that involved Claire?

4 A. Yes.

5 Q. If you had thought that she was in the hospital and just

6 for some reason you hadn't seen her at the beginning of

7 the ward round, is that something that you would have

8 made some efforts to see if she was actually wanting to

9 participate in the ward round or lead it, rather?

10 A. Yes, I would.

11 Q. Even as a professional courtesy apart from anything

12 else?

13 A. Yes. I wouldn't want to start the round unless I was

14 sure that's what Dr Steen wanted me to do or needed me

15 to do.

16 Q. Yes.

17 THE CHAIRMAN: Okay.

18 MS ANYADIKE-DANES: She says she personally can think of

19 nothing that would have prevented her doing the ward

20 round on the 22nd. Can you help with that?

21 THE CHAIRMAN: I don't think the doctor can comment on what

22 Dr Steen thinks. Let's move on.

23 MS ANYADIKE-DANES: No, but about anything else that might

24 have been going on in the hospital in the same way that

25 you are able to talk about lunchtime meetings and so

1 forth. There's nothing that you can think of going on?

2 A. No definite fixed Tuesday event, if you like. I also

3 take Dr Steen's point about the ward round seeming to be

4 relatively late. I do take that point. However, it was

5 me doing it, I probably would have been a fair bit

6 slower than Dr Steen about going round, and that may be

7 partly why it was maybe running behind, if you like, by

8 Dr Steen's standards. But I do take the point that it

9 seemed to be quite late by the time we were getting to

10 see Claire.

11 Q. And might you have waited for her, might that account

12 also for a slightly late start or you can't remember?

13 A. I can't remember. I don't think so.

14 Q. Thank you. She also indicated how the order of the ward

15 rounds was that they moved geographically and that

16 assisted her in determining, all things being equal,

17 when she would have expected that ward round to get to

18 Claire, if I can put it that way. Is that your

19 understanding of how the ward round, that it was

20 geographical unless somebody identified that the

21 condition of a child required higher priority?

22 A. Things are often done in a geographical way, but there

23 are exceptions to that. Such exceptions might be if

24 a patient is known to be unwell and someone says you

25 must start here, you must see this patient first.

1 Alternatively, I've been in situations and recall
2 situations where you perhaps had to go to Musgrave Ward
3 first of all to discharge a patient from there, or
4 potentially discharge a patient there, because perhaps
5 they needed a bed freed up or a parent said, "Look,
6 I have to go or I have somewhere to be, can you come and
7 see this patient first?". So I think you'd be obliged
8 to follow those sorts of -- those leads if you had to.

9 Q. How often did that sort of thing happen?

10 A. Oh, quite frequently.

11 Q. So is it not quite accurate to say that there was
12 a practice that you started at one particular end and
13 worked your way down to the other?

14 A. You did that, but you could quite often have deviated
15 from that for some of the reasons I have mentioned.

16 Q. Can you recall whether there was any of that on
17 22 October?

18 A. I don't recall specifically, though I think there
19 probably were patients in Musgrave Ward. I think I'm
20 right from file 150, there do seem to have been patients
21 in Musgrave Ward --

22 Q. That you think you might have seen out of order, if I
23 can put it that way?

24 A. Potentially only. I don't recall.

25 Q. Was there any sense that for some new admissions, if I

1 can put it that way, you might want to see them first?

2 Was there any sense of that?

3 A. Again, I think if they were flagged up as being an

4 unwell new admission, yes.

5 Q. Was Claire the kind of child you might have wanted to

6 see sooner rather than later?

7 A. I thought that when I got to Claire.

8 Q. It hadn't been flagged up to you beforehand, but when

9 you got to her, you thought: this is child I might like

10 to see sooner rather than later?

11 A. That's my recollection. I was concerned.

12 Q. Does that mean when you got to Claire you were in no

13 doubt as to your concerns about her presentation?

14 A. That's correct.

15 Q. If you had thought -- I know this is hypothetical --

16 that Dr Steen was somewhere available to you in the

17 hospital, when you got to Claire and had your concerns

18 about her, would you have tried to make contact with

19 her?

20 A. I would have.

21 Q. And would you have wanted her to come and see Claire?

22 A. I would have.

23 THE CHAIRMAN: And that must be right. Can we take it that

24 you wouldn't have gone off looking for Dr Webb if you

25 had thought that Dr Steen was available to you?

1 A. I think there were two reasons for going looking for
2 Dr Webb. One, it was my understanding that I couldn't
3 get Dr Steen in that way --

4 THE CHAIRMAN: I know you now describe that as your
5 understanding, but that must have been the reality of
6 the morning, mustn't it?

7 A. Absolutely. And the other reason was I believe that
8 Dr Webb, rather than somebody else, some other
9 consultant perhaps, was the best person to help.

10 MS ANYADIKE-DANES: Then if we are taking these things in
11 order, and you may have already dealt with some of them
12 so we can move quickly on, I take it that you have no
13 recollection of Dr Steen popping in and out of the ward
14 round?

15 A. I have no recollection.

16 Q. Apart from the fact that, if she had stayed sufficiently
17 long, you might have invited her to take the ward round
18 or deferred to her, but say it hadn't happened like
19 that, she really was just having a look to see how
20 things were going on because she had to do other
21 matters, would even that popping in and out have been
22 recorded on the note?

23 A. If she was actually contributing to patient care, yes,
24 I think it would be. If it really was very transient
25 and not contributing, just... Then conceivably not.

1 But if you're contributing to patient care, I would
2 expect it to be recorded.

3 Q. And however transient she had been, if you had been able
4 to see her, you would have wanted her to contribute to
5 Claire's care?

6 A. Yes.

7 Q. So anything she had to say would have been recorded?

8 A. Yes.

9 Q. Thank you. And then she says that at some point she was
10 in bay 7 in the morning to examine another child, and
11 you would have heard that. I don't want to go to 150 in
12 particular, but you would have heard that, that she
13 thought she was in there examining a child, you'd have
14 heard the exchange with the chairman as to how seriously
15 ill that child may or may not have been by comparison to
16 Claire. But her conclusion was she was in the proximity
17 of Claire and so she could have seen Claire. Were you
18 aware at all of her being in bay or ward 7?

19 A. Not that I can recall. That may have been quite early
20 in the morning.

21 Q. Yes. Had she been there at any point in time after the
22 ward round, is that something that you think would have
23 been drawn to your attention?

24 A. I think it would have been, yes.

25 Q. Well, without leading you, why do you think it would

1 have been drawn to your attention?

2 A. If she had returned to the ward maybe just to clarify,

3 is that --

4 Q. Yes, if she had returned to it and been seen in the

5 ward, more to the point in bay 7, examining a child,

6 is that something that you would think would have been

7 drawn to your attention?

8 A. Yes, because I think the staff would all have been aware

9 of my concern about Claire in particular and would have

10 said, "Dr Steen's here, don't you want to talk to her?"

11 THE CHAIRMAN: And if you weren't immediately available,

12 would the staff have said to Dr Steen, "There's an issue

13 about Claire Roberts, Dr Sands is going off looking for

14 Dr Webb", and that would highlight the issue for

15 Dr Steen if she was there?

16 A. I expect so, sir, yes.

17 MS ANYADIKE-DANES: Does that mean that you had sufficiently

18 well communicated your concerns about Claire, both to

19 the junior doctors and to the nurses, so that if they

20 had an opportunity to do that, you would expect them to

21 do that?

22 A. With hindsight, was the communication with the nursing

23 staff and the junior doctors good enough?

24 Q. Yes.

25 A. Um ... That may not have been good enough. They may

1 not have understood things as I -- understood my level
2 of concern. They may not have had a full grasp of that,
3 but they were with me on the ward round and we would
4 have talked.

5 THE CHAIRMAN: For instance, how would Dr Stevenson not get
6 your level of concern when he has noted that the plan is
7 rectal diazepam and then the next line is Dr Webb? That
8 would not be a standard entry from the limited number
9 that we've seen, it's not a standard entry for a ward
10 round by you to add the name of a different consultant.

11 A. No.

12 THE CHAIRMAN: Would he at least have known?

13 A. Yes. It's not standard at all. I suppose I'm thinking
14 particularly of the nursing staff and communication to
15 all of the nursing staff.

16 THE CHAIRMAN: Well, if there was a nurse with you on the
17 ward round --

18 A. I think she would have been aware, but would all of the
19 nurses have been aware, would the nurse in charge have
20 been aware? I can't say I would be certain of that.

21 THE CHAIRMAN: So it depends who was with you?

22 A. Yes.

23 MS ANYADIKE-DANES: And if the person who was with you was
24 not a very experienced nurse herself, would that
25 discussion, whatever discussion that you had with the

1 junior doctors to lead to that note being recorded, have
2 been sufficient, do you think, for such a nurse to have
3 understood the seriousness of Claire's condition?

4 A. Again, looking back, that might be a difficulty.

5 Q. They might not have?

6 A. They might not have fully appreciated my concern and
7 that of the doctors on the ward round. I think we would
8 have been quite open in discussing it, but they may not
9 have understood exactly how concerned --

10 Q. Yes.

11 A. -- we were. Depending on the level of experience,
12 depending who that person was and their background.

13 Q. Just so that I understand your evidence, are you saying
14 irrespective of whether they would have actually
15 appreciated that, what they would have appreciated
16 is that you would have wanted to get hold of Dr Steen
17 and so she was about, you'd have wanted something
18 communicated to her?

19 A. I do think so, yes.

20 Q. Just as we have the last part of Dr Stevenson's note
21 there where it says "Dr Webb", how common was it for you
22 as a registrar to go and seek a consultant opinion in
23 another discipline without discussing that or
24 communicating it to your consultant?

25 A. I think there are probably two types of referral to

1 another team. There are the sort that one might do as
2 a matter of course. An SHO or a registrar might go and
3 speak to an SHO or a registrar in another department and
4 say, "We have this patient, who you may wish to see,
5 they have these clinical signs and symptoms, would you
6 come and see them?" I think the patient in whom
7 a cardiology opinion was sought from the additional
8 notes falls into that sort of category, where the
9 cardiology team are at liberty to say, "We're not too
10 worried about that, we'll see that patient as an
11 outpatient", or alternatively, as Dr Mulholland was able
12 to do, come and see that patient in the afternoon.

13 This is different because the consultant is named,
14 the consultant neurologist is named, and I leave the
15 ward round to go and speak to him in person and that's
16 different I think from the routine everyday type of
17 referral that would have happened, that does happen,
18 happens to me today. If cardiology referrals come my
19 way, they often come through the junior staff and --

20 THE CHAIRMAN: You mean there's an urgency about this --

21 A. Yes.

22 THE CHAIRMAN: -- which isn't standard?

23 A. It's not standard.

24 THE CHAIRMAN: Okay.

25 MS ANYADIKE-DANES: Was there a registrar in nephrology?

1 Paediatric neurology, sorry. Was there a registrar?

2 A. There was, I'm told. I didn't know this until recently,
3 that he was on leave at this time.

4 Q. So you wouldn't have known that at the time?

5 A. I may well have done.

6 Q. What I'm trying to get at is: if you had thought this
7 was just a matter of trying to get some sort of
8 neurological insight, you might not -- well, I don't
9 know. Would you have just sought somebody from the
10 neurology team?

11 A. Most likely. Say it was a child who had a history of
12 seizure or seizures in the past and had come in with
13 a seizure, we might seek advice from the neurology team
14 as regards treatment. But that I think would have been
15 on a different scale and more like the cardiology
16 referral that I've mentioned.

17 Q. So as the chairman has picked up, this is going straight
18 to the consultant?

19 A. Yes.

20 THE CHAIRMAN: Sorry, one more point. Should I interpret
21 this sequence to mean that not only was Dr Steen not
22 there, but that she was not contactable?

23 A. That I can't be absolutely certain of, but my feeling
24 is that I didn't think I could get hold of Dr Steen
25 quickly enough. I may have already tried at this

1 stage -- I can't be certain of that -- but my feeling
2 was that I wasn't going to be able to get Dr Steen there
3 quickly enough to give me the help or us the help that
4 we needed with Claire. That may have reflected some
5 difficulty contacting Dr Steen or simply her saying
6 perhaps that she was going to be tied up in an important
7 meeting for an hour, hour and a half, and would prefer
8 not to be contacted during that period perhaps.
9 I certainly recall that having been said before by other
10 consultants.
11 THE CHAIRMAN: Then you need a feel for just how important
12 the meeting is, not to interrupt it, don't you?
13 A. Quite.
14 THE CHAIRMAN: Okay.
15 MR QUINN: Just before we leave this point, and I'm very
16 mindful of the time, there's one other issue that we
17 should perhaps raise at this point so we don't have to
18 come back to it.
19 Dr Steen made the case that perhaps there was an
20 emergency she was dealing with or some other issue on
21 the ward. And that's perhaps why the ward round was
22 a bit late. But she did raise this two or three
23 times -- and perhaps that could be put as maybe 6(a) or
24 7 and the witness could be asked now if he does recall
25 anything on this issue.

1 MS ANYADIKE-DANES: Thank you. That was the very next point
2 I was going to ask him about. That was her explanation,
3 in part, for maybe her absence or maybe the lateness of
4 the ... She said something was happening. I think she
5 referred to it as something abnormal, it wasn't the
6 usual day. Do you have any sense or recollection of
7 what that might be or whether that is the case? If
8 it is, what that might have been?

9 A. I don't recall a major event on that day. Which means
10 either I just don't remember, I may not have been
11 involved with it, whatever it was. Say it was happening
12 in casualty or something like that, I perhaps wouldn't
13 have been called there. Dr Steen might have been for
14 whatever reason. To be honest, my main recollection
15 from this day is interacting with Claire and not other
16 events.

17 THE CHAIRMAN: Can I ask you it in another way? It can't
18 have been -- correct me if I'm wrong -- another major
19 incident on Allen Ward because if it was, then you and
20 Dr Stewart and Dr Stevenson would not have been doing
21 the ward round together, would you?

22 A. I think that's correct.

23 THE CHAIRMAN: If there was a major incident, then surely
24 one of you would have been taken off on that with
25 Dr Steen.

1 A. I think, had it been in the Allen Ward, yes.

2 THE CHAIRMAN: Right.

3 MS ANYADIKE-DANES: Just one final question on that point,

4 Mr Chairman, if you'll permit.

5 Your ward round involved not just Allen Ward; isn't

6 that right?

7 A. That's right.

8 Q. Yes. So if it had been a major event not on Allen Ward

9 but on any of those other wards, like Musgrave Ward for

10 example. I think there was one on Cherry Tree Ward,

11 maybe, that you may have been involved in, but certainly

12 Musgrave Ward. If that had happened, do you think you

13 would have been aware of that as well as you're going

14 through?

15 A. Yes, I think so. I think so. Although --

16 THE CHAIRMAN: You would have been aware in 1996?

17 A. Yes, whether I'd remember it now, perhaps not. Unless

18 it's something that becomes really etched in your memory

19 for a particular reason. So I may not remember it now.

20 The other thing I can't quite remember is what the

21 provision was for the cardiac arrest team in 1996, and

22 say for example there was a cardiac arrest in the A&E

23 department, who would have gone to manage that, who

24 would have been expected to be there, managing that.

25 MS ANYADIKE-DANES: Is that something that the records might

1 show, who would be on duty for that, or be expected to
2 respond to that?

3 A. I expect somebody is able to find that out. I'm not
4 sure how relevant it is.

5 THE CHAIRMAN: We have to be a bit careful about who we ask
6 to find out. Okay, we'll take a break for the
7 stenographer and resume at 11.40.

8 (11.30 am)

9 (A short break)

10 (11.43 am)

11 MS ANYADIKE-DANES: Dr Sands, what textbooks were available
12 for people to have as a resource to assist them?

13 Medical textbooks, I mean.

14 A. I think there were probably a number. Most of them
15 would have been housed in the Allen reading room up on
16 the third floor, I think, of the old building in the
17 Children's Hospital.

18 THE CHAIRMAN: That has been described as a library before;
19 is that the same thing?

20 A. Yes, it's the same thing. So that had a reasonably
21 extensive range of books, both general and for some of
22 the paediatric specialties. Individual wards -- this is
23 a variable thing, but individual wards may keep one or
24 more books as well in, if you like, a mini library on
25 the ward.

1 MS ANYADIKE-DANES: Yes. Of those books, might they include
2 Nelson, for example?

3 A. It may have done, but perhaps not every ward.

4 Q. So far as you're aware, when you were the paediatric
5 registrar and moving around the wards, Allen Ward
6 included, would you have had, so far as you can recall,
7 ready access to Nelson?

8 A. I could have found one, yes.

9 Q. Without too much difficulty?

10 A. Yes.

11 Q. Forfar & Arneil?

12 A. Yes, I think it was also available, perhaps Nelson may
13 be a little more widely used, but Forfar as well.

14 Q. Just so that we're clear about that, I understand
15 "available" -- that might mean it's in the library and
16 I think from the evidence we heard yesterday, that might
17 take about ten minutes to fetch? You seem to be
18 suggesting something a little more available than that.

19 A. As I say, that's a variable thing. Not all wards would
20 have kept many books, but you might have, say, one in
21 Musgrave Ward, you might have a Forfar in Allen Ward and
22 you could --

23 Q. So in some shape or form you might be able to get your
24 hands on one rather more speedily than having to go all
25 the way up to the library?

1 A. Perhaps so, yes.

2 Q. Thank you. What about the Royal's own paediatric
3 prescriber?

4 A. I think that was readily available. The Children's
5 Hospital Paediatric Prescriber, yes.

6 Q. And the British National Formulary?

7 A. I think all the wards should have had a BNF.

8 Q. Dr Stevenson wasn't terribly sure about those textbooks,
9 but he said what he did have is some sort of condensed
10 notebook sort of book that he -- he indicated he sort of
11 carried it with him. Were you aware of anything else
12 that junior doctors might have had available to them?

13 A. He might be referring to the Oxford Handbook of Clinical
14 Specialties.

15 Q. Is that something that was commonly used by the junior
16 doctors?

17 A. I couldn't say how commonly. I think it would have been
18 around at the time.

19 Q. Not necessarily you personally, but did the more senior
20 clinicians guide the junior doctors as to what they
21 might be looking at and when they might be consulting
22 such works?

23 A. I think day-to-day, the larger textbook would have
24 probably been used not very frequently, or maybe not as
25 frequently as one would want, and that's probably due to

1 time constraints and people trying to get through their
2 day's work. They may have taken a textbook home, even
3 borrowed it from the library and gone and read up on a
4 particular topic. I don't think they would have used a
5 big book like Nelson or Forfar as a ready means of
6 getting information on a day-to-day basis in the ward,
7 so a smaller handbook may well have been more useful in
8 those circumstances.

9 Q. But the formulary, is that something that you would
10 expect them to be using more frequently?

11 A. Yes.

12 Q. In fact, would you expect them to look at it before they
13 prescribed if they were unfamiliar with the medication?

14 A. If uncertain, yes.

15 Q. For yourself, though, if you were uncertain with the
16 presentation, would you consult Nelson or Forfar if you
17 could get your hands on one?

18 A. If I was left on my own to try and work out a problem,
19 I would have had to go to a big textbook.

20 Q. And did you in those days?

21 A. I think I would have done at times if I felt that I --
22 I would have looked first of all, probably, for somebody
23 who could give me the information I needed more
24 directly, because that's ... Perhaps easier and better,
25 and more efficient. But if one was left with a clinical

1 problem for which one didn't have a ready answer, then
2 yes. We couldn't go online, if you like, to look things
3 up, which we maybe do now much more readily, so you
4 would have had to have had recourse to a textbook and
5 perhaps have a bit of time to look something up.

6 Q. Claire was a bit of a problem to you?

7 A. Yes.

8 Q. And if you were going to even contemplate differential
9 diagnoses such as status epilepticus, is that something
10 that you might look up in a textbook? It's not a very
11 common condition.

12 A. That's true, and at that stage that was an impression.

13 Q. Yes.

14 A. It wasn't a firm diagnosis.

15 Q. Yes.

16 A. It was a possible diagnosis. And if I had been left
17 with no support, no access, perhaps to neurology to
18 a paediatric neurologist, if I'd been trying to look
19 after things by myself, I would have had to sit down
20 with a textbook and perhaps work through not just that
21 possible diagnosis, but perhaps many others or some
22 others.

23 Q. Yes. But even if you didn't think to go and look at
24 what the textbook told you about that, in order to be
25 having that kind of impression or even formulating the

1 sorts of differential diagnoses that were ultimately
2 formulated for Claire, you would have had to presumably
3 know something of what those sorts of textbooks say
4 about that condition.

5 A. One would have had to have had some knowledge or -- not
6 necessarily textbook knowledge, theoretical knowledge,
7 perhaps experiential knowledge of having seen a patient
8 or patients with that condition. Sometimes that is what
9 brings a particular diagnosis to light if you've seen
10 something similar before.

11 Q. Because you'd formulated some of that before you
12 actually went to discuss with Dr Webb. In fact, that's
13 part of your reason for going to discuss these matters
14 with him because you thought you'd got yourself into
15 neurological territory, if I can put it that way.

16 A. Yes.

17 Q. Two things I've been asked, before we move away from
18 this, to ask you. Firstly, although you have told us
19 when you might -- if you were at the clinic that
20 Dr Nan Hill has spoken about, you have told us when you
21 think you might have been there. How long would it have
22 lasted for roughly?

23 A. I suppose her usual clinic length might end up some time
24 between 4.30 and 5 o'clock.

25 Q. So most of the afternoon if you were doing it?

1 A. Yes.

2 Q. And then another matter, which is: you think that you
3 might have tried to contact Dr Steen in the morning, but
4 you're not sure about that. You are sure about it
5 in the afternoon --

6 A. Yes.

7 Q. -- because you achieve it. In the morning, if you were
8 doing that, what means would you use?

9 A. It might depend if you knew where Dr Steen actually
10 physically was. If I knew where she was and had
11 a landline telephone number, I would probably use that
12 and may have left a message, if I couldn't talk to her
13 directly. For example, if she were in a meeting, I
14 would have left a message that she should phone back as
15 soon as possible or ...

16 Q. Was that a thing that you would do, use her bleeper?

17 A. I think we would have done, but again I'm not quite sure
18 whether everybody had a pager for all of the time during
19 that particular time frame.

20 Q. Did you know she had a mobile phone?

21 A. Again, I don't remember that.

22 Q. I understand.

23 THE CHAIRMAN: Did you know she had a secretary?

24 A. I believe so. As far as the evidence suggests, from
25 previously, maybe that secretary was based in

1 Cupar Street.

2 THE CHAIRMAN: So if you were particularly anxious to find
3 her and the pager didn't work and you didn't have
4 a direct line, asking her secretary where she was and
5 when she might be available would be a fairly obvious
6 recourse?

7 A. Yes, and a senior nurse would often know the
8 consultant's whereabouts.

9 THE CHAIRMAN: As she says sometimes, and you have agreed,
10 sometimes she's in before you in the mornings and she
11 had to go off to something urgent, then since the nurses
12 are there -- their shift change is at 8 am and yours is
13 at 9 -- there might well be a nurse who's able to say
14 she was in for 20 minutes and then went on somewhere.

15 A. Yes.

16 MS ANYADIKE-DANES: If we move into the substance of the
17 ward round in relation to Claire now. Were her parents
18 there?

19 A. My recollection is that they were. Particularly, I have
20 to say, I particularly remember Mrs Roberts, but I'm
21 very content to concede that Mr Roberts was probably
22 there too given the other evidence I've heard. But
23 I remember Mrs Roberts particularly.

24 Q. Do you remember being called to see Claire at all before
25 you actually reached her in the normal order in the ward

1 round?

2 A. No, I don't remember that. I know that has been
3 mentioned in some of the nursing evidence, I think.

4 Q. Yes.

5 A. And if we weren't coming to Claire or at her already,
6 I think we must have been very close. I'm not saying
7 that they mightn't have deviated slightly to see Claire
8 because of a comment made or advice.

9 Q. So as opposed to perhaps a separate visit to see her,
10 you might have, in the way that you were explaining to
11 the chairman before the break, actually simply bumped
12 her up in the order in which you'd have seen her in the
13 ward round --

14 A. Yes.

15 Q. -- and incorporated that in your ward round visit?

16 A. Yes.

17 Q. Do you remember the actual examination of Claire at that
18 ward round?

19 A. I do.

20 Q. Do you remember the information that Claire's parents
21 whether it be Mrs Roberts or both her parents, gave you
22 in relation to Claire?

23 A. I believe I do.

24 Q. Do you recall them saying that they thought she actually
25 wasn't any better that morning?

1 A. I think that's correct.

2 Q. And how did that affect your thinking, bearing in mind
3 that Dr O'Hare had thought she was a little improved
4 and, for that matter, the nurses had?

5 A. It made me concerned, and at the time I thought: why are
6 we only seeing Claire now?

7 Q. And what does that mean?

8 A. Well, I was concerned that we were -- that she perhaps
9 hadn't been flagged up as a patient whom we should see
10 sooner because it was clear to me that Claire's parents
11 were worried about her, that she was unwell, and that
12 I also believed her to be unwell. I agreed with them.
13 And I would have expected and hoped perhaps that we
14 might have seen her sooner or that she would have
15 been -- I would have been alerted to her presence
16 sooner.

17 Q. So even if her parents hadn't drawn to your attention
18 that, in their view, she wasn't any better, leaving
19 aside that, are you saying that on your examination of
20 her, her condition was such that you would have been
21 wanting to have been alerted to her before and seen her
22 sooner?

23 A. Ideally, yes.

24 Q. So how long do you believe, if you can remember, you
25 spent in combination examining Claire and talking to her

1 parents?

2 A. At an estimate, the whole thing, perhaps 20 minutes.

3 That has to be an estimate.

4 THE CHAIRMAN: In relative terms, doctor, for those of us

5 who don't know, is that longer than usual than you spend

6 with a child on a ward round or shorter?

7 A. Longer.

8 THE CHAIRMAN: If there is such a thing as a norm, what that

9 might be?

10 A. It really depends on the complexity of the problem, and

11 it depends whether there's a parent there or not. If

12 there's no parent there and you just do a clinical

13 examination, it might be five minutes. If there's

14 a parent there, you're obviously obliged to engage in

15 a conversation with the parent, take a history from them

16 perhaps and relay some information so that at least

17 doubles the time to 10 minutes.

18 THE CHAIRMAN: Is 20 a significant amount of time?

19 A. It may have been longer still. I can only give a very

20 rough idea that we spent longer, I believe, with Claire

21 than we would have done with other patients on the ward

22 round that day.

23 THE CHAIRMAN: Thank you.

24 MS ANYADIKE-DANES: Claire's parents think that actually you

25 were only there -- and it will be for them to give

1 evidence as to whether they mean talking to them or
2 there all told -- five to ten minutes with Claire.

3 MR GREEN: Forgive me, that's not an accurate reflection of
4 the statement in question.

5 MS ANYADIKE-DANES: Let's pull it up. 253/1, page 7.

6 MR GREEN: It relates to a point you yourself made, sir, the
7 other day. You raised the point and you'll see it once
8 you see the material on the screen.

9 THE CHAIRMAN: It's the conversation with Dr Sands lasted
10 for five to ten minutes, not the total time there.

11 MR GREEN: Exactly the point you made the other day, sir.

12 MS ANYADIKE-DANES: Sorry, I thought I had already
13 distinguished that. It's not entirely clear whether the
14 five to ten minutes related to the time spent talking
15 with them or the conversation. I'd already made that
16 distinction and that we would hear evidence from them
17 about it. I'm alive to that point, I'm simply asking
18 him how he --

19 THE CHAIRMAN: I think Mr Green's objection is that your
20 question, Ms Anyadike-Danes, was: Claire's parents think
21 that actually you were only there all told talking to
22 them five to ten minutes.

23 MS ANYADIKE-DANES: That's what I meant, whether the talking
24 to them was the five to ten minutes or whether the full
25 examination including that was five to ten minutes.

1 That's what I anticipate they will give evidence over.

2 MR GREEN: But forgive me, the statement on the face of it,

3 subject to any clarification or expansion when they do

4 give their evidence, appears quite clear.

5 THE CHAIRMAN: Okay. In any event, doctor, if it is

6 suggested that you were only with Claire, including

7 talking to her parents, for five to ten minutes, would

8 you agree with that or not?

9 A. I think I would have been with Claire for more than five

10 to ten minutes, talking time -- I think it's very

11 difficult to say and it's very difficult to remember for

12 me as well just how long we would have spent and trying

13 to quantify the time spent talking. My recollection of

14 it is that I had to take a history from Claire's mum and

15 that she was able to tell me what Claire was normally

16 like, what she could do, and the things that she had

17 difficulties with. I'm aware too of Claire's mum

18 telling me that although Claire could be quite drowsy

19 and lethargic when unwell, this wasn't Claire, this

20 wasn't Claire's usual situation. I believed that.

21 Having been there and seen Claire and examined Claire,

22 I believed that, that this wasn't how Claire usually

23 was, and that there was something significantly wrong.

24 So there was some of that history taking. I was

25 obviously aware that Claire had been seen by ... That

1 Claire had been seen by Dr Gaston and had been followed
2 up in the Ulster Hospital, and we were aware that it
3 might be important to get that information from the
4 Ulster Hospital, that might add something to the overall
5 picture of how Claire was. Because initially, when
6 faced with a child whose level of consciousness doesn't
7 seem normal, it's very important to know what point
8 you're starting from, what Claire is usually like.

9 MS ANYADIKE-DANES: What your comparator is?

10 A. Yes. So Claire's mum's history would have been vital.

11 MR McCREA: Mr Chairman, we have taken very specific
12 instructions on this point and our instructions are that
13 Dr Sands examined Claire and talked to the parents or
14 asked the parents questions as he was carrying out the
15 examination. So the conversation and examination went
16 in tandem and their recall is that the entire
17 examination/conversation was five to ten minutes.

18 THE CHAIRMAN: I'm not going to challenge Mr and
19 Mrs Roberts' recollection, but as everybody in this
20 chamber knows, estimates of time are notoriously
21 inaccurate. That's not a point against Mr and
22 Mrs Roberts, I'm sure they'll understand that. When
23 Dr Sands gives an estimate of 20, he's also struggling
24 to put a time on it. Of more importance is what
25 information was gleaned and what was found on

1 examination rather than us getting bogged down in
2 whether it was five, ten, 20 minutes or longer.

3 MS ANYADIKE-DANES: Maybe this point might be what underlies
4 some of that concern: your consultant wasn't there, you
5 were conducting the ward rounds for all these patients.
6 Did you feel under any more pressure than usual to
7 complete that work?

8 A. I take your point. There would have been a certain time
9 constraint. And the other thing too, whilst not wanting
10 to truncate time with Claire or with Claire's mum and
11 dad, I would have felt as well that it was important to
12 not delay getting Dr Webb.

13 Q. Does that mean that once you'd felt that what you were
14 dealing with is quite a sick child, then your priority
15 then is trying to get the consultant input?

16 A. I think that's right, and again I don't mean to say that
17 the conversation with Claire's parents was truncated or
18 time with Claire was truncated because I don't think
19 that's the case.

20 Q. I understand. When you have examined her and you've
21 spoken to her parents, whether you do that separately or
22 all at the same time, you end up with an impression.
23 If we keep up 090-022-053, that is your impression.
24 If we leave aside the encephalitis and encephalopathy,
25 the impression is: non-fitting status.

1 At the time you have that, you know, because apart
2 from any other thing -- we can see it from slightly
3 higher up -- that she's been on IV fluids really since
4 being admitted to the ward. And even if you didn't look
5 at the notes yourself, you would have known what IV
6 fluids she was on because, if you were in that
7 territory, you'd have asked Dr Stevenson.

8 A. Yes, I think we would have talked about it. It would
9 have been mentioned and been at the side of the bed.

10 Q. And you'd have known that that U&E result of sodium of
11 132 related to blood that was taken the previous
12 evening. Sorry, would you have known that?

13 A. Yes, I think that's a reasonable question. I would
14 have ... I may not have known the exact time that blood
15 was taken, I think is my answer to that. Insofar as
16 I would have known that it related to her admission, but
17 as to what time thereafter it had been taken, I may not
18 have been completely clear on.

19 Q. Let me put it this way. Would you have thought it was
20 something that related to the previous evening, even if
21 you didn't know exactly when it was taken, as opposed to
22 something closer to the actual ward round?

23 A. I think on looking at it, we may have thought it was
24 done late on in the evening or in the early hours or
25 something like that. But quite possibly we may have

1 considered it something -- or I may have considered
2 it -- something even a little bit thereafter.

3 Q. Dr Stevenson doesn't seem to think it was anything more
4 than recording the result that is on the previous page,
5 if you like, that has been recorded by someone whose
6 hand we're not entirely clear on.

7 A. Yes.

8 Q. And if he's got the medical notes and records and you're
9 having the discussion with him, would it be reasonable
10 that you might have formed the same view or discussed
11 the same thing with him?

12 A. It depends very much how it's put to me.

13 Q. Well, I think the evidence that he gave is that it would
14 be unusual to have had blood tests taken that morning
15 and have got the result back and therefore that been
16 a result from the morning -- and by "morning" I don't
17 mean the early hours of the morning, I mean shortly
18 before the ward round. He said that would be unusual.

19 A. I think it would be unusual if that blood had been taken
20 at 8 or 9 o'clock.

21 Q. Exactly. So it is relating to some time further back,
22 even though you can't put your hand exactly on when the
23 specimen would have been taken to give rise to that?

24 A. That's right.

25 Q. So his view was that this 132 is in fact a recitation of

1 the 132 in the previous page, and not a new 132
2 generated by a new blood test. And would you have
3 understood the same thing?

4 A. I can't say what I would have understood then, but that
5 seems likely now, certainly as I read the notes.

6 Q. Yes. So if you saw that, her serum sodium level from
7 blood taken at some stage the previous evening -- or
8 even maybe the early hours of the morning -- was 132 and
9 she had been on IV fluids since about 8 o'clock or
10 whenever they had been erected when she came to the
11 ward, and you had seen that Dr O'Hare wanted her to be
12 reassessed after fluids and had reassessed her and
13 wanted her reassessed again in the morning, would you
14 have wanted to consider again her fluid regime as part
15 of your plan during the ward round?

16 A. I don't think Dr O'Hare's second request for
17 a reassessment in the morning specifically relates to
18 reassess the fluids.

19 Q. No.

20 A. At least that's my impression.

21 Q. Understood.

22 A. So I think the reassessment would have been the ward
23 round assessment.

24 Q. Yes.

25 A. But yes, as part of that, one would have wanted to

1 discuss blood tests and I think there likely would have
2 been a discussion about fluids and what fluid we should
3 use, whether we should continue with the present fluids.

4 Q. So you think that is a logical thing to have wanted to
5 discuss and, if you think that, can you recall actually
6 doing that?

7 A. I don't recall doing that, but I think it's consistent
8 with what one would do on a ward round at this time.

9 Q. If you were going to continue the IV fluids and you were
10 aware that she'd been on them for some period of time,
11 she had a slightly below normal serum sodium level, you
12 think at that time, in 1996, it would be logical to have
13 thought about what IV fluids she should continue to
14 remain on?

15 A. I think there would have been some discussion about IV
16 fluids and whether to continue them and at the present
17 rate.

18 Q. Yes.

19 A. That might have been a short discussion, given the
20 overall context of Claire and the focus on the
21 neurological problem, and given that we were using
22 fifth-normal saline, which, again, was what one would
23 have commonly used in a child being admitted to
24 hospital, a medical patient being admitted to hospital.
25 So the discussion around that might have been brief.

1 Q. If you'd had any discussion at all around that, would
2 you have expected that to be recorded, however brief
3 a note about it was, in her medical notes and records?
4 A. Not necessarily.
5 Q. Although the fifth-normal saline that she was on, you
6 say, was fairly standard at that time, certainly in the
7 hospital, to administer that, in view of the slightly
8 low serum sodium level and the fact that she had been on
9 that regime for some time and that she did present with
10 some neurological problems, did it occur to you that
11 maybe you should think a little bit more carefully about
12 the fluid regime?
13 A. I don't recall thinking that at the time. I don't have
14 an independent recollection that that went through my
15 mind, or our mind at the ward round at the time. It may
16 have done.
17 Q. Would it have been appropriate to think in those terms?
18 A. With hindsight, yes.
19 Q. Then let me put it another way: did you have enough
20 knowledge in 1996 for that to have been appropriate for
21 you to think in those terms?
22 A. I suppose I can only compare with the knowledge that
23 I have now, that we have now, and I think our knowledge
24 was limited. My knowledge was limited in terms of how
25 to manage a slightly low serum sodium in an unwell

1 patient. And I think that view has changed, my view has
2 changed, and perhaps the views of many other people have
3 changed.

4 Q. If you have been looking at the textbooks, Nelson in
5 particular, you might have been consulting them to see
6 whether they offered any guidance as to what to do in
7 a situation like that. I'm thinking in particular of,
8 say, Nelson, that we have an extract from that at
9 311-018-009. It starts:

10 "The serum sodium level is most commonly reduced as
11 a result of true sodium depletion, water intoxication or
12 a combination of both."

13 In other words, water overload, and I think you had
14 conceded earlier that that can produce it. And then it
15 says:

16 "A low serum sodium level thought to be a result of
17 redistribution of total body sodium may be associated
18 with severe illnesses or occur in the terminally ill
19 patient."

20 Then I think it goes on, two paragraphs down:

21 "With water overload, fluid restriction is the
22 appropriate measure and the serum sodium level may
23 return rapidly to normal if there is good renal
24 function, but this may take several days ..."

25 And then it talks about:

1 "... increasing the sodium concentration of
2 parenterally administered fluid often corrects a sodium
3 deficit."

4 And then it talks about measuring urinary sodium
5 concentration.

6 With the information that you had at your disposal,
7 which was that her serum sodium level taken from
8 a sample at some time in the previous evening or the
9 early hours of the morning, and the combination of her
10 presentations in terms of her neurological signs and the
11 length of time she had been on fluids, did you think
12 that you may be in a situation where you perhaps ought
13 to consult something or think about maybe increasing the
14 sodium concentration of her fluids?

15 A. Again, I don't have an independent memory of what we
16 considered at the time. Looking back at it, I think
17 that the sodium of 132 wouldn't have caused a lot of
18 alarm. We may not have been exactly clear how long
19 Claire had been on No.18 Solution, although we could
20 have calculated that. I appreciate that we could have
21 looked at that more carefully. But I don't think the
22 serum sodium of 132 would have made us think: this is
23 a hyponatraemic child or a child who's potentially going
24 to suffer from symptomatic hyponatraemia. Even though
25 technically the result is hyponatraemic insofar as it's

1 less than 135.

2 Q. You'd have known how long she was on her fluid regime
3 because that's in her medical notes and records. What
4 you're saying is that you wouldn't have known how long
5 her serum sodium level had been 132.

6 A. We wouldn't have known at what time exactly perhaps that
7 was taken and we would have needed to look at the fluid
8 balance sheet to work out how long the IV fluids had
9 been running for in order to know exactly how much
10 fifth-normal saline had been administered.

11 MS WOODS: Mr Chairman, if I could just raise the point when
12 we're dealing with Nelson and this discussion about
13 hyponatraemia? It may be that my learned friend is
14 planning to come to this, but in the Nelson textbook,
15 which I believe comes from 1996, on page 311-018-005,
16 you will see right at the bottom of the page another
17 thing that says, "Hyponatraemia".

18 THE CHAIRMAN: The left-hand column?

19 MS WOODS: That's correct, yes. You will see what appears
20 to be a definition of hyponatraemia. We see it's a
21 serum sodium of less than 130.

22 THE CHAIRMAN: Right.

23 You just said that technically it was hyponatraemia
24 because the level's under 135 and there's a bit of
25 edginess about what exactly the cut-off point is. Is

1 your point, doctor, that even if we take 135 as the
2 relevant marker, 132 is below it but not significantly
3 below it, and your concerns about Claire were focused
4 not on hyponatraemia but other issues?

5 A. I think that's correct. To many doctors at the time,
6 hyponatraemia simply meant literally hyponatraemia,
7 a lower than normal sodium level, without a full
8 appreciation of what it might mean and particularly what
9 symptomatic hyponatraemia -- how it might develop, what
10 its implications might be. I think the chairman's
11 correct insofar as I think our focus wasn't on the serum
12 sodium and its potential importance at this point.

13 MS ANYADIKE-DANES: No, but I think one of the things we're
14 trying to see is the extent to which perhaps it ought to
15 have been, I suppose. Finally on that point,
16 particularly as you didn't actually know when that
17 sample was taken and therefore when her serum sodium
18 level would have been 132, did it not occur to you that
19 you ought to try and find that out in case it had
20 stabilised itself or, which would be more problematic,
21 reduced yet further?

22 A. We may have done that, we may have done that. I think
23 more likely -- and I've said this in my witness
24 statement -- is that I think we would have viewed this
25 as a result that should be done again. Sorry, a test

1 that should be done again.

2 Q. So this would be part and parcel, would it not, of the
3 tests that you would want to have done as part of your
4 plan for Claire?

5 A. Yes. I would have to say, though, probably not at the
6 top of the list in terms of how I and we were thinking
7 at this moment in time.

8 Q. But that her electrolytes should be tested at some point
9 after that ward round?

10 A. Yes. And we may not have specified a time, and I don't
11 have an independent recollection to say that we said or
12 that I said we must do another U&E.

13 Q. It's not recorded.

14 A. I know that.

15 THE CHAIRMAN: Just to get to the point on this: if it's not
16 recorded in the plan, whereas three other points are
17 recorded in the plan, do I not infer from that that it
18 was actually not intended to be done?

19 A. Obviously not everything that's discussed is written
20 down.

21 THE CHAIRMAN: I understand.

22 A. And sometimes I think -- again, I've maybe made this
23 point in my witness statement -- quite often when
24 we were doing a ward round, indeed when I do ward rounds
25 now, I think best practice is to write that you plan to

1 do a U&E, to write it in the notes, but also to write it
2 on another piece of paper for the SHO or whoever is
3 going to come back and do the blood tests. And the
4 reason I say that is that when you've done a ward round,
5 and when you've finished with all the charts and they're
6 all back on the trolley and back at the nurses' station,
7 the SHO or the registrar, whoever's there, won't know
8 what tests to do, what know in what order to do them,
9 unless they go through every chart again one by one to
10 look at what has been discussed on the ward round. So
11 you need a piece of paper, you need a to-do list.

12 THE CHAIRMAN: Right, so there was a bit of discussion about
13 this earlier in the week, but does that mean that the
14 plan should have a to-do list and then the SHO might be
15 keeping a separate note so that when the ward round is
16 over, he has a list of things which he has to do or
17 organise for different patients?

18 A. Yes.

19 THE CHAIRMAN: Right. I understand.

20 MS ANYADIKE-DANES: Dr Stevenson's evidence is, I'm sure you
21 heard, he doesn't recollect that practice at all.
22 Sorry, he didn't recollect doing that or that being
23 something to do.

24 A. Mm-hm.

25 Q. I think you also refer to it might have been included in

1 a book, and he wasn't sure about that either.

2 A. Yes, I ward round book or a ward diary, if you like.

3 Q. Is the other place where that sort of prescription or

4 part of the plan might be in the nursing notes?

5 A. Again, sometimes. Sometimes, but not always. And there

6 are points where it is noted down in Claire's chart and

7 others that a U&E has been done, and there'll be a tick

8 beside it.

9 Q. There's none recorded for just after this ward round.

10 You'd accept that?

11 A. Yes.

12 THE CHAIRMAN: Well, in hindsight, let's suppose for the

13 moment that the evidence doesn't really support

14 the suggestion that that was planned. Do you accept,

15 with hindsight, that it should have been planned?

16 A. Yes, I think it's something that should have been done

17 during that day. If I may: after hearing of Claire's

18 collapse, I believe it was from Dr Bartholome, I was

19 surprised to hear that the serum sodium was 121 at

20 11.30. I was surprised that there wasn't a blood result

21 available before that. Now, I don't put it any more

22 strongly than I was just surprised to hear that. I've

23 said that in my third witness statement to the inquiry.

24 And I have thought about this and asked myself what

25 does that mean, and it was something I wasn't sure

1 whether I should put in because I wasn't sure exactly
2 what it meant to me now. But to me now, it suggests to
3 me that at least I had expected that a blood result or
4 a blood test had been done or had been requested, that
5 it might be due back in the five to six slot when blood
6 results usually came back. Or alternatively, if I or we
7 discovered that it hadn't been done, or the sample had
8 been lost or misplaced or unsuitable for analysis, that
9 we would mention it again at 5 o'clock or 5.30 with
10 a plan to do it shortly thereafter. And that might
11 explain why it surprised me that there wasn't a result
12 available until, you know, much later on in that
13 evening. That's only a fragment of memory, but I put it
14 in witness statement 3 because I remember it.

15 MS ANYADIKE-DANES: As you put it in that way, during the
16 course of Claire's care and treatment over the day,
17 irrespective of whether it had been specifically noted
18 or requested during the ward round, would you have
19 expected somebody to have wanted to know or have an
20 up-to-date reading of her serum sodium levels?

21 A. If we were aware that the sample was from 10 o'clock the
22 previous evening, yes, definitely.

23 Q. Even if you thought it was from the early hours of the
24 morning, would you still have wanted to know that?

25 A. Still yes because -- and the reason I go back to the

1 point about trying to do routine blood work. I think it
2 would have been considered routine blood work to try to
3 do that between the hours of 9 and 5, if at all
4 possible. I think that would have been standard
5 practice and it's what we were encouraged to do. And
6 doing blood tests outside of that, we were -- it was
7 suggested to us that you needed to have a reason to do
8 that, there had to be a purpose to that and try and
9 concentrate routine work within the hours of 9 to 5. So
10 yes, I would have -- and clearly, with hindsight it
11 would have been the right thing to do, to have a result
12 in the chart.

13 Q. The purpose to it might have been that her neurological
14 signs continued to deteriorate, she remained on the same
15 type and rate of IV fluid and nobody knew whether the
16 one related to the other in any way and nobody knew what
17 her serum sodium level was. That might be the reason to
18 do it.

19 A. I think, again, with the knowledge that we have now,
20 absolutely, a serum sodium would have been very helpful.

21 Q. Dr Steen's witness statement -- I think her first
22 witness statement -- has considered ... We can pull it
23 up, I think. 143/1, page 55:

24 "State whether you agree that Claire was at risk of
25 electrolyte imbalance between 21 and 23 October, and if

1 not, explain why not. I agree that Claire's overall
2 clinical condition including vomiting, deteriorating
3 level of consciousness and requirement for IV fluids put
4 her at risk of electrolyte imbalance (sodium and
5 potassium) along with an increase in urea and possible
6 hypoglycaemia."

7 Would you accept that?

8 A. I think Claire probably had stopped vomiting by the time
9 the ward round had come to see her.

10 Q. Yes.

11 A. I'm not sure that I would have appreciated that the
12 deteriorating level of consciousness would have alerted
13 me to the serum sodium as being particularly important.

14 Q. So does that mean you did or you did not think that she
15 was at risk of electrolyte imbalance?

16 A. I can't recall if it was part of my thinking at that
17 time except to say that I'm sure we would have
18 acknowledged that the sodium was lower than the normal
19 range and that that sodium ought to be repeated. That's
20 my feeling on reviewing the chart as well.

21 Q. If we then go back up to 090-022-053, let's look at the
22 first impression of what might be the cause of her
23 condition. Non-fitting status. What led you to
24 identify that as a possibility?

25 A. Again, I think this is based on probably several things:

1 the history from the GP, which was probably related as
2 part of the ward round presentation; the history given
3 by Claire's mother that she had had a history of
4 seizures in the past, though had been seizure-free for
5 some time now and indeed off medication for about 18
6 months and, I think, had just had one seizure at the age
7 of 4. So a lot of those seizures seemed to be
8 concentrated around about the six months to one year
9 period when that was her most troublesome time. But
10 nonetheless, a child with a history of seizures. The
11 GP, I believe, had raised the concern over possible
12 further seizure activity.

13 Q. The GP had two possible concerns. That was one of them,
14 seizures.

15 THE CHAIRMAN: Sorry, let the witness finish this answer
16 about -- the basis of your impression that this was
17 non-fitting status. We've got the GP's note, you have
18 Mrs Roberts' history of seizures in the past, admittedly
19 some time in the past.

20 A. And I believe Dr O'Hare as well has mentioned about
21 "query if seizure, given IV diazepam". So I think it
22 was in several people's thinking that this might be part
23 of a seizure disorder or presentation of a seizure
24 disorder. The fact was, though, that on examining
25 Claire, her neurology was very abnormal, but I didn't

1 think she was having overt seizures, that is visible
2 tonic-clonic jerking type seizures. So I wondered
3 whether this might be a seizure disorder but without the
4 overt jerking that one perhaps associates more usually
5 with seizure activity.

6 MS ANYADIKE-DANES: Had you any experience of that before?

7 A. I believe I'd seen one patient perhaps with this
8 condition at some time previously. So my experience
9 would have been very limited in practical terms.
10 I might have had some theoretical book knowledge about
11 it.

12 Q. Did you know how you would confirm such an impression?

13 A. Again, I don't know at the time whether I give that
14 a lot of thought, other than to go and get expert advice
15 on the matter, because this is an unusual condition, one
16 that perhaps I might have seen once. And my feeling
17 would have been that I needed somebody much more senior
18 with much more experience to either confirm or refute
19 that diagnosis completely. And just while I'm
20 mentioning that, I maybe should say now that very much
21 high up in my thinking, but not recorded here in the
22 notes, is the fact that I felt that Claire may need an
23 urgent CT scan, and that has been my independent
24 recollection from the very start, as part of my desire
25 to go to speak to Dr Webb and my discussion with

1 Dr Webb.

2 Q. And just so that we finish off that, why would that
3 thought that she might need an urgent CT scan cause you
4 to go and talk to Dr Webb, apart from any other reason
5 that you might have wanted to talk to him about her
6 presentation?

7 A. Because it's my understanding that we would have needed
8 a consultant neurologist to authorise that.

9 Q. Can we then just go back -- I had interrupted you, for
10 which I apologise. When you had referred back to the
11 GP's referral, there is a query under "further fits",
12 there's also a query about "underlying infection". When
13 you talk about gleaning these impressions or
14 understanding what the clinicians before you had
15 thought, is that because they were drawn to your
16 attention at the time or is it because you have now or
17 since looked at them and seen this pattern?

18 A. I think it's likely because they were drawn to my
19 attention at the time as part of the history of
20 presenting complaint.

21 Q. In addition to the GP identifying an underlying
22 infection, did not Dr O'Hare also consider there might
23 have been a viral illness? That was one of her notes,
24 and under that she had "encephalitis", which she had
25 thought about and then struck through. But in any

1 event, something else other than pure seizures, if I can
2 put it that way. And if you had had that drawn to your
3 attention, what else would that have caused you to do?

4 A. Well, I think we did actually think of viral infection,
5 specifically encephalitis, because again, as part of the
6 wanting a CT scan, I remember thinking about what a CT
7 scan might show, and it might show some kind of focal
8 inflammation in the brain.

9 Q. And do you think that was discussed during the ward
10 round, the encephalitis?

11 A. I think it was discussed amongst the medical staff, and
12 I may not have used those words with Mr and Mrs Roberts.
13 I may have couched it in different terms. But yes, I do
14 think it was discussed at the ward round and it's not
15 noted.

16 Q. Yes, it's not noted. If you had discussed the
17 possibility of blood tests, that's not noted here, but
18 in addition, that bit isn't noted. Is that to you
19 important that that wasn't noted at that time?

20 A. I think that's a ... It just doesn't reflect my memory
21 of the ward round.

22 Q. So it should have been noted; is that what you're
23 saying?

24 A. I think so, yes.

25 THE CHAIRMAN: So that I understand that, the note doesn't

1 fully reflect your memory of the ward round --

2 A. That's right.

3 THE CHAIRMAN: -- in terms of the alternatives which were

4 discussed or in terms of what tests were to be done?

5 A. I think that's -- I don't have an independent memory of

6 requesting a urea and electrolytes -- I repeat,

7 I don't -- at that point.

8 THE CHAIRMAN: But reading back from when you found out

9 about Claire's collapse, your reason that you give that

10 piece of evidence was because you were surprised that

11 there hadn't been a test done with results before 11 pm

12 or 11.30.

13 A. Yes, but the other things that aren't recorded in the

14 ward round note are discussion with mum and dad and

15 again I have a recollection --

16 THE CHAIRMAN: If we go back a page, can you give us

17 page 052 as well as 053, please?

18 MS ANYADIKE-DANES: There is a reference.

19 THE CHAIRMAN: There is a reference to the parents, I think

20 it says, at the bottom of the previous page. Just so

21 that you have the full note, doctor:

22 "Usually very active. Has not spoken to parents as

23 per normal."

24 And then the last line:

25 "Vagueness/vacant (apparent to parents)."

1 A. So there is some history-taking from mum and dad, but
2 nothing about what was said to mum and dad.

3 THE CHAIRMAN: I understand.

4 MS ANYADIKE-DANES: When you had, in your mind, seizures --
5 even not evident seizures -- as something that might be
6 giving rise, did it occur to you to try and think
7 through what might be causing those seizures?

8 A. Well, I think this is part of where the possibility of
9 encephalitis comes in as a possible contributing factor
10 to a seizure disorder. I'm not sure that we went into
11 it in a lot more detail, but I would suspect that if
12 we were thinking about a CT scan, it's quite a major
13 investigation to undertake -- and again I can't remember
14 this directly -- but what else might a CT scan show or
15 rule out? I suppose that we might have been thinking
16 that it would rule out something like a cerebral
17 haemorrhage or even a tumour, unlikely though those
18 might be as a cause of the clinical presentation.

19 Q. And if you were going to put in train the kind of test
20 to help you or any consultant coming after you who was
21 going to deal with Claire's care as to what might be
22 causing the seizures, what sort of test do you think,
23 from 1996, you would have wanted to have carried out?

24 A. At the time, I think I would particularly have wanted to
25 get advice from a neurologist to advise on that, because

1 I think I would have felt unable to put down
2 a comprehensive plan or -- maybe not unable to, but
3 it would have been better, more efficient, more full to
4 get that advice about those tests from a consultant
5 neurologist.

6 Q. Yes, but while you're going off to go and do that, could
7 you, for example, not have directed, "For a start, let's
8 have full blood and urine tests done? That will help us
9 with whether there is any kind of toxicity involved in
10 there, anything of that sort going on, any other sort of
11 abnormality that might be reflected whilst I'm going to
12 find the neurologist who may guide me yet further as to
13 more particular things"? Did that occur?

14 A. I'm not sure that occurred at the time. Again, you
15 could do a very wide range of blood tests and toxicology
16 screens, although you'd need to know what toxins you
17 were looking for. You'd need to have a list of what
18 laboratory tests you wanted the toxicologist to look
19 for. Liver function tests, you could do, and the result
20 would probably be available -- well, it may be available
21 that evening or possibly the following day. But
22 I appreciate there are other causes of Claire's --
23 potential causes of Claire's presentation that weren't
24 explored in detail.

25 Q. I think Dr O'Hare thought that there -- it was either

1 Dr O'Hare or Dr Bartholome who thought there might be
2 a liver function test that could be done. It's
3 Dr O'Hare. So that could have occurred to you in 1996,
4 that's not a hindsight point?

5 A. Yes.

6 Q. And it could have occurred to you to have had full
7 bloods carried out?

8 A. Full blood count?

9 Q. Yes.

10 A. There was a full blood count done. It wasn't markedly
11 abnormal, but the white cell count was elevated at 16.5.

12 Q. Might you have wanted to see where that was now?

13 A. Whether it was rising or changing? Yes, I think that's
14 not unreasonable.

15 Q. That might have been useful?

16 A. Yes.

17 Q. If those are all things that you could have known about
18 and therefore could have prescribed or put in the plan
19 for the SHOs to do, why didn't you?

20 A. I think because my impression was that I was going to
21 speak to Dr Webb and that he, in fact, would come, I --
22 hoped soon -- and would give us a steer, give us
23 a direction to go down, because it seemed to me quite
24 clear that this child, that Claire, had a major
25 neurological problem that Dr Webb would be able to help

1 with, and that he would guide us in terms of a line of
2 investigation or lines of investigation, rather than me
3 suggesting a number of investigations. And then I'd
4 have had to think probably for quite some time, maybe
5 with a book in front of me, to decide what would be the
6 most sensible lines of investigations to go down in this
7 case.

8 Q. I can understand that if -- well, it's not for me to
9 understand. I understand what you're saying, if you had
10 gone off and been able to get hold of Dr Webb fairly
11 speedily to return and start to formulate a plan and put
12 something in motion, if I can put it that way, for
13 Claire. But by the time you left for that clinic,
14 there'd been two hours, roughly, from the way we've been
15 able to calculate it, of you really wanting Dr Webb to
16 come and assist and nothing had happened. So from the
17 point of view of finding out what was causing her
18 deterioration, really you'd had a sort of standstill for
19 about two hours. Did it occur to you at some point
20 during that -- and certainly before you left, when you
21 still really didn't know when Dr Webb was going to
22 come -- that you should have at least some of these
23 things put in train?

24 A. I'm not sure if that did occur to me at that time. That
25 time interval of 2 hours that we're estimating was

1 probably longer than I had anticipated. And I think
2 probably the bloods would have taken at least that
3 length of time, if not longer, to actually have any
4 results back within that two-hour time frame. But yes,
5 we could have, perhaps should have, had those tests
6 under way, at least some of the tests under way.

7 Q. Is that not the point, that there is a time lag, even if
8 you ask them to come urgently, it's maybe an hour, even
9 if you really tell them you need them quickly. But
10 that's the point, is it not? There is a time lag. So
11 all the time you haven't sent them off, you're
12 postponing knowing what the position is, and if they had
13 been sent off fairly speedily, it might have been that
14 some or other of them could have come back in time to
15 inform whatever Dr Webb is going to start thinking about
16 when he examines Claire.

17 A. I take that point.

18 Q. And so even though it is with retrospect, do you think
19 that it would have been prudent at that time to have set
20 those things in train?

21 A. I do.

22 Q. Thank you. I know you have couched these in terms of
23 impressions, so you haven't actually identified them as
24 differential diagnoses at the time, have you? They're
25 just your thoughts as to what might be the problem. Did

1 you think about raised intracranial pressure in some
2 way, SIADH maybe?

3 A. I don't recall thinking that.

4 Q. From what you have said before about the history that
5 you got from the referral letter, do you think the fact
6 that you knew she had had seizures before in any way led
7 you maybe more quickly to focus on the whole aspect of
8 seizures as opposed to retain a broader perspective of
9 the things that could be causing her presentation?

10 A. Looking at it now, looking at the chart now, I think
11 that's a fair comment, that there is a focus on seizure
12 history and that undoubtedly influenced probably not
13 just me but undoubtedly influenced probably several of
14 the doctors in terms of how they interpreted Claire's
15 condition and managed Claire's condition. A history of
16 seizures was important and did have an influence.

17 Q. Is that because it provided an explanation?

18 A. Partly that.

19 THE CHAIRMAN: There's nothing unnatural about that, doctor,
20 is there?

21 A. No. It's an important history.

22 THE CHAIRMAN: It is. And if that is part of Claire's
23 history, even though it's somewhat distant, then that is
24 at least a starting point for investigating why she is
25 unwell on the Tuesday morning. I think really the issue

1 is: at least with the benefit of hindsight, did it lead
2 you to focus too much on that and perhaps not consider
3 as prominently as you might have done other
4 possibilities?

5 A. I take the point you make, sir, and I think it became
6 central to Claire's management, the history of seizures,
7 and I do think it is an important history in any child.
8 Whether it then made people a little bit less aware of
9 other possibilities, what else might be going on, that's
10 a point that one could make, and I can see that point.

11 MS ANYADIKE-DANES: Could that have been assisted by the
12 fact that the consultant who was actually providing
13 advice and guidance was a neurological consultant, and
14 so may be naturally focusing on the neurological aspects
15 because that's what you brought the consultant in to
16 guide you on, as opposed to also having at your disposal
17 a paediatric consultant, who might have looked at some
18 of these broader possibilities for producing that kind
19 of presentation, if I can put it that way?

20 A. I think all of these things rather fall within
21 neurological conditions. Again, I can only -- I'm bound
22 to, I suppose, draw comparisons between my own practice
23 and if I'm called to see a child in whom there is
24 a cardiac diagnosis, and that's established, I would
25 seek to manage that child.

1 Q. Yes.

2 A. And yes, I'd want to have a word with the consultant
3 under whom that child had been admitted, but I would
4 want to manage that child, all of that child, unless
5 there were multiple other organ system disorders that
6 needed other input.

7 Q. Yes.

8 A. So I suppose I'm bound to make that comparison in this
9 case.

10 Q. I suppose what I was inviting you to consider is, if you
11 had had -- maybe you would say it wouldn't make any
12 difference and that's actually what I'm asking you to
13 consider. If you had had the expertise and guidance of
14 Dr Steen as well -- so you'd got two consultants, one
15 who is specialising on the neurology and the other who
16 is an experienced paediatric consultant -- do you think
17 that it may have been you could have had a broader
18 approach to the underlying causes of Claire's
19 presentation?

20 A. I'm not sure how much difference that would have made,
21 but it's certainly good to have two consultants instead
22 of one. Two people thinking about the same problem,
23 three people thinking about the same problem or
24 problems.

25 Q. Yes. Then can I ask you about the non-fitting

1 status epilepticus specifically? I'd like to put to you
2 what the inquiry's expert, Professor Neville, says about
3 that. It comes in two pages of his report, 232-002-005,
4 and if we can pull up along side that 006.

5 It really comes from (iv), if you see it there on
6 005, which is the quality of your diagnostic assessment
7 and management of Claire, including the reasonableness
8 or otherwise of your diagnosis of non-convulsive
9 status epilepticus on that morning.

10 And he gives a number of reasons why he doesn't
11 think that non-convulsive status epilepticus was the
12 likely diagnosis, and the first really is that it wasn't
13 common, epilepsy was not prominent in Claire's recent
14 history; would you accept that?

15 A. That is the case, that it's an uncommon diagnosis as I
16 understand it, and that epilepsy was part of Claire's
17 history, but not her recent history.

18 Q. He says in his opinion that that really needs to be
19 proven by urgent EEG. Did you think about, in addition
20 to the CT scan, perhaps if you were along the lines of
21 considering status epilepticus, whether you should have
22 also been querying with Dr Webb: should we not be
23 arranging an EEG?

24 A. We may have discussed an EEG. I may have discussed it
25 with Dr Webb, but again, the consultant neurologist held

1 the keys to the EEG, if you like, and I would have
2 needed him to say, "Yes, I think that's what's going on
3 and the only way to confirm that is to do an EEG", if
4 that were possible.

5 Q. Did you know from your own knowledge that the only way
6 to confirm that was through an EEG?

7 A. I don't remember at the time. I don't remember at the
8 time.

9 Q. Did you know whether it was possible to -- I used the
10 poor expression of "bump" when I spoke to Dr Steen. The
11 EEG department has its slots with patients who are
12 planned for their EEGs, as I have understood it from the
13 evidence. Did you know if it was possible for a child
14 who urgently needed an EEG to be substituted for another
15 child? Had you any experience of that at all?

16 A. I don't recall having any experience of that. I'm not
17 sure as well -- and again there will be others who maybe
18 will know this -- whether a bedside EEG could be done at
19 that time because the alternative would have been to
20 bring Claire round to the EEG department, and whether
21 that could accommodate a bed or not ... I'm not
22 certain.

23 Q. What sort of equipment would be required to do a bedside
24 EEG and do you know if the Children's Hospital, or for
25 that matter the hospital, had access to that in 1996?

1 A. I don't know if there was access to it, and to be
2 honest, I don't really know exactly what equipment is
3 required. I've seen it done since and I believe the
4 equipment is there now, and it basically is a portable
5 trolley with all of the electrodes and computer screens
6 on it. I assume it would have been a more rudimentary
7 affair were it available back then.

8 Q. Perhaps we can make enquiries about that. In any event,
9 I think what I'm understanding you to say is that if
10 that sort of thing was going to be arranged, whilst you
11 might have raised it, you would have been in Dr Webb's
12 hands for whether he felt that was appropriate and how
13 and when it could be arranged?

14 A. Yes.

15 Q. He also says that one of the reasons why he says it's so
16 important to get this right is that an incorrect
17 diagnosis of non-convulsive status can lead to
18 inappropriate treatment and that means that you could be
19 having anti-epilepsy drugs, which could further affect
20 consciousness level and respiratory drive; would you
21 accept that?

22 A. Yes.

23 Q. And I suppose that's part of wanting to see Dr Webb.
24 You're just offering up a suggestion; is that how you'd
25 have seen that?

1 A. Yes, and my independent memory of it is that CT was,
2 rightly or wrongly, up there in my mind too as well as
3 getting his input and his directs hands-on input.

4 Q. And then finally what he says -- and you may not have
5 had the knowledge of that at the time -- is that:
6 "Cerebral oedema relating to hyponatraemia was
7 a more likely cause of the reduced consciousness level
8 and poorly reacting pupils, and should have been
9 considered as a matter of urgency, as it is reversible
10 by treatment in its early stages."

11 Leaving aside whether you'd have known enough to
12 formulate that at the time, do you accept that as
13 accurate?

14 A. Sorry, could you just point out exactly where that is?

15 Q. It's on page 005, if you go up a few lines, above 1:
16 "Another more likely cause ..."
17 Would you accept that as you read it?

18 A. Again, I'm not --

19 THE CHAIRMAN: We're going back to 1996 now.

20 A. Yes. I'm not sure what my knowledge would have been of
21 this in 1996. Even now, would I know now that ...
22 Would I believe now that a more likely cause of reduced
23 conscious level, et cetera, would be cerebral oedema
24 related to hyponatraemia? I'm not sure that I would
25 know that in my practice now necessarily if I saw

1 a child exactly the same as Claire, you know. But
2 I accept it would be something that one would be
3 thinking about much, much more readily.

4 MS ANYADIKE-DANES: But was Claire's level of consciousness
5 something of concern to you as you examined her at that
6 ward round?

7 A. Yes.

8 Q. Is that something that you communicated to her parents?

9 A. I think, in effect, they communicated it to me and
10 I agreed with that.

11 Q. Well, as I understand their evidence, they were
12 communicating to you that she didn't seem any better to
13 them, and this was not her normal presentation. I've
14 asked you something slightly different, whether your
15 concerns as a doctor about their child's condition were
16 communicated to them.

17 A. Yes, I believe I did raise concerns -- not raise, but
18 endorse their concerns that Claire wasn't behaving
19 normally, that her level of consciousness didn't appear
20 normal.

21 Q. At that stage, how seriously ill did you fear Claire
22 was?

23 A. I think I didn't really know. But I thought there was
24 a major neurological problem there that I didn't fully
25 understand, that I didn't perhaps even partially

1 understand, but thought that she was neurologically
2 unwell in a way I couldn't explain.

3 Q. Yes, that's why I put it in a different way. I didn't
4 ask you, "Did you know?", I asked you what you feared
5 and whether you were likely to have communicated any of
6 that to the family.

7 A. I think my own concern, fear if you like, would have
8 been balanced by what I remember as Claire's mum's
9 optimism to -- although they recognised Claire wasn't
10 well, they were optimistic that she would soon be well,
11 she would bounce back, she would in a while be herself
12 again.

13 THE CHAIRMAN: That's a parent's natural aspiration, isn't
14 it? My child's not well, she's drowsy, she's not
15 responding. You then endorse that. I think what you're
16 being asked about is specifically in relation to the
17 ward round, but it leads into the general concern, which
18 is that Mr and Mrs Roberts didn't ever understand that
19 Claire was seriously ill. At the lowest level, that's
20 why they went home on the Tuesday night.

21 On Tuesday morning, at the ward round, would it have
22 been premature for you to believe that she was seriously
23 ill as opposed to -- a phrase which was used
24 yesterday -- a patient of concern? Had it got to that
25 stage?

1 A. To me, I think one understates it a bit that she was
2 a patient of concern. I think to me it felt like more
3 than that. I would have wanted to try and tell Mr and
4 Mr Roberts that in a way that I hope was sensitive, that
5 didn't completely take away their optimism. I would
6 have said it as a registrar at the time, so I would have
7 had to be pretty careful about what I said and not try
8 and overstate what I knew or thought I knew. And also,
9 try and do it, saying, "Look, I am going to try and talk
10 to someone else, a neurologist, who I think well might
11 be able to help us out more here and whom, I would have
12 hoped, tell you more". And I have to accept as
13 a clinician that we -- I -- talk to parents, try and
14 give an honest appraisal of how things are and what
15 I think is going on, and acknowledge that I don't always
16 get the message across and what I say isn't always what
17 parents pick up and remember and take on board. I feel
18 that that's probably something that comes with
19 experience as well. I hope I'm more experienced and
20 perhaps better at that now, trying to gauge a parent's
21 understanding of what I've told them, whether I've done
22 a good job or not about telling them.

23 MS ANYADIKE-DANES: We can pick up the witness statement as
24 to what they did understand at that time, which is
25 253/1, page 8. I think it's the answer to question

1 7(c).

2 MR QUINN: Mr Chairman, if I can come in for one moment
3 here. The parents are very concerned about this, and
4 you actually hit the nail on the head when you said the
5 parents went home that night not knowing, not aware.
6 Mr and Mrs Roberts have conveyed to me this morning that
7 they would like the inquiry to maybe try and unearth the
8 answers as to why they were let even go away at
9 lunchtime if this particular doctor thought Claire was
10 very unwell. They make that point because two factors
11 arise. Number 1, Claire was responding and was awake
12 and wasn't well, but was responding during the
13 examination by the doctor in the morning. And
14 therefore, that put the parents at ease, but now, over
15 two days, they have heard a very different picture.
16 They have heard a picture that would make them very
17 uneasy to leave the hospital at all, even at lunchtime,
18 never mind at 9.30 in the evening.

19 So perhaps we could ask two things: was Claire
20 responding and did she seem reasonably bright? The
21 grandparents will say she was still responding at
22 lunchtime.

23 Secondly, did this doctor in any way convey to the
24 parents the seriousness of the condition?

25 MS ANYADIKE-DANES: In fairness to the doctor, it should be

1 pointed out what they have put in their statement about
2 that, which I think appears at (c)(i) and (ii):

3 "Whether [you] expressed at any time during your
4 discussions [this is with Mr Roberts] his view of the
5 seriousness or otherwise of Claire's condition."

6 They say:

7 "Dr Sands did not express any view on the
8 seriousness or otherwise of Claire's condition."

9 The second question is:

10 "Any concerns about her condition."

11 And their answer to that is:

12 "Dr Sands did not express any concerns about
13 Claire's condition."

14 That is their recollection. That is their evidence.

15 Were you trying to communicate to them your concerns?

16 A. I believe I was, but again, I have to say, I wouldn't
17 have wanted to take away their optimism that Claire was
18 going to recover. And I didn't know what was going on,
19 I wasn't sure, but I thought there was something serious
20 going on.

21 Q. Before we go to that specific question about her
22 brightness and responsiveness and so forth, in your
23 view, what were you telling them then?

24 A. That I thought Claire had a major neurological problem,
25 that her consciousness level didn't seem normal to me

1 and to the ward round and, I think, to Claire's mum and
2 dad.

3 Q. And?

4 A. And that one possibility -- I believe we would have
5 mentioned to them the possibility that Claire was
6 fitting. I know Mr and Mrs Roberts have put in their
7 witness statement "experiencing some form of internal
8 fitting", and that may have been a form of words that
9 I may have used.

10 Q. Is there anything else you think you would have been
11 telling them?

12 A. I think I would have raised the issue about possible
13 infection causing some of Claire's problems, infection
14 that might have -- I probably wouldn't have used the
15 word "encephalitis", but may have felt there was an
16 infection also playing a part.

17 Q. Encephalitis is a particular kind of infection. We're
18 not talking about a more run-of-the-mill infection or
19 a tummy bug, if we're talking about viral illness.
20 Encephalitis and encephalopathy are in a completely
21 different league, I would anticipate, from that. So
22 even if you might not have used those terms because you
23 might not have thought they would understand what those
24 terms meant, did you try and interpret for them what
25 that was?

1 A. I think I did to some degree, yes, in terms of an
2 infection that might be causing a problem with Claire's
3 brain and thus the need to see a neurologist to get
4 specialist advice.

5 Q. And if you were telling them that sort of thing, do you
6 think that that is something that should have been
7 recorded, whether it's by your SHO or by the nurses?

8 A. I think it should have been recorded. Now, I would
9 record it myself.

10 Q. But you think it should have been recorded at the time?

11 A. That would have been the correct thing to do.

12 Q. Apart from anything else, so that anybody coming after
13 you -- particularly as you had in mind Dr Webb -- would
14 know, could appreciate, what level of understanding that
15 Claire's family already had.

16 A. Yes.

17 Q. I'm being directed to question 8(b):

18 "Describe, so far as you can recall, your
19 understanding of Claire's condition before you left the
20 hospital at around 13.00 based on your impression of her
21 and the information given to you by the doctors/nurses.

22 "My understanding of Claire's condition was that she
23 was unwell, lethargic and pale and that her sickness was
24 no more than a 24 to 48-hour tummy bug."

25 THE CHAIRMAN: If that's the impression they got, it's not

1 the impression that you meant to give.

2 A. No.

3 MS ANYADIKE-DANES: And it would be incorrect?

4 A. Mr and Mrs Roberts' impression would be incorrect?

5 Q. Yes.

6 A. That wasn't my impression and it's not the impression

7 that I thought I had given to Mr and Mrs Roberts.

8 Q. I understand and if they had that impression of their

9 daughter's condition, it would be incorrect?

10 A. Sorry, I'm not quite sure that ...

11 THE CHAIRMAN: If Mr and Mrs Roberts went off thinking that

12 what Claire had was no more than a 24 or 48-hour tummy

13 bug, that would be an incorrect impression?

14 A. From my point of view, yes.

15 THE CHAIRMAN: Let me take you back to a question Mr Quinn

16 had raised a few moments ago. Mr and Mrs Roberts'

17 memory is that Claire was responding, at least to some

18 degree, during her examination by you and that they want

19 you to be asked to confirm whether you agree with that,

20 that she was responding, I think, to some degree during

21 examination; is that correct?

22 A. I don't believe she was totally unresponsive.

23 I wouldn't disagree with that. It's a question of

24 degree.

25 THE CHAIRMAN: Mr Quinn used the phrase: did she seem

1 reasonably bright?

2 A. No.

3 THE CHAIRMAN: So any level of response was more limited

4 than that?

5 A. Yes.

6 MS ANYADIKE-DANES: Can I maybe put it in this way to you.

7 It's a hypothetical, so if you don't feel you can answer

8 it, please say so. But if, after that, the parents had

9 wanted to know whether it was safe for them to have gone

10 off, if they'd had some other engagement that was going

11 to take them away for a large part of the day, for

12 example, how would you have responded if they had wanted

13 at that stage to know how Claire's condition was and was

14 it okay for them just to go away for a little bit?

15 A. I think I would have suggested they stay if possible.

16 Not just because I thought Claire was unwell, but

17 because I thought the neurologist was going to come and

18 would probably want to talk to them.

19 Q. But perhaps also because of your concern over her

20 condition?

21 A. Yes.

22 Q. Thank you.

23 THE CHAIRMAN: It's 1.05. We'll break for lunch, doctor,

24 until 2 o'clock.

25 I think there's an issue, Mr McAlinden, that we

1 might have to deal with at 2 o'clock about a nursing
2 expert. I understand that a letter has arrived from DLS
3 while I have been sitting this morning, so I will look
4 at that and then decide whether we will deal with it at
5 2 o'clock. If you were ready to deal with it then, that
6 might be the appropriate time.

7 2 o'clock, ladies and gentlemen.

8 (1.05 pm)

9 (The Short Adjournment)

10 (2.00 pm)

11 (Delay in proceedings)

12 (2.08 pm)

13 Discussion

14 THE CHAIRMAN: Mr McAlinden, just to explain to everybody
15 the point that is under discussion, we received
16 yesterday a request from DLS, on behalf of the
17 Belfast Trust, authority to release to a nursing expert
18 papers, including the inquiry's independent expert
19 report from Ms Sally Ramsay and the nurses' witness
20 statements. The purpose of that, we were told
21 initially, was to obtain an independent expert's opinion
22 in respect of Ms Ramsay's report. That has been
23 clarified at my instigation this morning and I think
24 now, Mr McAlinden, the remit of the report is to obtain
25 an independent nursing report from a nursing expert,

1 which would be a critique of Ms Ramsay's report, and
2 which would also address the quality of nursing care
3 provided to Claire.

4 MR McALINDEN: Yes.

5 THE CHAIRMAN: In the inquiry's procedures, the hearing
6 procedures, there is a provision at paragraph 6, which
7 deals with witnesses and expert witnesses being called.
8 What it requires in general terms is that a party has to
9 provide any written evidence at least 28 days before the
10 opening of that segment of the inquiry to which the
11 evidence relates. And also:

12 "To provide additional documents, such as all
13 reports, statements, letters, et cetera, written by or
14 on behalf of the proposed witness."

15 MR McALINDEN: Yes.

16 THE CHAIRMAN: In this current situation, the experts'
17 reports were sent out in Claire's clinical hearing on
18 19 July. I understand from what we've now been told by
19 this morning's letter that there were then consultations
20 held in late August and, at that point, concerns were
21 raised about, in essence, whether Ms Ramsay was too
22 harsh.

23 MR McALINDEN: Yes.

24 THE CHAIRMAN: And you have been trying since then to find
25 a nursing expert.

1 If I pause at that point. I entirely accept the
2 difficulties which anybody would have in finding an
3 expert who's willing to give evidence and provide
4 a report to the inquiry because we have been repeatedly
5 delayed over the last few years in finding experts
6 willing to engage. So I'm not concerned about the
7 length of time which it has taken to find an expert who
8 is willing to report. That's not a problem. I also
9 accept that when papers were sent out just after
10 12 July, by the time they were circulated and
11 consultations start, you are up to mid to late August,
12 and that's not a problem either.

13 Subject to anything which is said by any other
14 party, my concern is this: part of a reason for getting
15 a report, in effect, is to see whether you get a report
16 which, to put it bluntly, is more favourable to the
17 nurses than Ms Ramsay's report.

18 MR McALINDEN: Yes.

19 THE CHAIRMAN: So my position, subject to submissions,
20 is that I will authorise the release to a nursing expert
21 the papers which went to Ms Ramsay and the subsequent
22 nurses' witness statements, but not Ms Ramsay's report
23 because if we're going to have an independent nursing
24 expert to give a report, I want that nursing expert not
25 to have a message, express or implied, that the purpose

1 of the report is to attack Ms Ramsay.

2 MR McALINDEN: Yes.

3 THE CHAIRMAN: So do you have any contrary view to put on

4 that?

5 MR McALINDEN: What I would hope that she would be able to

6 do, if she hasn't sight of the report, is that the

7 letter of instructions to her could highlight the issues

8 that have been raised so that she can, in the timescale

9 permitted, really focus in on those issues, so that

10 there would be a twofold response from this

11 expert: first of all, a commentary on the care provided

12 by the nurses; and, secondly, highlighting or dealing

13 with the issues that have already been highlighted by

14 Ms Ramsay in her report.

15 THE CHAIRMAN: But that's really getting Ms Ramsay's report

16 by another method, isn't it? That letter of instruction

17 to the expert who you've now identified would be, in

18 essence, summarising what Ms Ramsay's criticisms are and

19 asking does she agree with them.

20 MR McALINDEN: Yes.

21 THE CHAIRMAN: We may as well give them Ms Ramsay's report

22 then. That doesn't deal with the issue at all, with

23 respect. If you want an independent nursing expert's

24 report, which may or may not take issue with what

25 Ms Ramsay has said, then I don't agree that the Trust's

1 independent expert should be armed with Ms Ramsay's
2 report or a summary of the criticisms which she makes in
3 her report. I want that expert to come with a fresh
4 approach, which may or may not chime exactly or largely
5 with Ms Ramsay's, but to the extent that they are the
6 same, that's fine, and to the extent that they are
7 different, we can then deal with that in a way which
8 I'll need to come on it in a few minutes.

9 MR McALINDEN: There is a logistical issue, Mr Chairman, of
10 whether such a report would be available within the
11 timescale that's foreseeable for the hearing of the
12 nurses' evidence and also for the hearing of evidence
13 from Ms Ramsay. It certainly wouldn't be the Trust's
14 wish or desire that this matter should be put back,
15 pending the production of such a report. So if a report
16 cannot be obtained within the timescale, within the
17 likely timescale that's envisaged for the hearing of
18 this evidence, then the Trust would take the matter no
19 further. If a report can be available, but the author
20 of the report is not available to give evidence at any
21 time convenient to the inquiry, the purpose in essence
22 of obtaining such a report for the nurses was simply to
23 obtain expert advice on the issues raised by Ms Ramsay
24 in her report in order to ascertain whether questions
25 could be submitted to the inquiry counsel to put to

1 Ms Ramsay during her oral evidence. It wasn't actually
2 envisaged that another expert should be added to the
3 list of witnesses and this inquiry should be postponed
4 until that expert is available for hearing.

5 So in a sense, for that exercise to be in any way
6 successful or purposeful, the author of that report
7 would have to have access to Ms Ramsay's report in order
8 to address the issues so that instructions could be
9 obtained by the Trust and then forwarded to counsel for
10 the inquiry to address to Ms Ramsay.

11 THE CHAIRMAN: There's a couple of issues about the timing,
12 which trouble me. One is, let's suppose that if this
13 goes ahead, that the expert identified by the Trust is
14 actually critical of the nurses. And let's suppose
15 she's critical of the nurses in a way that Ms Ramsay
16 wasn't. We know from the history of this inquiry, for
17 instance Professor Neville against Dr Scott-Jupp, to the
18 extent that they are critical, their criticisms vary,
19 and on some points they're milder or more gentle on one
20 doctor than they are on another, and then they switch.

21 MR McALINDEN: And in the context of nursing care, we have
22 the report from Sarah Chapman, who was the coroner's
23 expert, who was in no way critical of the nursing care
24 in this case.

25 THE CHAIRMAN: She was particularly involved in the PSNI

1 investigation, wasn't she?

2 MR McALINDEN: Yes.

3 THE CHAIRMAN: In the PSNI investigation, the issue which
4 was being addressed, fundamentally, was whether there
5 was a basis for bringing any criminal charges against
6 the nurses, which is something of a different scale to
7 anything that I'm involved in.

8 MR McALINDEN: My recollection of it was it was not a case
9 of her saying that any shortcomings didn't reach the
10 criminal standard; it was a case of her saying that she
11 didn't consider that there were any significant
12 shortcomings.

13 THE CHAIRMAN: Sorry, I think that's broadly right, but
14 you have to consider the context in which she was
15 writing the report, which was for the purposes of
16 investigating whether any crime had been committed.
17 What concerns me is -- I'm sorry all parties don't have
18 this correspondence, but I think it's been copied to the
19 ones most directly affected. Mr Quinn, I think you have
20 it and, Mr Campbell, you have it.

21 What concerns me a bit about this is that you're
22 agreeing you don't want to hold back the inquiry, you're
23 not asking for anything to be adjourned, the nurses will
24 go ahead and give their evidence. What happens
25 if we then do have a report from your expert, which is

1 more critical of one or two of the nurses? In essence,
2 they'll have to be recalled, won't they, on those
3 points?

4 MR McALINDEN: Yes.

5 THE CHAIRMAN: Okay. Let me hear -- sorry, you go on ahead.

6 MR McALINDEN: The only point I would make, Mr Chairman, is
7 this: in order for this exercise, which I would envisage
8 would be important in this case, to take place, I would
9 respectfully submit that the expert retained on behalf
10 of the Trust should have access to the nursing expert
11 report from Sally Ramsay just as other experts retained
12 by you in this case have had access to not only the
13 statements of the various witnesses, but to other
14 experts' reports.

15 THE CHAIRMAN: Typically, by and large, they haven't,
16 actually. What we've tried to do as much as possible is
17 not to give one expert another expert's report until the
18 second expert has provided a report. An exchange does
19 then follow. But we have typically not, for instance,
20 sent Dr Scott-Jupp, before he did his first report, any
21 report we had from Professor Neville or vice versa.
22 I think it's happened in one or two occasions in
23 particular circumstances, but generally we've been
24 avoiding that in order to avoid this mischief.

25 MR McALINDEN: I would be content with that if a nursing

1 expert could produce a report and then, as
2 a supplementary, comment on the report from Ms Ramsay.
3 The only difficulty I envisage is that that prolongs the
4 time point, and in order to shorten the timescale
5 involved it might be, in this particular exceptional
6 circumstance, necessary to provide the expert with all
7 the information at this stage.

8 THE CHAIRMAN: Okay, thank you.

9 Mr Quinn, do you have anything?

10 MR QUINN: Yes, Mr Chairman. The concerns that we have are
11 really on a time point. That is the main concern. We
12 want to avoid delay. So I want to make that point for
13 the record.

14 The second point to make is that this report -- and
15 I listened very carefully to your comments earlier and
16 they've touched upon it. This report makes this inquiry
17 more adversarial than inquisitorial. And certainly if
18 you release the report to the Trust's nursing expert,
19 that becomes even more of a contest then. It becomes
20 a ping-pong match, with respect. So that's the other
21 point I want to make.

22 In essence, we're in your hands, Mr Chairman, but we
23 just don't want delay and this to turn into a contest.
24 We want it as it is now: we want to have questions asked
25 and fairly answered.

1 THE CHAIRMAN: Yes, on the basis that Mr and Mrs Roberts and
2 various other people have been waiting for too long
3 already?

4 MR QUINN: I should follow-up and make the point that it may
5 set a precedent that when the other children come along
6 to be investigated that other reports are then produced,
7 which could then add more delay.

8 THE CHAIRMAN: Mr Campbell?

9 MR CAMPBELL: On behalf of Nurse McCann and Nurse Field, my
10 principal concern would be the possibility of delay,
11 with the Trust's confirmation that they don't envisage
12 any delay being caused by this report being obtained, I
13 would be basically neutral as to whether such a report
14 is obtained or not.

15 THE CHAIRMAN: Okay, thank you.

16 Mr McAlinden, did the Trust consider approaching
17 Miss Chapman? Because she's already familiar with the
18 papers and it's not exactly the same as Mr Koffman was
19 in Adam's case. But Mr Koffman had provided a report at
20 an earlier stage, not for the inquiry, in Adam's case,
21 and was then, at the instigation of Mr Keane's
22 solicitors, the inquiry agreed to call him as a witness.

23 MR McALINDEN: Rightly or wrongly, the Trust decided
24 it would not approach Miss Chapman simply because she
25 had already given an opinion which was, in a sense,

1 favourable to the nurses, and it would appear that if
2 the Trust did approach Miss Chapman, it was simply
3 approaching her on the basis that she would give
4 favourable evidence. It was for that reason that no
5 approach was made and it was decided to try to ascertain
6 the identity of a new expert to instruct.

7 THE CHAIRMAN: Okay. Thank you. Ms Anyadike-Danes?

8 MS ANYADIKE-DANES: Mr Chairman, one point to make first,
9 and that is I think my learned friend Mr McAlinden
10 referred to the letter of instruction. If, Mr Chairman,
11 you had the view that the appropriate way was in fact
12 was to put the new expert on the same footing, so far as
13 that could be done, as the inquiry's expert, it might be
14 helpful that not only did that expert receive the same
15 documents as the inquiry's expert received, but also
16 received the same brief, so, so far as possible, that
17 expert was in the same place.

18 THE CHAIRMAN: So she would know at least what brief had
19 gone to the inquiry's expert?

20 MS ANYADIKE-DANES: Yes, and with the addition of the
21 nurses' witness statements, because the inquiry's expert
22 has already seen that and that has not given rise to her
23 wishing to put in a supplemental report. That's one
24 point.

25 The other point would be to pick up on something my

1 learned friend Mr Quinn made. You have been throughout
2 this inquiry -- and it's indeed in all our procedures --
3 that this is an inquisitorial exercise, not an
4 adversarial one, and there is a concern if people feel
5 that some experts are harsher on them than they would
6 like them to be, that that would create some sort of
7 precedent -- and there is still a way to go in this
8 inquiry -- of people wanting to consult alternative
9 experts, which they can do, but in any event to use them
10 as rebuttal witnesses. That could not only change the
11 nature and character of the inquiry, which is your
12 inquiry, but also prolong it without it necessarily
13 assisting you in the task you have before you.

14 THE CHAIRMAN: Thank you. I'm naturally attracted by the
15 idea that we don't need any more experts. I think
16 I would be in very difficult territory legally if I said
17 no party is entitled to seek to engage an independent
18 expert to give evidence on any specific area, which is
19 causing concern to the inquiry.

20 For that reason, Mr McAlinden, I'm going to agree to
21 the Trust engaging the expert who has been identified.
22 I will not, however, agree to that expert receiving
23 Ms Ramsay's report until she has provided a report of
24 her own.

25 So the inquiry can arrange to provide to your

1 instructing solicitor -- in fact, you already have brief
2 which went to Ms Ramsay --

3 MR McALINDEN: Yes.

4 THE CHAIRMAN: -- because it's in the expert papers, and you
5 probably have that on CD-ROM also.

6 MR McALINDEN: Yes.

7 THE CHAIRMAN: You have the brief and the documentation,
8 I think, is identified in that. If there's any query
9 about the documentation, please liaise with us between
10 now and Monday. In addition to that, the other
11 documentation which can go are the nurses' witness
12 statements for the inquiry.

13 I really would like to know when the Trust's expert
14 will provide a report.

15 MR McALINDEN: I certainly will be able to give you an
16 update in relation to that matter very early next week.
17 I understand the expert is on holiday this weekend and
18 could not be contacted this weekend about a timescale as
19 such, but I would hope to be able to advise you,
20 Mr Chairman, in correspondence very early next week as
21 to the likely timescale.

22 THE CHAIRMAN: Ms Ramsay is due to give evidence three weeks
23 from yesterday.

24 MR McALINDEN: Yes.

25 THE CHAIRMAN: And it seems to me that there will inevitably

1 be difficulties if the report from your expert, even
2 with a supplementary report dealing with Ms Ramsay's
3 criticisms, isn't available before that.

4 MS ANYADIKE-DANES: There might be some suggestion that if
5 the report was maybe going to come in later, maybe the
6 Trust would choose not to use it. Whenever the report
7 comes, I would ask that we see it. I think that would
8 be relevant.

9 MR McALINDEN: I hope the correspondence made clear that
10 when the report is produced, it will be furnished
11 immediately to the inquiry.

12 THE CHAIRMAN: There are a couple of conditions in
13 paragraph 6, sub-paragraph 9, and I presume that they
14 will be met.

15 MR McALINDEN: They will be.

16 THE CHAIRMAN: Thank you very much.

17 Dr Sands, please.

18 DR ANDREW SANDS (continued)

19 Questions from MS ANYADIKE-DANES (continued)

20 MS ANYADIKE-DANES: Good afternoon, Dr Sands.

21 I think, when we left off, we were dealing with
22 discussions that you might have had with the Roberts
23 family, either during the course of that ward round or
24 at the end of it, and what impression they might have
25 been left with about their child's condition.

1 Dr Scott-Jupp has dealt with what, in his view, in 1996,
2 the parents ought to have been being told. I think we
3 see that at 234-003-007.

4 If one summarises from that page:

5 "Any changes in diagnosis, the possible reasons for
6 any deterioration and the management plan and any
7 significant neurological deterioration."

8 Although I think he concedes that he wouldn't expect
9 the parents to be told that periodic neurological
10 assessments and/or Glasgow Coma Scale recordings were
11 being done. Leaving that aside, would you accept that's
12 the sort of information that should be provided to the
13 parents?

14 A. Yes, I think that's a fairly full list of information
15 that might be passed on to parents, perhaps not all at
16 the one time. Again, sometimes this information is
17 given over a period of time, particularly to reflect any
18 changes in a child's condition. I think the points made
19 are well made though.

20 Q. Can I ask you this, though: however it was explained to
21 them, or over what period of time you chose to do it, is
22 it the case that parents should not be left in any doubt
23 as to whether their child is considered seriously ill by
24 the clinicians treating her or the nurses treating her?

25 A. I think parents should be fully informed in a way that

1 they will understand and I do have to say that I think
2 we as clinicians -- and me as a clinician -- haven't
3 always taken care to ensure that a parent has absolutely
4 understood what I've said. That's something I've learnt
5 over time and I think still we -- and still I -- don't
6 always achieve that understanding in parents.

7 Q. I see what you are saying. But in any event, so that
8 we're clear: if the clinician feels the child they're
9 examining is seriously ill, at some point in time, the
10 parents need to know that?

11 A. Yes.

12 Q. Would that sum that up?

13 A. Yes.

14 Q. Given that you had not been in your position for very
15 long and you were missing, at that stage, your
16 consultant, if I can put it that way, is that sort of
17 discussion to really convey to the parents exactly where
18 you think their daughter's condition lay in terms of the
19 spectrum of seriousness, is that something that you
20 would have wanted Dr Steen to have discussed with the
21 parents at some point?

22 A. I think a consultant, so by that I mean Dr Steen or
23 Dr Webb.

24 Q. Would it have made any difference in relation to
25 Dr Steen since that was Claire's named consultant?

1 A. Again, if Claire's condition was felt to be acknowledged
2 to be a neurological problem, I think it would be
3 reasonable that a neurologist would give that advice,
4 that extra information, that more definitive
5 information.

6 Q. So at some point in time, at least at consultant level,
7 for that discussion to happen?

8 A. Yes.

9 Q. That obviously wasn't going to happen at the ward round
10 because neither Dr Steen was there and you hadn't had an
11 opportunity to locate Dr Webb and brief him on it. Can
12 I get some sense from you as to when you think that kind
13 of discussion, all things being equal, ought really to
14 have been had with Claire's parents?

15 A. I think the short answer to that is as early as
16 possible.

17 Q. Some time before lunch?

18 A. If possible.

19 Q. Thank you.

20 THE CHAIRMAN: Well, at least by lunchtime or when the ward
21 round is finished, as I understand what you're saying,
22 doctor, what you would have liked them to understand
23 from you is that you were worried about Claire and you
24 weren't sure what exactly was wrong with her, that
25 wasn't apparent, and for that reason, you were now going

1 to bring in a specialist neurologist, who would help to
2 identify what's wrong and hopefully you would be in
3 a position or he would be in a better position to advise
4 them over the next hour or two.

5 A. Yes.

6 THE CHAIRMAN: That doesn't appear to be what they picked up
7 at all, sure it isn't.

8 A. I would agree.

9 MS ANYADIKE-DANES: Then if we move on to what happened
10 after the ward round, which is that you're trying to
11 locate Dr Webb.

12 MR GREEN: Sir, if we're moving on from the ward round and
13 the diagnosis as issues, may I raise a matter? It's
14 in relation to the reference before lunch to
15 Professor Neville's report. I had rather hoped that, as
16 a matter of balance, my learned friend would put what
17 Dr Scott-Jupp said about the impression of non-fitting
18 status. Because it's an example of where one expert is
19 significantly more critical than another. And I simply
20 raise it because I have well in mind what my learned
21 friend said about these proceedings being inquisitorial
22 and it's therefore important that they're characterised
23 by balance, not polemic.

24 THE CHAIRMAN: Give us the reference.

25 MR GREEN: 234-002-004. If we go down in the first

1 paragraph just to where the cross is there, in the
2 middle of that sentence it starts:

3 "This diagnosis was not unreasonable, but other
4 differentials probably should have been considered
5 at the time."

6 It then goes on to deal with the issue of an EEG
7 being desirable, and then in the paragraph below, with
8 an asterisk at the side of it, a reference to Dr Webb's
9 statement, and the concession to the effect that if no
10 urgent EEG service was available at the Children's
11 Hospital at the time, that the particular criticism
12 in the paragraph above may therefore be unjustified.

13 I simply raise it because Ms Anyadike-Danes, before
14 lunch, put it to Dr Sands that Professor Neville was
15 critical of the provisional diagnosis. In the
16 interests, as I say, of balance, I would simply point
17 out that Dr Scott-Jupp's position seems to be somewhat
18 different.

19 THE CHAIRMAN: Okay, thank you.

20 MS ANYADIKE-DANES: Thank you very much. I do try and
21 present a balanced view, and if anybody, as I circulate
22 round and ask for their comments, ever thinks that there
23 is something else I can put, I'm always receptive to
24 that and seek it throughout the day. In any event,
25 thank you for that.

1 Mr Chairman, you will see there the entirety of what
2 Dr Scott-Jupp has said in relation to that diagnosis.
3 THE CHAIRMAN: I've got it, thank you.
4 MS ANYADIKE-DANES: In due course we will deal with the
5 issue of the urgent EEG.
6 Mr Chairman, you'll be aware of the fact that
7 in that file 150, there was a patient of Dr Webb, who in
8 fact had an EEG that morning, and unfortunately we don't
9 have Dr Webb here to have found out how, if it was
10 indeed possible, for one child to be substituted for
11 another. The Trust, I think, has also given us
12 information to the effect that there were, I think, five
13 children who had EEGs in addition to that during that
14 day, and we hope to find more information out about the
15 possibilities of that during the day. Thank you very
16 much indeed.
17 THE CHAIRMAN: That would primarily be a point for Dr Webb
18 because, as I understand it, there can only be any
19 bumping in the EEG queue at the instigation of the
20 neurologist.
21 MS ANYADIKE-DANES: That's correct.
22 THE CHAIRMAN: So while Dr Sands might convey to Dr Webb how
23 concerned he is about the condition and that is why he's
24 bringing him in, when he does bring in Dr Webb, if
25 Dr Webb isn't so concerned, he will not bump Claire

1 in the queue --

2 MS ANYADIKE-DANES: That's correct.

3 THE CHAIRMAN: -- or he will have an idea, which Dr Sands

4 won't possibly have, about what the urgency is of the

5 people who are in the queued for an EEG.

6 MS ANYADIKE-DANES: That's correct. I think Dr Scott-Jupp's

7 point was not necessarily that. He was expressing some

8 surprise -- it's just below that first highlighting --

9 that there was no record of a discussion about

10 attempting to do that, that that is a discussion that

11 Dr Sands might have had with Dr Webb. I think he

12 concedes himself he might have had a discussion like,

13 that although ultimately it will be a matter for

14 Dr Webb.

15 That's just where I'm going to now, discussions with

16 Dr Webb. After that ward round, is it a priority of

17 yours to try and locate Dr Webb?

18 A. Yes.

19 Q. And I think I asked you this -- and forgive me if I did

20 and you've already answered it -- did you think of

21 trying, at that stage, to notify Dr Steen that you are

22 trying to seek a specialist opinion?

23 A. I don't recall whether I did try and contact Dr Steen at

24 that point or perhaps knew that she -- it wasn't going

25 to be easy to get Dr Steen just at that time. So

1 I can't clearly recall my thought processes at that
2 point.

3 Q. If you thought you could get hold of her, would you have
4 tried to let her know that that was your take on matters
5 and that's who you were going to seek specialist advice
6 from?

7 A. I'm not sure exactly what order I would have done things
8 in as I wouldn't have wanted to delay or miss an
9 opportunity to get to Dr Webb.

10 Q. But at some point, you would have been telling her that?

11 A. Yes.

12 Q. Thank you. Can you help us with exactly what your
13 discussion, so far as you can, with Dr Webb would have
14 included?

15 A. Here I have to try and reconstruct what I might have
16 done at the time rather than have a definite memory,
17 except I do remember talking about a CT scan.

18 Q. You have a definite memory of that?

19 A. Of a CT scan being part of the discussion.

20 Q. Do you have a definite memory of anything else in that
21 discussion?

22 A. I don't.

23 Q. I understand. So doing the best you can, and everybody
24 else has been pretty much in your situation so far,
25 can you try and help us with what you think you would

1 have wanted to discuss with Dr Webb?

2 A. I think I would have come to him with a clinical history
3 and said, "This is a girl who was admitted", what
4 Claire's problems were, maybe a little bit about her
5 background history, what her physical findings were on
6 examination and what the concerns -- maybe from the time
7 of admission and indeed as part of the ward round
8 examination -- what the concerns currently were.

9 Q. Would have you conveyed to him that you thought she
10 might have deteriorated since she had first been
11 admitted?

12 A. That I'm not sure of.

13 MS ANYADIKE-DANES: I understand.

14 THE CHAIRMAN: Surely he would have asked you in this
15 discussion, "How has she been responding?"

16 A. In which case I would have done my best to answer that.

17 THE CHAIRMAN: It's a bit unlikely that there would not have
18 been some discussion about how she had been since she
19 came in on the previous evening.

20 A. Yes, I think as part of her history, yes, that probably
21 would have been discussed.

22 MS ANYADIKE-DANES: And I think elsewhere in your witness
23 statement you think you raised the issue of rectal
24 diazepam with him.

25 A. Yes.

1 Q. That might have indicated to you, might it not, that you
2 had said something about her condition because the
3 seizure issue, if I can put it that way, was only
4 a query from the previous evening with Dr O'Hare?

5 A. Yes.

6 Q. And you've actually formed an impression about it, and
7 actually thought about something which was, effectively,
8 an anticonvulsant and therefore seeking to address that?

9 A. Yes.

10 Q. So that would mark a deterioration, is that right, in
11 your mind?

12 A. Not necessarily. If it had been something that had been
13 there when Dr O'Hare was seeing Claire as well, because
14 her neurology seemed to be quite abnormal at that stage
15 as well. So it might have difficult to determine
16 whether it was something that had been fluctuating,
17 perhaps had been quite bad at one at that stage, had
18 improved at 12 midnight or thereabouts, and perhaps had
19 gone back to some degree by the time of the ward round.
20 So it may have been a fluctuating picture is maybe how
21 I would have conveyed it as I understood it.

22 Q. It may be that you didn't know sufficient at that time
23 about the non-fitting status. But is that
24 a characteristic of it, that it can fluctuate in that
25 way or does it go in one direction?

1 A. I don't know, but I think seizure disorders be variable.
2 They're could be that variability, I would suspect,
3 although it's not something I know too much about.
4 Q. In any event, you would have presented that to him?
5 A. Yes.
6 Q. Can you think of anything else that you might have told
7 him about?
8 A. I think we probably would have mentioned -- in
9 discussion about a CT scan I think I would have wanted
10 to say why a CT scan or why the ward round and I though
11 a CT scan would be helpful. That may have raised the
12 issue of possible brain infection or encephalitis.
13 Q. Do you think you might have mentioned encephalitis to
14 him then?
15 A. Yes, because I think I would have needed to have some --
16 I think if I came to Dr Webb and said, "I wonder about
17 a CT scan", I would have needed to say why. And again,
18 I'm having to reconstruct that.
19 Q. I understand that. Have you any sense of how long you
20 might have been having that discussion with Dr Webb?
21 A. Not very long.
22 Q. And where it might have been taking place?
23 A. Although I can picture the room, I can't picture it
24 exactly, where it is in the Children's Hospital. It
25 wasn't in Paul Ward and it wasn't along the main

1 corridor. I think it was in a room off the main
2 corridor somewhere where I actually found Dr Webb and
3 spoke to him.

4 Q. 138/1, page 5, and I think it's the answer to question
5 2(a). There we are:

6 "State the time at which Dr Sands first contacted
7 you, the means and nature of the contact, what you
8 discussed at that time, and whether this was prior to
9 Dr Sands coming to talk to you in person."

10 THE CHAIRMAN: We took this a bit out of order this morning,
11 didn't we? We've been through this.

12 You don't think it was as late as 2 o'clock --

13 A. No.

14 THE CHAIRMAN: -- or 1.45/2-ish, which is what he suggests
15 at 2(b).

16 A. I think that's correct. I don't think it was as late as
17 that.

18 MS ANYADIKE-DANES: Leaving aside the time point, I was
19 actually bringing you back, we had seen it before, but
20 I was bringing you back more now to look at the
21 substance of what you were discussing. Although he says
22 he can't remember the exact details, he thinks you were
23 seeking advice on the management of the child who you
24 felt had non-fitting status. So you had communicated
25 your impression to him, and you were seeking advice on

1 what medication to prescribe for further seizures and
2 that you wanted him to assess Claire and that you might
3 have asked for a CT scan. And then if we go over the
4 page --

5 THE CHAIRMAN: Can we stop there and ask: doctor, to what
6 extent do you agree or disagree with what Dr Webb
7 recalls at 2(a)?

8 A. I think that has most of the key elements in the
9 discussion, that that was the impression of possible
10 non-fitting status, that we were thinking about diazepam
11 as a possible treatment, and that I did want him to
12 assess Claire and that I did mention a CT scan, but
13 I think I probably would have gone on, or I think
14 I would have expected Dr Webb to say: why do you want
15 a CT scan?

16 MS ANYADIKE-DANES: I'm going to go over the page because
17 I think, in fairness to you, he does go on. Page 6.
18 So:

19 "It's likely that we discussed the possible
20 differential diagnoses, including meningoencephalitis
21 and epileptic encephalopathy. I would have recommended
22 regular neurological nursing assessments of the Glasgow
23 Coma Scale."

24 So that's the other part. Would you recollect that?

25 A. I don't. I don't, but again I could try and reconstruct

1 it and think that that may not be unreasonable. I don't
2 quite know whether it was Dr Webb or a result of the
3 ward round that the Glasgow Coma Scale observations, the
4 neuro observations, were started. And I've said that in
5 witness statements, that I'm not certain whether they
6 were already started prior to my going to speak to
7 Dr Webb or following on from my discussion with him.

8 Q. If they started prior to that, is that because you
9 directed that that should have happened at the ward
10 round?

11 A. If so, then it would have been part of the ward round --
12 as a result of the ward round.

13 Q. Is that something that should have been noted as to when
14 they were to start?

15 A. Yes.

16 Q. They, in fact, appear to have started at 1 o'clock --

17 A. Yes.

18 Q. -- but I will stand to be corrected. I'm not sure that
19 there's a record as to why they were being started at
20 that time.

21 A. Yes, I think the normal observations seemed to stop --
22 or the routine observations seemed to stop at 12 and the
23 neuro observations seem to begin at 1. I can't be
24 certain whether it was a result of the ward round or
25 because of Dr Webb's discussion with me.

1 Q. But if you were looking for matters that perhaps might
2 have been included by 1996 standards, in the ward round
3 note, that might have been one of them if that was
4 discussed?

5 A. Yes.

6 Q. Then you said that you don't actually remember the
7 encephalitis/encephalopathy matter being discussed.

8 A. I think -- I remember a little about this. I think
9 encephalitis was something that we had mentioned on the
10 ward round, and indeed in association with talking about
11 the CT scan, I expect that came up in conversation with
12 Dr Webb as to perhaps something that a CT scan might
13 help with.

14 Q. Yes.

15 A. I recall that encephalopathy, epileptic or otherwise,
16 was Dr Webb's term, not one that I thought of, not one
17 that I'd considered.

18 Q. So if you were having anything to do with
19 encephalopathy, that's because you had received some
20 kind of guidance from Dr Webb about it?

21 A. Probably he mentioned it to me. That's my recollection,
22 that encephalopathy was Dr Webb's word, and that he had
23 mentioned that to me, not that I'd mentioned it to him.

24 Q. Did you at that time, in 1996, understand what these
25 terms meant, how they would affect a patient's

1 presentation and actually what the underlying causes of
2 them might be?

3 A. My understanding of encephalitis would have been
4 limited, having not seen perhaps any cases of
5 encephalitis, of definite encephalitis. My
6 understanding would have been limited at that time. And
7 even more so of encephalopathy, I think, because it
8 seems to me now, and it seemed probably -- I'm sure it
9 would have seemed to me then a very broad term with many
10 possible features, and indeed an overlap between
11 encephalitis and encephalopathy when I look at the
12 textbooks now.

13 Q. Are you aware of having looked it up at the time?

14 A. I don't recall that I looked it up at the time.
15 I believe that I hoped that Dr Webb could give direction
16 as to where along the lines of encephalopathy he wanted
17 us to go. I think my understanding of it would have
18 been quite limited as to what he meant by that. I'm not
19 sure he put it in terms of epileptic encephalopathy to
20 me, which is a more clearly defined, perhaps a more ...
21 a narrower diagnosis rather than encephalopathy, which
22 seems to be a very wide diagnosis with many possible
23 elements to it.

24 Q. If you had had that discussion with him when these
25 things had been mentioned, so now you have three things

1 in your mind, you have the non-fitting status, the
2 encephalitis and the encephalopathy, given, as I think
3 you said, it was a rather brief discussion, when did you
4 think the plan for how to deal with all of that would
5 emerge?

6 A. Well, as I've said, I thought Dr Webb was going to lead
7 on that and would guide us as to how he wanted this
8 investigated managed. And I think again I would have
9 probably had a number of other things that I needed to
10 do as well in addition to trying to get some help for
11 Claire and get some guidance for the staff looking after
12 Claire, me included.

13 Q. Did you get any sense of urgency from Dr Webb that
14 if these are the differential diagnoses, that this is
15 really a very serious situation we're dealing with here?

16 A. I think he took me seriously. He listened to me, he
17 took me seriously and I was pleased that he agreed to
18 come and see Claire. I'm not sure that he specified
19 exactly when or how quickly he would come or be able to
20 come.

21 Q. Did this, so far as you are concerned, put Claire
22 slightly higher up the list of priority in terms of
23 concerns for you once you heard Dr Webb discuss her
24 condition in that way?

25 A. I don't recall that. I don't recall whether that did

1 cause that change in my thinking.

2 Q. Well, will you at least confirm that your concerns and

3 fears that what you had on your hands was a seriously

4 ill little girl -- did you have that confirmation?

5 A. Except that Dr Webb hadn't actually seen her so he could

6 have come along and said, "I don't think it's exactly as

7 you see it and things are different".

8 Q. I understand.

9 A. And we go in this direction, in fact.

10 Q. Yes. If we look at the notes, which we've had up

11 a number of times, 090-022-053. Just halfway down, the

12 addition to "non-fitting status" of

13 "encephalopathy/encephalitis". That's your handwriting,

14 is it?

15 A. It is.

16 Q. Do you know when you actually added that?

17 A. After speaking to Dr Webb, I came back to Allen Ward and

18 I put that down in the notes. I appreciate it's not

19 signed and dated and timed.

20 Q. Should it have been?

21 A. Yes.

22 Q. When you put that in the notes, are you aware of

23 explaining to Dr Stevenson or Dr Stewart, if indeed

24 he was about, what this now meant in terms of Claire's

25 condition, if any of that was substantiated, if I can

1 put it that way?

2 A. I don't recall conversations with Dr Stevenson or

3 Dr Stewart immediately after that point. There may have

4 been, but I can't remember that.

5 Q. Well, if they just saw that in the notes, let's assume

6 that they did, and given that you yourself were not

7 entirely clear of the full ramifications of that, how

8 were they to understand what the implications of that

9 were for the attention they should be giving Claire

10 until Dr Webb arrived and gave better direction, if I

11 can put it that way?

12 A. Again, I think my anticipation was that they wouldn't

13 have to wait long for Dr Webb to come and provide that

14 guidance. I'm not sure whether I was there and able to

15 give some guidance or some discussion about it. I can't

16 remember on that point.

17 Q. Well, what was your feeling, if you can remember it?

18 It is at least possible that you went to the clinic at

19 2 o'clock. What is your feeling, leaving Claire and the

20 junior doctors and nurses in that situation?

21 A. I would have been concerned still about Claire, but

22 I would have felt that I had spoken to a specialist whom

23 I knew was going to come and review Claire, I hoped

24 soon. I believe at that stage I would have been trying

25 to or may already have spoken to Dr Steen to let her

1 know that I'd contacted Dr Webb and he's agreed to come
2 and see Claire. It wouldn't have allayed my concerns
3 completely about Claire, I don't believe so, but I would
4 have felt at least that we were making some progress and
5 that I had got senior help.

6 Q. Yes. Did you attempt to speak to Claire's family before
7 you left to appraise them of the fact that you had seen
8 Dr Webb or give them any indication as to what was to
9 happen next?

10 A. I don't remember, I can't remember that. I don't
11 remember whether Claire's mum and dad were there when
12 I came back from seeing Dr Webb. I'm not certain on
13 that point.

14 Q. Well, did you leave any message for the nurses to convey
15 to Claire's parents, which might have put their mind at
16 rest that you'd actually got in touch with
17 a neurological consultant who was going to come and see
18 Claire? Did you do that maybe?

19 A. I may have done, but I don't remember. I don't
20 remember.

21 Q. Would it have been appropriate for you to do that if
22 they hadn't been there for you to speak to?

23 A. Yes.

24 Q. And I presume that means that if they had been there,
25 you would have spoken to them about it?

1 A. Yes.

2 Q. From what you have said, when you said you got the
3 impression having explained all these matters to Dr Webb
4 and got his further thoughts about other things you
5 might be thinking of, if I can put it that way, that
6 he was going to come and see Claire, did you get any
7 indication of what you might have been doing in the
8 interim period, however long it took him to finally get
9 to Claire, from Dr Webb?

10 A. Sorry, just repeat that, please.

11 Q. Did you get any impression from Dr Webb as to what you
12 might be doing, how you might be treating Claire, what
13 might be going on whilst he was getting himself to see
14 her?

15 A. I don't remember specific instructions from Dr Webb
16 about what we should do, although I think he had agreed
17 that we should go ahead and give a dose of diazepam, and
18 he may well have been the one who said you should start
19 some neuro obs as well.

20 Q. Would you have asked him: what's the best thing for us
21 to be doing at this stage?

22 A. I think I would have had some discussion of that type,
23 perhaps: is there anything else that we should be doing
24 or anything else you'd like us to do?

25 Q. And the CT scan. Can you remember what he said about

1 the CT scan?

2 A. I don't. I'm not certain what he said to me at that
3 point or whether he only records it later in the notes
4 about a CT scan the following morning if the conscious
5 level -- Claire's conscious level doesn't improve. He
6 may have mentioned maybe tomorrow for the CT scan or he
7 may have only written that in the note subsequently.
8 I'm not certain of that.

9 Q. So that has happened, you have come back and you've
10 written this up in the notes. Is there anything else
11 that you do in relation to Claire -- let's call it the
12 morning? I should say longer than the morning. Take it
13 up to, say, 1 o'clock.

14 A. I'm not quite sure what else was happening at that
15 stage, whether there were other patients as well also
16 needing things done at that point. I'm not sure what
17 else we were doing with Claire. Perhaps we were still
18 trying to get notes from the Ulster Hospital as well at
19 that point. I'm not quite certain.

20 Q. Now that you mention the notes from the Ulster Hospital,
21 something was faxed through, was it not, from the
22 Ulster Hospital?

23 A. I believe so. I've seen it since.

24 Q. Well, do you recall ever seeing it at the time?

25 A. I don't recall seeing it at the time. I'm not sure

1 exactly what time the fax came through at. It may be
2 possible to see that now.

3 Q. I think we can try and find it. It starts at
4 090-013-015. It says the time is 3.15. Is this
5 something that would have been brought to your attention
6 as soon as it came in?

7 A. It might not have been, unless it contained something
8 that needed to be passed on urgently.

9 Q. I'm sure that you've looked at these medical notes and
10 records many times --

11 A. Yes.

12 Q. -- quite apart from at that time. Do you recall ever
13 reading this, apart from knowing it might have come in,
14 ever reading the two letters that came from Dr Gaston?

15 A. I may have done, perhaps at the end of the day, but
16 I don't have a clear recollection of reading them at the
17 time.

18 Q. Whenever it is that you became aware of what was in
19 them -- whether because you read them or somebody told
20 you what was in them -- can you recall whether it made
21 any difference so far as you are concerned to your
22 treatment of Claire?

23 A. My impression is it probably didn't make -- have a big
24 impact on treatment. That's my impression.

25 Q. And why might that have been?

1 A. Perhaps the information in this is not quite what
2 we would maybe hope for, not telling us terribly much
3 more about Claire's background, because I think
4 Dr Gaston maybe had actually come to see Claire or had
5 seen Claire only quite recently and perhaps just the
6 once or twice. And it may have been Dr Major in the
7 Ulster Hospital and Dr Gleadhill who maybe had been
8 responsible for quite a bit of Claire's care previously.

9 Q. When you had written as part of your plan in the medical
10 notes and records, "Discussed with Dr Gaston re previous
11 medical history", what exactly was it you were hoping to
12 learn that would have assisted you in your care and
13 treatment of Claire?

14 A. I don't remember exactly at the time, but I would
15 suspect it was what her neurological examination was
16 like as well as her usual level of functioning. But
17 I think mum and dad were able to provide most of that
18 very effectively.

19 Q. But in addition to receiving these two letters, which
20 are not directed to your specific queries at the time,
21 they are reporting letters as to what was happening.
22 Because it says, "Discussed with", did you actually
23 intend to speak to Dr Gaston and have a discussion with
24 Dr Gaston?

25 A. I don't think that was particularly the intention.

1 Q. Oh. That's not what the "D/W" means in the notes?

2 A. May I see that?

3 Q. Of course, I beg your pardon. It's 090-022-053. Sorry.

4 Do you see that under the plan? It's the last line of

5 the plan.

6 A. I think it means "Discussed with Dr Gaston to get

7 information about the past medical history". That's

8 what I take from it.

9 Q. Does that mean your preference would have been to

10 actually talk to Dr Gaston?

11 A. If that were possible, if he were available to do that.

12 I'm not sure he was and that may have been his secretary

13 who faxed those letters, which were the last available.

14 Q. Do you know what actually generated those particular

15 letters? Well, when it says, "Discussed with

16 Dr Gaston", one response to that might have been that

17 your SHO went away to see if you could get hold of

18 Dr Gaston on the phone and you could have had an actual

19 discussion with him. It might have been that the upshot

20 of it is: can't find Dr Gaston, he's going to fax

21 something through. Do you know what produced this fax?

22 A. I can try and help with that. I think that the fax was

23 addressed to Dr Neil Stewart, so I'm assuming Dr Stewart

24 probably phoned the Ulster Hospital to try to talk to

25 Dr Gaston to get some information and the result of that

1 seems to have been the faxed letters.

2 Q. Which may have been the most recent documents on the
3 file for example?

4 A. Yes.

5 Q. So far as you're concerned, you're not entirely sure why
6 there's no reference to you in the afternoon, but you
7 think it might be explained by the fact that you went
8 off to that clinic, and if you did go off to that
9 clinic, you'd be doing that at about 2 o'clock.

10 A. I probably would have gone a little bit before that, I
11 think.

12 Q. I think you did say earlier than that. In fairness to
13 you, I think you said 1.30 or thereabouts.

14 Dr Steen's evidence was that -- she has absolutely
15 no recollection of 22 October, so all she can help us
16 with is what her normal practice would be -- she would
17 leave -- unless there was a pressing reason to do
18 otherwise -- the Children's Hospital at about 1 o'clock.
19 And her practice was that she would try and get a sense
20 of where the children were at that stage before leaving.
21 A sort of final briefing, I suppose.

22 Were you aware at all of being in a position to give
23 Dr Steen any briefing about Claire at that stage?

24 A. No. No, I don't think I had ready access to Dr Steen at
25 that stage. I think, had she been in the Children's

1 Hospital, I would have contacted her directly. I would
2 have just gone to her, as I did to Dr Webb, and spoken
3 to her directly. And it may be that I couldn't get her
4 directly by phone, or I knew there was going to be at
5 least some delay because of whatever important issue she
6 had to deal with at that time. Perhaps a meeting that
7 was outside of the hospital. And that's my
8 understanding, that she wasn't in the hospital at that
9 point.

10 Q. And you are not there then when Dr Webb comes and
11 actually examines Claire at about 2 o'clock.

12 A. That's true.

13 Q. Did you leave any instructions for the junior doctors as
14 to what should happen when Dr Webb came, which you hoped
15 would be fairly speedily?

16 A. I think I hoped that I would be there --

17 Q. I understand that.

18 A. -- because I'd gone and spoken to him and would have
19 hoped to be there to discuss things with him. I'm not
20 sure if I did have a discussion with the senior house
21 officers to say: Dr Webb is coming and you need to make
22 him aware of this or that. I'm not sure that -- that we
23 did speak like that. They would have known that Dr Webb
24 was coming.

25 Q. That's what I was going to ask you. Would the nurses

1 have known that as well just in case the junior doctor
2 wasn't there?

3 A. I think so. I would have told the nurse in charge or
4 maybe the nurse looking after Claire that I'd been able
5 to contact Dr Webb and that he was coming.

6 Q. As it happens, it seems from the note that he came at
7 2 o'clock. Well, you can't tell that from the note, but
8 I think we have verified from other ways that that seems
9 to have been 2 o'clock. Had you left any kind of
10 instructions as to what should have happened if it was
11 very much more prolonged?

12 A. I don't recall if I left instructions of that sort.
13 I would have hoped that a nurse would have phoned me or
14 contacted one of the junior doctors, the SHOs, who would
15 have contacted me and said, "Dr Webb hasn't appeared
16 yet, we need to do something", or, "What do you want us
17 to do?"

18 Q. If they were in that situation where you had obviously
19 told them that you were expecting Dr Webb shortly, he
20 didn't come within that two hours, he hadn't come by the
21 time you left and there was still some time when he
22 wasn't coming, would you have expected your junior
23 doctors not just to have contacted you, but themselves
24 to have tried to get hold of Dr Webb?

25 A. Yes, I think that -- I don't think Dr Webb would have

1 minded that and I think that that would have been not
2 unheard of and perhaps reasonable in the circumstances.
3 Q. Or if it's passed to a clerk when everybody would have
4 realised that Dr Steen should be at her clinic in
5 Cupar Street, is that something you might have expected
6 them to alert her to?
7 A. Again that's possible, yes, assuming they knew where she
8 was -- and I think they would have done. A message
9 could then have been delivered to Cupar Street by
10 telephone.
11 Q. Is it correct then that you, the nurses, and junior
12 doctors would know how to reach her at Cupar Street?
13 A. I think if we were sure that Dr Steen was in
14 Cupar Street we would have the number for Cupar Street,
15 yes.
16 Q. Thank you. I think the first record of you actually
17 coming back, just so that we benchmark this, is round
18 about 5 o'clock when you administer the sodium
19 valproate. I think it is actually 5.15 when you
20 administer the sodium valproate. There's no record and
21 you have found no evidence of a record of you being on
22 the ward or dealing with Claire any time prior to that?
23 A. That's right.
24 Q. I mean other than the ward round, of course. As you
25 left -- you think you might have left to go to that

1 clinic -- who did you think was the consultant with
2 overall responsibility for Claire?

3 A. Obviously Dr Steen was the consultant under whom Claire
4 was admitted. I'd been to speak to Dr Webb, but in
5 fairness to him, he hadn't yet been to see Claire,
6 though I think he was already having -- having agreed to
7 see Claire, he was already involved to some degree. So
8 I think this is perhaps the beginning of a sharing of
9 care, but Dr Steen, I think, would have still been the
10 consultant in charge at that stage.

11 Q. We'll come back to when you come back at 5 o'clock. As
12 you left, your feeling that the consultant in charge,
13 not just because she's the named consultant, is actually
14 Dr Steen?

15 A. Yes.

16 Q. Did it worry you that you had not been actually able to
17 reach Dr Steen by the time you think you might have been
18 going off for possibly most of the afternoon?

19 A. Well, I may have talked to Dr Steen by that point.
20 I know that I talked to Dr Steen after I had spoken to
21 Dr Webb, but I can't time my conversation with Dr Steen
22 exactly.

23 Q. You have given some evidence as to that in your first
24 witness statement, and indeed in your second witness
25 statement. I'm not going to pull it up because it

1 essentially reflects what you have just said now. What
2 you have really said is you think you might have spoken
3 to her before you would have gone off, if that's what
4 you did, to the clinic at about 2 o'clock.

5 A. I certainly think I would have tried to do that at that
6 point. Whether in fact then Dr Steen phoned me back.
7 If I'd had to leave a message, if she was perhaps still
8 in a meeting, and then she had then returned my call, so
9 it may have been done in that fashion.

10 Q. What I'm trying to get a sense of, Dr Sands, or invite
11 you to help us with is: if you were having any
12 discussion at all with Dr Steen, whether because you
13 reached her first time or because she called you back,
14 is roughly when that might have been? Can you help with
15 that?

16 A. My recollection is that it was early in the afternoon,
17 that it wasn't at the end of the afternoon, but I really
18 can't be -- I cannot be precise about that, I'm sorry.

19 Q. Help us in this way: if you had gone to a clinic, when
20 you say "early in the afternoon", might it mean before
21 then or might it have been in the early part of such
22 a clinic?

23 A. It may have been in the early part of such a clinic.
24 That's possible. Or it may have been just before
25 I went.

1 Q. If you're talking about early in the afternoon, then in
2 terms of your knowledge of Claire's condition, that's
3 really before you could have known (a) that Dr Webb had
4 been to see her and (b) whatever the outcome was of that
5 examination. So if we were to pull up 310-001-001, and
6 if we were perhaps to stop -- if we don't look further
7 than, say, 1400 hours. From about 9 o'clock, is that
8 the information you would have had to have passed on to
9 her?

10 A. Yes.

11 Q. So she would have --

12 A. Perhaps I would have been able to also comment on
13 Claire's admission details, her presentation and that
14 type of --

15 Q. From the previous evening?

16 A. Yes.

17 Q. Yes. So you would have been able to tell her about
18 that, essentially what was found when she was at A&E,
19 what Dr O'Hare had found, what her serum sodium levels
20 had been at that stage, what IV fluids she was on, what
21 you found during your ward round, your concerns during
22 your ward round and Claire's parents' concerns the fact
23 that you had spoken to Dr Webb, he was going to see her,
24 and that he had confirmed the administration of rectal
25 diazepam and that she had been started on hourly

1 observations.

2 A. Yes.

3 Q. And you would have known that. And you would have known
4 what that initial observation was?

5 A. Yes.

6 Q. And that's the information that you would have had to
7 impart to her?

8 A. If that's the point that we spoke at, yes.

9 Q. And also, if your recollection is correct, that not only
10 had you started off with your impression that she might
11 have non-fitting status, but although he hadn't examined
12 her at that stage, but other possibilities were
13 encephalitis/encephalopathy?

14 A. Yes.

15 Q. If you had been conveying that to Dr Steen, apart from
16 keeping her up-to-date with it, how serious do you think
17 Claire's condition was that you were describing to her
18 in that way?

19 A. I think I would have described it in much the way
20 you have done, starting with how Claire had been
21 admitted, what her presentation was, and perhaps most
22 importantly what I felt, because I had just examined her
23 on the ward round, and what my specific concerns were.

24 THE CHAIRMAN: When you said to me before lunch that when
25 you saw her on the ward round she was more than

1 a patient of concern, is there a phrase beyond that
2 which might describe how seriously you regarded her?

3 A. "Neurologically very unwell" is a term that I've used,
4 I think in witness statements, and I think did describe
5 how I felt about Claire, that her problems appeared to
6 me to be neurological and of a serious nature.

7 MS ANYADIKE-DANES: What was your expectation that Dr Steen
8 might do as a result of realising her patient was
9 in that condition so far as you saw it at that stage?

10 A. I'm not sure. I'm not sure at the time what I would
11 have expected Dr Steen to do except to perhaps keep in
12 touch, preferably to talk to Dr Webb if at all possible.

13 Q. What would you have actually wanted her to do?

14 A. Ideally, I would have liked her there.

15 Q. Yes. And if you'd had the option of her coming back,
16 even if only at the end of her clinic, would you have
17 liked her to do that?

18 A. That would rather depend on what Dr Webb had been able
19 to do, was doing, how he felt about the case, whether he
20 felt he was on top of things. I don't think I would
21 have countermanded his instructions or suggestions and
22 said, "No, we'd better have Dr Steen's view on that as
23 well".

24 Q. No, but at that stage, he hasn't actually turned up when
25 you're reporting that.

1 A. Quite.

2 Q. So maybe I can help you another way: did you think she
3 was sufficiently ill that you would have liked her to
4 come from Cupar Street to see Claire?

5 A. I may not have suggested that there and then because
6 I believed that Dr Webb was coming, who was a paediatric
7 neurologist, perhaps duly accredited and perhaps a
8 consultant paediatrician as well as a paediatric
9 neurologist and he had agreed to come and see Claire.

10 If he had said, "No, I'm not going to be able to do
11 that", I think I certainly would have wanted Dr Steen to
12 be there and would have asked her if it was possible for
13 her to come.

14 THE CHAIRMAN: Then it seems to me to follow, Dr Sands, that
15 you're talking to Dr Steen after you'd spoken to
16 Dr Webb, but you're not sure exactly how long after
17 that. However, it's before you have any update about
18 what Dr Webb has found in his examination of Claire and
19 what he's recommended.

20 A. I believe that is the case, sir.

21 THE CHAIRMAN: Right. So that must surely be why your
22 primary expectation at that point would be that Dr Steen
23 and Dr Webb would talk. Because if Dr Webb's going to
24 come and see to Claire, the person who can best update
25 Dr Steen would be either Dr Webb directly or through

1 Dr Stevenson or Dr Stewart.

2 A. Yes, and perhaps I felt that Dr Steen was going to phone
3 back and speak to Dr Webb or somebody else who had been
4 there when Dr Webb had seen and assessed Claire.

5 MS ANYADIKE-DANES: In retrospect, because I think it is
6 only retrospect, do you think it would have been
7 preferable to have actually made a record somewhere in
8 the notes that you had contacted Dr Steen when you had
9 done it and what the substance of your communication had
10 been --

11 A. Yes.

12 Q. -- because that might, for example, have helped Dr Webb
13 or whomsoever is coming afterwards?

14 A. Yes. That would have been my practice, would be my
15 practice. I wonder now was it because when Dr Steen and
16 I spoke, whether I wasn't actually perhaps in Allen Ward
17 at the time and didn't have Claire's notes in front of
18 me to make a note. That may be an explanation. Or
19 I just didn't do it. That is I didn't make a note of
20 it.

21 Q. Dr Scott-Jupp has said in his report, I think
22 234-002-004 -- and I think maybe it goes on to 005 --
23 that he found it concerning that there is no record that
24 you discussed the case with Dr Steen, and if, as you
25 say, she was unavailable, that he thought that was

1 certainly unacceptable that that was the case, that she
2 was not available to you in a situation such as that.

3 A. I'm not suggesting that Dr Steen was unavailable by
4 telephone throughout the whole day because I know we
5 talked by telephone.

6 Q. Do you know if you talked more than once?

7 A. I don't know that. I can't be certain of that. I have
8 a clear recollection of one phone call and me describing
9 Dr Webb's involvement, and I believe that was after I'd
10 spoken to him. I think that that was probably before
11 his first attendance.

12 THE CHAIRMAN: Do you recall what Dr Steen's reaction was to
13 the information you were giving her about your own views
14 and the involvement of Dr Webb?

15 A. I don't recall, sir, what we discussed or what Dr Steen
16 said to me.

17 MS ANYADIKE-DANES: But leaving aside whether you thought it
18 was unacceptable or not, she wasn't where you would like
19 her to be in relation to Claire?

20 A. Ideally, ideally ... As I said, one consultant's good,
21 two consultants are even better.

22 Q. Okay. So what steps -- this is, I think, difficult
23 because you are imminently expecting Dr Webb, if I can
24 put it that way. But what steps do you take to ensure
25 that when you leave or are not available during the

1 afternoon for whatever reason, whatever period of time,
2 that these junior doctors actually understand what they
3 should be doing and how serious Claire's condition is?

4 A. I don't recall exactly what discussion we had with the
5 junior doctors or what discussion I had with the SHOs at
6 that time. I can't remember that. I think I would have
7 told them that I'd been to see Dr Webb, he said it was
8 okay to go ahead and give the diazepam, and we had
9 started CNS observations, that the Ulster Hospital were
10 being contacted. I'm not sure what further detail we
11 went into at that point. I just don't remember.

12 Q. Even though you can't remember the detail, would you
13 have wanted them to appreciate that Claire really was
14 very ill?

15 A. Yes, I would have wanted them to appreciate that
16 Claire -- it was my belief and it seemed that Dr Webb
17 didn't particularly disagree that she had a major
18 neurological problem.

19 Q. So you'd have wanted them to know that --

20 A. Yes.

21 Q. -- and the nurses to know that and appreciate that?

22 A. Yes.

23 Q. And is the responsibility for that, given that your
24 consultant isn't there, fall to you to communicate that?

25 A. I think there would have been a responsibility for me to

1 tell the junior staff my thoughts. I don't know to what
2 extent Dr Webb could have completely corroborated what
3 I'd thought on the ward round, so the nursing staff and
4 the junior medical staff would have had my thoughts from
5 the ward round, they would have had those there.

6 I would have told them what Dr Webb had said to me, but
7 I don't think he could have fully corroborated or agreed
8 with everything without having seen Claire.

9 Q. Then Dr Webb does come and see Claire and we have the
10 notes of that. If we pull up 090-022-053. He sees her
11 at about 2 o'clock even though it says "14". Maybe
12 1400 hours would have been more accurate. Anyway, he
13 sees her and he takes that history. You see what he
14 says on examination. Then if we go over the page to
15 054, then you see what he says about clonus and tone and
16 so on.

17 Then he gives his impression, mainly that he doesn't
18 have a clear idea, and you see his suggestions, starting
19 IV phenytoin, and he gives the formula for it, as stat
20 dose followed by an infusion and then hourly obs. So he
21 has got the hourly obs. Does that mean because the
22 hourly obs had already been instituted, does that mean
23 that he thinks that they should be continued? Is that
24 how one reads that?

25 A. Yes, I think he's just recording that it's happening.

1 Q. And the CT tomorrow if she doesn't wake up. You have
2 the note at 2.30. That's a note by Dr Stevenson. And
3 then over the page to 022-055. You have a note that
4 Dr Stevenson records of Dr Webb's attendance, which
5 would seem to be at about 3 o'clock. And then you have
6 Dr Webb's final attendance at 5 o'clock and a note that
7 he has there.

8 Can you recall when in relation to any of those
9 observations you may have been on the ward or indeed
10 present when the examination was taking place?

11 A. I don't, I don't remember where I was when Dr Webb was
12 seeing Claire on those occasions, but I have to infer,
13 because I gave a dose of sodium valproate at 5.15, that
14 I was there at that time.

15 Q. Yes.

16 A. I may well have been there when Dr Webb was seeing
17 Claire round about 5 o'clock.

18 Q. Given that you had very much wanted him to come and have
19 his view about Claire, would you not have remembered if
20 you'd actually been there when he was examining Claire
21 so that you could ask him some questions and understand
22 better for yourself what was happening?

23 A. I may or may not remember that. As I say, I have said
24 in my statement to the coroner that I felt Claire
25 remained unwell, very unwell, at round about 5 o'clock.

1 So I do have a recollection that I was there at that
2 time. I don't remember what Dr Webb and I may or may
3 not have discussed at that stage. I simply don't
4 remember that.

5 Q. So he may have examined her on those three occasions,
6 had his first suggestion, then instituted a plan and
7 come back again, and that may all have happened before
8 you were able to get yourself back to the ward from
9 wherever you were, perhaps the clinic or whatever was
10 otherwise occupying you?

11 A. I think that may be so.

12 Q. So when you do come back and you do administer some
13 medication -- so when you do come back, firstly, are you
14 asking anybody whether Dr Webb's been there?

15 A. Yes, I would have done unless he was actually standing
16 there at the time.

17 Q. Irrespective of that, do you look at the notes to see
18 what has happened in the intervening period?

19 A. I think I would have asked him directly, maybe even
20 before looking at the notes if he was there if he and
21 I were both there at the same time, we would have --

22 Q. If he hadn't been there when you were there because he'd
23 come and literally gone as you'd arrived, would you be
24 looking at the notes?

25 A. I'd probably talk to the doctors as well. Before

1 actually looking at the notes, I'd probably talk to
2 Dr Stevenson and/or Dr Stewart and said, "What's been
3 happening?"

4 Q. Dr Stevenson was reasonably junior in these matters, and
5 Dr Stewart -- if Dr Stewart was there -- even more
6 junior. It may be, might it not, that if you wanted to
7 get a clearer impression of what Dr Webb thought, absent
8 being able to actually discuss it with Dr Webb, the
9 better thing might be to actually read his note of his
10 examination, since those junior doctors may not fully
11 appreciate his view?

12 A. Yes. I may have done that as well. Or, as I say, we
13 may have directly spoken at that time and had
14 a conversation.

15 Q. At some point though, before you actually leave Claire,
16 do you look at the notes as to what has happened in the
17 intervening period?

18 A. I'm not certain that I've read the notes at that time.
19 I'm not sure that I have. I will have spoken to people.

20 Q. Should you have looked at the notes?

21 A. Again, with hindsight, I think it is -- it's instructive
22 to look at the notes. I think day-to-day we often talk
23 a lot more than we write and we use word of mouth and we
24 speak to our colleagues and get information in that
25 fashion first before we perhaps look at what's been

1 written. So if I hadn't had a chance to speak to
2 Dr Webb at all, I think I would have wanted to look
3 at the notes to see what he'd said, yes.

4 Q. I beg your pardon, Dr Sands, that was the basis I was
5 asking you the question. Assuming you hadn't had an
6 opportunity to speak to Dr Webb, would you have wanted
7 to look at the notes?

8 A. Yes.

9 Q. Thank you. I'm sorry, I should have made that clear.
10 So you would have looked at those notes. Would you
11 have looked at other parts of the charts, the medication
12 that has been prescribed and so on and so forth?

13 A. I may or may not have done.

14 Q. Would have you wanted to look at the result of the
15 hourly observations to see where she now was on the
16 Glasgow Coma Scale?

17 A. Knowing that Dr Webb had been seeing her three times or
18 had seen her three times, if I was aware of that and
19 knew he had been in attendance on several occasions,
20 I may not have looked through all of that in detail.

21 Q. But you might have looked at the note that he inserted
22 into her medical notes and records?

23 A. Yes.

24 Q. And would you have spoken to the nurses who are in fact
25 the people carrying out those observations?

1 A. Yes, I think so.

2 Q. And if you had done that -- and we now appreciate that
3 you wouldn't necessarily have looked at all the
4 information that's recorded on this. But if we pull
5 301-001-001, the timeline again, it gets distinctly
6 busier after 2 o'clock. And if you had had some of that
7 information, if you had looked at the medical notes and
8 records, you would have appreciated what is being
9 suggested should be administered by way of
10 anticonvulsant medication. You would have seen that she
11 had been examined three times by Dr Webb, and if you'd
12 spoken to the nurses, you might have learned there had
13 been what might have been considered to be a seizure
14 a little after 3 o'clock and there had been some other
15 episodes as well, well, one episode of teeth tightening
16 some time between 4 and 5. You might have learned that.

17 And if you had learned all of that, how ill do you
18 think you would have considered Claire to have been?

19 A. I think I would still have considered her to be
20 neurologically very unwell. But I have to balance that
21 by saying that if I believed she was being looked after
22 by a paediatric neurologist, and had had these
23 neurological problems, that they were being addressed by
24 the best person possible.

25 Q. Sorry, Dr Sands, that's a slightly different point. I'm

1 not saying that you didn't have the impression that
2 there was a consultant neurologist there who had
3 a plan -- and whether you were able to comment on the
4 adequacy of that plan is another matter -- but you had
5 somebody in there who had a plan. But that's
6 a different thing from forming the view that:
7 I previously thought this child was unwell and now
8 I think she really is very unwell. Is that how you
9 would have regarded it?

10 A. Yes, I think ...

11 THE CHAIRMAN: I think it's the same -- "neurologically
12 seriously unwell" was your description earlier and it's
13 your description at that point too.

14 MS ANYADIKE-DANES: So it doesn't change. If you thought
15 she was neurologically seriously unwell from what you
16 knew in the early part of the afternoon before you had
17 seen any writings by Dr Webb or any other results, would
18 you have thought that she had deteriorated, for example,
19 over the afternoon?

20 A. I don't think my impression on leaving the hospital was
21 that Claire was getting progressively worse and worse.
22 I felt she hadn't improved. But I felt that Dr Webb was
23 taking what I assumed were very reasonable steps to try
24 and address her problems. So I probably -- my own
25 recollection is that I didn't feel that she was

1 progressively getting worse and worse.

2 Q. Can I put it to you in a slightly different way? Did
3 you think from when you saw her during the ward round
4 and when you saw her at 5 or 5.15, whenever it was when
5 you administered the sodium valproate, do you think she
6 was worse at 5.15?

7 A. Looking back now, I think yes, she probably was. But
8 that's with hindsight.

9 Q. Yes. But at the time, did she strike you as any worse
10 than when you had seen her during the ward round at
11 11 o'clock-ish in the morning?

12 A. I can only tell what you I recall, that is I still felt
13 she was very unwell neurologically. She didn't seem to
14 me to have improved.

15 Q. I'm trying to see why you would not have noticed, for
16 example, the difference in her Glasgow Coma Scale.
17 Because the Glasgow Coma Scale is simply a way of trying
18 to reflect her responsiveness, and at the time that you
19 would have been there, at 5 o'clock, it's really quite
20 low. And it's certainly lower than it was when they
21 started recording it, if I can put it that way, at
22 1 o'clock. So I'm trying to see why it is that you
23 would not have seen that she was actually worse at 5
24 o'clock than she had been when you examined her at, say,
25 11 o'clock.

1 A. I think most of us working in Allen Ward and working in
2 general medical wards wouldn't have been very familiar
3 with the Glasgow Coma Scale, which was largely used in
4 patients with head injury or patients with neurological
5 impairment, not something that we were using all the
6 time in medical patients. We would have all been -- at
7 least would have had some knowledge of the Glasgow Coma
8 Scale and what it meant. But if I felt that Dr Webb had
9 been there and prescribed medication which potentially
10 could have maybe lowered the Glasgow Coma Scale, I may
11 not have treated it with the seriousness that I now
12 think it should have been treated with. That is the
13 falling coma scale.

14 Q. Did you understand at the time that the medication that
15 you would have seen recorded in her medical notes and
16 records of having been administered to her could
17 actually have produced the lower Glasgow Coma Scales
18 that were being recorded at 5 o'clock than when they
19 first started recording them at 1 o'clock?

20 A. I think I would have known that Claire had had
21 anticonvulsant medication and would have perhaps known
22 that those could affect her Glasgow Coma Scale.

23 Q. I'm just going to pull up an actual schedule that we put
24 together of the Glasgow Coma Scales, which might help.
25 310-011-001. So 1 o'clock -- and this would have been

1 a time roughly when you were still there -- it's 9 or,
2 based on Dr Webb's calculation, it's 10. Then if we get
3 to 5 o'clock, it's 6 or, based on Dr Webb's calculation,
4 7. In fact, it was also 6 or 7 at 4 o'clock.

5 Those who have given evidence already have said that
6 that's very low, that's very serious for a child to be
7 recording that. And that is significantly lower than
8 what it was when they first started recording it.

9 I think when you were giving evidence in response to
10 a question from counsel for Claire's family, you said
11 that when you were examining her, although you wouldn't
12 describe her as bright, she was interacting in some way.

13 A. I'm not sure exactly what I said on that point.

14 THE CHAIRMAN: I think he said, "She was not totally
15 unresponsive".

16 MS ANYADIKE-DANES: Not totally unresponsive. Thank you,
17 Mr Chairman.

18 A. Not behaving normally --

19 MS ANYADIKE-DANES: No, no. I didn't for one moment suggest
20 that she was. But she was at least not completely
21 unresponsive. So you have that at 11, 11.30-ish,
22 whenever it is. Then you have, at 1 o'clock, your first
23 reading. That's 9. That's not good, but you know ...
24 Then by the time you are back, it's 6 or 7, depending,
25 and it's actually been like that for two hours. Are you

1 saying, really saying, that you didn't appreciate that
2 there had been a deterioration?

3 A. I don't recall what I thought at that time. I think if
4 I was aware that Dr Webb had been there, who knows much
5 more about these things than me -- and again, I have to
6 relate back to my own practice now, trying to remember
7 what I might have thought. If a specialist is there
8 who's seen the child, who's prescribed medication, and
9 who's been privy to the same information, if they are
10 not worried and doing something different and anxious,
11 then my anxiety, whilst real enough, would be allayed to
12 some degree by the fact that they seem to be in control.

13 Q. I understand that, but that's a different question to
14 the one that I had asked. There had also been
15 a seizure. When you were examining her, you thought
16 what was happening was that -- in fact, I think you
17 expressly said you didn't see any seizures. So that was
18 why you thought it was --

19 A. Yes.

20 Q. -- non-fitting status there.

21 A. Yes.

22 Q. But in fact, there had been at least one seizure
23 recorded and something else, an episode of teeth
24 tightening. So that was a deterioration, was it not?

25 A. I am not sure if I knew of that.

1 Q. Sorry, if you had spoken to the nurses, then would they
2 have told you?

3 A. They may have done.

4 Q. Well, if they were telling you anything about what had
5 happened with Claire, surely they would have told you
6 that she had had a seizure? That would be a relevant
7 thing to tell you, would it not?

8 A. I can't speak for what the nurses told me. I don't
9 know.

10 Q. Sorry, it would have been a relevant thing, if you were
11 asking about her condition, to tell you that she had had
12 a seizure.

13 A. Yes.

14 Q. Equally, that she'd had an episode of teeth tightening.

15 A. They may have told me that.

16 Q. That's part of her condition. I'm not so much getting
17 at whether you think you've got the right consultant, if
18 you like, to take care of her. I'm talking about your
19 own impression. At some point, you are going to have to
20 do maybe some sort of handover to whoever is going to
21 look after Claire during the night. For that matter,
22 Dr Steen might phone you and ask you about what's been
23 happening with Claire. There will be junior doctors
24 that you might have to guide to make sure that Claire is
25 adequately looked after. You're not sure that you've

1 actually met Dr Webb yourself, so it's not as if
2 you have necessarily got any comfort from him. All you
3 would know is that he had seen her three times, so she
4 had been sufficiently serious for that, and at that
5 stage, she's had three different sorts of anticonvulsant
6 medication, and quite a bit of it.

7 I'm simply asking you to reflect on your answer that
8 you didn't think that she was necessarily any worse than
9 when you saw her at 11 or 11.30 in the morning. That is
10 all I'm asking you.

11 A. My best recollection is that I didn't think Claire's
12 condition had improved. I don't get a strong sense that
13 I thought she was deteriorating, from memory. From
14 memory.

15 Q. I understand.

16 THE CHAIRMAN: If you had picked up, whether from Dr Webb or
17 anybody else, that she was worse than she had been, in
18 other words that she was worse than she had been when
19 you were already worried about her, can you say how that
20 would have affected your departure from the hospital?

21 A. I probably would have wanted to have had a prolonged
22 conversation with the Dr Webb, who had been the
23 consultant there and we may well have talked. I think
24 there's every chance we did talk at that stage, given
25 that the timing of the sodium valproate ... But I may

1 well have -- if I'd felt that Claire was deteriorating,
2 I think I would have wanted to talk to him and ask him
3 what we should do next or what he wanted done next, and
4 I would wanted to know had he spoken to Dr Steen as
5 well, even though I felt by that stage that Dr Webb was
6 managing what seemed to be a neurological condition.

7 THE CHAIRMAN: Am I right in understanding that Dr Webb also
8 left at round about the normal time?

9 MS ANYADIKE-DANES: I think that's so. About 5-ish.

10 A. I'm not sure.

11 THE CHAIRMAN: If you didn't think that Claire was
12 significantly worse than she had been earlier, and you
13 were going home on that understanding, as was Dr Webb,
14 who was also leaving, then how likely is it that you
15 would have picked up from Dr Webb directly or indirectly
16 that she was significantly worse?

17 A. I think he would have told me.

18 THE CHAIRMAN: If that's what he thought.

19 A. Yes.

20 THE CHAIRMAN: Well, as a consultant -- and this is
21 obviously hypothetical -- but if you were brought in, as
22 Dr Webb was, to help care for Claire and you saw her
23 condition deteriorate and you believed that it was
24 a significant deterioration, what would you do before
25 you went home at 5-ish?

1 A. If I was the consultant?

2 THE CHAIRMAN: Yes. Would you go home at 5-ish?

3 A. I wouldn't go home. I would make sure there was a plan,
4 that I was involved in that plan, that ... Well, that
5 we had a plan for the evening. I know Dr Webb has felt
6 that intensive care might have been appropriate at this
7 stage. I know again that we're 16 years down the line.
8 Would that have been appropriate? I think we're
9 probably all agreed that intensive care would have been
10 appropriate, and certainly by today's standards that is
11 something that would have been considered. So as
12 a cardiologist now, if I had a patient who I considered
13 was sick and getting sicker, I'd be talking to the ICU.

14 THE CHAIRMAN: Just on this point, can we bring up at the
15 same time, please, 090-022-054 and, beside it, 055? It
16 just relates, doctor, to the issue of who's in the lead.
17 On the left hand page, 054, at about 2 o'clock,
18 Dr Webb's notes end with an impression and then below
19 that, he suggests; right? And then at 5 o'clock, he
20 sees her again and he then sets out a plan within the
21 bottom third. Does that suggest anything?

22 A. That is that initially he felt he may have been giving
23 more of an opinion rather than stepping in and taking
24 over, if you like.

25 THE CHAIRMAN: Yes.

1 A. I wouldn't read too much into that. I think for some
2 people that is what it means in their practice, and
3 I know people who do that still, and will say,
4 "Thank you for referral, I would suggest ..." However,
5 my own view would be that if one sees a child with
6 a condition that is within one's area of expertise,
7 specific expertise, and that those problems are
8 neurological or cardiological, you are then taking on
9 responsibility, you're then showing that you're involved
10 and that you are continuing to be involved. There may
11 be some process happening here in that he then moves on
12 to talk about a plan rather than a suggestion, but I'm
13 not sure how much I would read into that as a gradual
14 change or a fairly quick change in terms of
15 responsibility. But it's more evidenced by the fact
16 perhaps that Dr Webb has seen Claire on three occasions,
17 he seems to have acknowledged that her problems are
18 neurological and that he has taken a large part of
19 trying to manage those problems.

20 THE CHAIRMAN: Thank you.

21 MS ANYADIKE-DANES: Mr Chairman, I've been passed a note
22 about a short break for the stenographer.

23 THE CHAIRMAN: Okay. I'll sit again at 3.55.

24 In the meantime, can you agree on how much longer
25 we can sit today? I will sit for as long as we can, but

1 if that could be arranged when I'm out.

2 (3.45 pm)

3 (A short break)

4 (3.55 pm)

5 THE CHAIRMAN: Can we try to sit on and finish Dr Sands?

6 MS ANYADIKE-DANES: Yes, that's exactly the idea.

7 MR GREEN: Just as a matter of courtesy, I should indicate

8 that, for personal reasons, I'm leaving at 4.30. I hope

9 you won't take any discourtesy from that.

10 THE CHAIRMAN: I've been offended by a lot worse than that!

11 Thank you.

12 MS ANYADIKE-DANES: As well as you can do it, you're back on

13 that ward around 5-ish. Also, as well as you can do it,

14 you've had at least one telephone conversation with

15 Dr Steen, which may have been in the very early part of

16 the afternoon --

17 A. Yes.

18 Q. -- certainly before you knew anything about Dr Webb

19 having actually seen Claire and what he thought from his

20 examination; would that be fair?

21 A. That's my best recollection, yes.

22 Q. When you get back there, do you have any thought that

23 you might like to bring her up to speed now?

24 A. I'm not sure what I thought at that stage about bringing

25 Dr Steen up to speed or whether I knew that she had been

1 on the phone or whether she'd said to me earlier "I'll
2 keep in touch". Those are some of the things perhaps
3 that I might have expected her to say. Again, I'm
4 having to reconstruct that because I don't remember
5 ringing Dr Steen again at 5 o'clock.

6 Q. If Dr Steen had spoken to somebody else in the middle of
7 the afternoon, say, or at some point, whether it was in
8 the middle of the afternoon or closer to when you
9 actually came back on the ward, have you any idea whom
10 she might be speaking to to get some sort of reliable
11 update as to Claire's condition?

12 A. A senior nurse, a doctor. Ideally, Dr Webb.

13 Q. It seems that didn't happen. So if it's not the senior
14 nurse, it's Dr Stewart or Dr Stevenson.

15 A. Those would have been the options: either a member of
16 nursing staff or one of the junior doctors in the
17 absence of a conversation with Dr Webb.

18 Q. Yes. And if anybody was relaying anything to Dr Steen,
19 whether it's mid-afternoon or 5-ish, would Dr Steen have
20 had the impression that Claire was neurologically very
21 unwell?

22 A. From what I know and from what I can read from the
23 notes, I believe she would have known that.

24 THE CHAIRMAN: Sorry. If she was accurately updated --

25 A. Yes.

1 THE CHAIRMAN: -- that's what she would have been told?

2 A. Yes.

3 THE CHAIRMAN: Since that was your view from when you saw

4 Claire late morning and, at the very least, her

5 condition had not improved --

6 A. Yes.

7 THE CHAIRMAN: -- probably got somewhat worse --

8 A. I think with hindsight, yes.

9 THE CHAIRMAN: -- so anybody who was giving Dr Steen an

10 accurate update, if Dr Steen asked for an update, could

11 not have led her to believe that things were on the

12 mend?

13 A. I think that's the case.

14 THE CHAIRMAN: Yes.

15 MS ANYADIKE-DANES: And in fact, by the time you spoke to

16 Dr Steen, which would have been after your ward round

17 and so forth, you had the view then that she was

18 neurologically very unwell?

19 A. Yes.

20 Q. And when you reported that information to Dr Steen,

21 quite apart from Dr Steen, in your view, perhaps being

22 in touch with Dr Webb, which is something you thought

23 might have happened, what else did you expect over the

24 passage of that afternoon for Dr Steen to actually be

25 doing or do?

1 A. I would have expected her to perhaps keep in touch with
2 the ward to see what was happening with Claire. This is
3 assuming that she was doing a clinic in Cupar Street and
4 felt perhaps that she shouldn't abandon the clinic
5 completely. Arguably, she may have wanted to come to
6 the ward and see Claire. I don't know. But assuming
7 that she felt she couldn't do that, then she might have
8 phoned perhaps once or twice to be updated as to
9 Claire's progress. I can only guess at that, obviously.

10 Q. I understand. In all of this -- and I know you are not
11 necessarily there all afternoon -- who is the person who
12 is responsible for keeping the parents up-to-date with
13 the actual condition of their child, the prognosis and
14 the plan going forward? Who's in charge of that?

15 A. I think, again, there's a hierarchy here. All medical
16 and nursing staff have a responsibility to communicate
17 with parents, patients. The responsibility is most
18 onerous or largest on the consultant, and so on down the
19 line, but it applies to medical and nursing staff,
20 I think.

21 Q. And if that had been happening, by whomsoever it would
22 have been, whether it's the senior nurse, the junior
23 doctors or Dr Webb, or even Dr Steen, if she had come
24 back at 5 o'clock and informed herself about it, whoever
25 did that, is it your view that the parents couldn't

1 really have been told anything that would enable them to
2 leave the hospital at 9.30, believing that Claire would
3 be all right the next day and that she wasn't seriously
4 ill?

5 A. Again, I can only speculate about that. I think the
6 evidence -- my evidence has been and my recollection
7 is that I believed Claire to be neurologically very
8 unwell. What was said to Claire's parents throughout
9 the afternoon, I can only guess at, and their
10 interpretation of that I can only guess at.

11 THE CHAIRMAN: Let's bring this to a head, doctor.

12 I understand why you say there is a hierarchy and
13 I understand that, as part of the nursing code, they
14 don't just do what doctors say and they have an
15 independent responsibility. But if there is a hierarchy
16 of any sort -- as it happened that afternoon, Dr Webb
17 was the consultant who saw Claire three times.

18 A. Yes.

19 THE CHAIRMAN: As a consultant now of some years' standing,
20 would you accept with your patients -- or with patients
21 who you were involved in treating, to put it more
22 neutrally -- that you had the primary obligation to keep
23 those parents informed of what was happening?

24 A. Yes, I would.

25 THE CHAIRMAN: And if I formed the view that Dr Webb had the

1 primary obligation as Tuesday afternoon developed, as he
2 saw her for a second and then third time and became more
3 and more actively involved, would you suggest that I was
4 being unfair or harsh?

5 A. No.

6 THE CHAIRMAN: Thank you.

7 MS ANYADIKE-DANES: And if Dr Webb didn't actually, for one
8 reason or another, speak to the parents at that last
9 examination -- maybe for some reason a parent had gone
10 to make a cup of coffee or whatever -- but if that
11 didn't happen and you were aware that that had not
12 happened, when you were there, you were, at that stage,
13 the most senior doctor?

14 A. Well, I think Dr Webb was there.

15 Q. No, when you came back, you said that you may not have
16 met him. We know that you are there at 5.15 because
17 you're administering sodium valproate. So if he had
18 already come and gone, made his note literally as the
19 last act and then he's out at 5 o'clock, then at 5.15,
20 you are the most senior doctor on the ward.

21 A. Yes, and if I had known that Dr Webb hadn't spoken to
22 the parents and the parents would have needed somebody
23 to speak to them, I think I would have tried to do my
24 best to do that.

25 Q. And would it have occurred to you to try and find that

1 out before you left, because you know you're leaving,
2 the parents are still there, you're actually going off
3 duty, Dr Webb is going to be on call, but you're going
4 off duty and you've been the senior paediatrician there
5 all through the day, if I can put it that way, one way
6 or another. Would you have tried to find out what the
7 parents actually knew about their daughter's care or
8 their daughter's condition, more to the point?

9 A. I may have done, but if I was aware that Dr Webb had
10 spoken to mum and dad or to whichever parents were
11 there, I may not have done that, deferring to his having
12 done that.

13 Q. My premise was slightly different. If you had not
14 received any information to the effect that the last
15 examination had led to a discussion between Dr Webb and
16 the parents, so whatever he might have said to them when
17 he examined the child at 2 o'clock or whenever it was,
18 but at 5 o'clock the last examination, if you were of
19 the view that Dr Webb had, for various reasons not been
20 able to speak to either of the parents then, do you
21 think that it would have been incumbent upon you to have
22 a discussion with the parents before you go off duty
23 finally?

24 A. Yes, I think I would have needed to say something, but
25 I probably would have wanted to get Dr Webb back again

1 to talk to the parents because -- particularly if I knew
2 he wan on call that night and if I thought he hadn't yet
3 spoken to the parents, I would actually want him to do
4 it --

5 Q. I can quite see why you would.

6 A. -- and I would ask him to do that.

7 Q. If he's not available to do that, and there is any way
8 of contacting Dr Steen so that she could divert, if you
9 like, on the way home to the hospital -- as she said she
10 sometimes did after the clinic ... I should ask you,
11 did you know she did that sometimes?

12 A. I can't recall. I can't recall that that would have
13 been a typical thing or something I would have expected
14 her to do.

15 Q. If you thought you could have got hold of her and asked
16 her to do that, in lieu of Dr Webb, would you have
17 wanted her to do that?

18 A. Yes.

19 Q. Had you any sense of whether you had tried to reach her
20 when you got back to the ward, which would have been
21 5-ish or so?

22 A. I don't recall whether I tried again at that stage to
23 speak to Dr Webb -- or Dr Steen, rather.

24 Q. When you did get back to the ward, and at some point
25 you're looking at Claire's notes in the intervening

1 period, you're not entirely sure when you would have
2 done that, but presumably you would have done that at
3 some point before you actually left the ward off duty.

4 A. I may not have done if I was able to speak to Dr Webb.

5 Q. I have understood you to have said that. I think you're
6 not clear whether you actually did speak to Dr Webb at
7 5 o'clock.

8 A. But I think it is likely, if we were both there at the
9 same time, that we wouldn't have spoken.

10 Q. If that had happened, would there have been a note in
11 the notes to say "discussed with"?

12 A. Not necessarily, no. If Dr Webb has made the note from
13 5 o'clock.

14 Q. Well, when you got there at 5, would you be trying to
15 see what investigations have actually been carried out
16 over the afternoon?

17 A. I may make an enquiry of that sort. Again, I can only
18 speculate or try and reconstruct that. I don't recall
19 if I asked what investigations had been done, what line
20 is Dr Webb pursuing. I don't recall if that was
21 discussed.

22 Q. Would you have known there are no blood results
23 associated with that time?

24 A. It depends really when the blood results come back.

25 Q. No, sorry, there's no blood results entered into her

1 medical notes associated with that time.

2 A. Yes.

3 Q. And so I think in your witness statement, 137/2,
4 page 16, in answer to question (c), I think the answer
5 there is:

6 "Although such blood investigations would have often
7 been carried out by a senior house officer, I believe
8 that as part of the medical team, I would have had some
9 responsibility for checking that serum electrolyte
10 testing had not been overlooked. The results of blood
11 investigations often did not return to the ward until
12 quite late in the day."

13 But would you at least have expected them before you
14 went off duty? If that had been done in the normal
15 time, would you have expected them back for 5 o'clock?

16 A. Not necessarily, no.

17 Q. Then if you didn't see them, would you not be trying to
18 check that that had actually happened?

19 A. I think I would have been asking somebody to look out
20 for the results to see if they were there.

21 Q. Is that something that you would have wanted to draw to
22 at least the SHOs' attention because, if they're going
23 off duty as well, they need to flag it up in their
24 handover or you need to flag it up as you hand over to
25 a registrar that this might be outstanding, this might

1 be something that should be chased up; would that be
2 fair?

3 A. Yes, and although I don't remember what we did on this
4 particular occasion, I've been in that situation before
5 when we have waited for a result to come back, maybe
6 between 5 and 6 pm, found it just wasn't there for
7 whatever reason and found we were missing a result
8 either because it hadn't been requested or overlooked or
9 hadn't made it to the lab.

10 Q. But in this witness statement, you're assuming some
11 responsibility for making sure that that is happening
12 and if, for any reason it's not there, that something is
13 done about it.

14 A. Yes.

15 Q. But you don't recall anything being done about that?

16 A. I think if I'd been aware that the result was missing or
17 at least we hadn't a result up-to-date, I'd have asked
18 a senior house officer, most probably, to look out for
19 that result. That would involve the oncoming SHO
20 looking out for it, perhaps, if it wasn't through in the
21 lab results. And if it wasn't done, to try and make
22 sure it was done as soon as possible.

23 Q. Was it your business to be aware?

24 A. I think as part of the ward staff, yes.

25 Q. Thank you. Can I pick up a point that the chairman had

1 asked you, which was who was responsible for the care.
2 You, I think, said whether you spoke to Dr Webb or not,
3 I think you would have assumed that if he had been
4 seeing her that amount of times, that effectively he was
5 managing her care; would that be right?

6 A. I think that's right. If I may, this has been
7 a difficulty in the Children's Hospital, determining how
8 care is shared between consultants, when care transfers
9 from one consultant to another. I've been aware of this
10 as part of the inquiry and, in looking at a serious
11 adverse incident recently within the Children's
12 Hospital, I flagged this up. Dr Steen made reference in
13 her evidence that a circular has gone around now to try
14 and clarify this issue about consultant responsibility
15 and transfer of consultant responsibility because whilst
16 it can work very well where two consultants share the
17 care of a patient, it can also lead to ambiguity.

18 Q. Yes. We put together a schedule where we tried to
19 summarise people's views on who they thought had the
20 care. The reference is 310-005-002. That's where
21 a summary of your own views starts, which is all gleaned
22 from your witness statements. Part of what you say
23 is that you thought that you were under the supervision
24 of Dr Steen and that when Dr Webb saw and examined
25 Claire, you thought yourself partly under the

1 supervision of Dr Webb also, and that following
2 Dr Webb's first attendance, you understood that Claire
3 was being jointly cared for by the medical and neurology
4 team.

5 You didn't actually have any discussion with Dr Webb
6 after his first attendance, so thinking that her care
7 was being jointly managed in that way, is that something
8 you deduced from the circumstances or something you
9 gleaned from information given to you?

10 A. It may have been a combination of both, but I think it
11 was largely based on the fact that Dr Webb seemed to
12 have agreed that Claire's problems were neurological and
13 had taken upon itself to see Claire on three occasions
14 to manage Claire's condition and to prescribe her
15 medication and to set out a treatment plan. So I think
16 that's what I base that on.

17 Q. When you talk about a treatment plan and the fact that
18 Dr Webb thought Claire's problems were neurological,
19 which is something that you would glean from the medical
20 notes and records, how would you know that other than if
21 you read the medical notes and records?

22 A. Probably from nursing staff as well and from talking to
23 the junior doctors as well as hopefully talking to
24 Dr Webb as well, perhaps at the end of the day.

25 Q. If when you're coming back and looking at the management

1 plan or wanting to know what the management plan is and
2 looking at what's happened in the intervening period,
3 right at the outset of all of this, you had three things
4 in your mind that as possibilities: the non-fitting
5 status, which we've gone into, the encephalitis, and the
6 encephalopathy. What did you understand, when you came
7 back, had been the plan in relation to the encephalitis
8 and the encephalopathy throughout that day?

9 A. Those issues I put down in the chart really as a cue for
10 Dr Webb to reflect the discussion on the ward round, and
11 the encephalopathy -- because I believe that was
12 Dr Webb's word -- to acknowledge that he had mentioned
13 that to me. And to then seek his direction as to where
14 we go with those diagnoses or those possible diagnoses
15 in terms of investigation, what lines to go down.

16 Q. So presumably you'd want to know that when you came back
17 on to the ward?

18 A. Yes.

19 Q. Where did we go with that, if I can put it that way?

20 A. Yes.

21 Q. What did you understand the management plan was that had
22 been instituted to address the encephalitis and the
23 encephalopathy from -- it would have been 2 o'clock when
24 he first saw Claire?

25 A. I think I would have appreciated the information that

1 Dr Webb thought that Claire's problems were primarily
2 seizure-related and was treating her accordingly. Now,
3 I acknowledge that in his note at 5 o'clock he does make
4 reference to the possibility of meningoencephalitis, so
5 he think that's unlikely, but he says we had better
6 cover that anyway. I am not sure where it has been in
7 his thinking prior to that.

8 Q. In terms of the actual medications, you're recorded, and
9 we saw it on the prescription sheet, as having
10 administered the sodium valproate. Is there any reason
11 why you didn't, at the same time, for example,
12 administer any of the other medications that Dr Webb had
13 identified? For example, I think it's the acyclovir is
14 identified by Dr Webb at that same consultation at
15 5 o'clock. But it seems not to have been written up to
16 be administered until 21.30, 9.30. I presume you would
17 have seen that when you were looking at what sodium
18 valproate you had to administer.

19 Did you wonder why that was, if Dr Webb had come at
20 5 o'clock and said, "These things have to be
21 administered", why it was that your SHO was prescribing
22 that to be administered at 9.30?

23 A. I don't recall exactly what discussion took place around
24 acyclovir at that time. I'm not sure whether Dr Webb
25 did ask for a stat dose of acyclovir or whether he asks

1 for it to be written up as a routine prescription. I'm
2 not sure. The cefotaxime, I think, is given at around
3 5.30, but that is in accordance with how it was
4 prescribed on the drug kardex.

5 Q. Yes, but if one looks at 090-022-055, that's his plan.
6 I think the drugs we're talking about are the first part
7 of the plan. Is there anything there to indicate that
8 that shouldn't happen soon thereafter 5 o'clock and that
9 in fact should happen at 9.30?

10 A. There's nothing to indicate that.

11 Q. No.

12 A. It just says, as I read it, "Cover with cefotaxime and
13 acyclovir for 48 hours". I think that's to allow time
14 for any cultures to come back that might indicate
15 whether you're along the right lines in terms of
16 infection treatment.

17 Q. You're now there at roughly the same time as your SHO is
18 there. And is it not your responsibility to make sure
19 that the plan of the consultant neurologist is being put
20 into effect properly and at least to ask him, "Why
21 is that happening at 9.30?"

22 A. I can't easily explain that because I don't know what he
23 specified as to when he'd like it to start. It may not
24 have been immediately available. I think part of the
25 problem is that it's written up the way it is rather

1 than as a once only, as a stat dose, and then as
2 a regular prescription.

3 Q. Shouldn't you have found that out? This is a junior
4 doctor, you are there to give them guidance as well as
5 take responsibility for Claire's own care when you're
6 the most senior person there. Shouldn't you have
7 satisfied yourself that what this expert, who you wanted
8 to bring in, has formulated as a plan is actually being
9 properly implemented?

10 A. Yes. I can't really comment, except to say that perhaps
11 the acyclovir wasn't there to be given at that stage.
12 I just don't know. Claforan, or cefotaxime, would have
13 been in the ward right there and then. I'm not sure
14 whether acyclovir would have been. That is one possible
15 reason why it wasn't. I can't think of a good reason
16 otherwise.

17 Q. Let me put it a slightly different way. Is it not your
18 responsibility to satisfy yourself that Dr Webb's plan
19 is being properly implemented by the junior medical
20 team?

21 THE CHAIRMAN: Just one moment. Mr Green?

22 MR GREEN: It may help if we remind ourselves of what
23 Dr Webb says himself on this issue. It's at WS138/1,
24 page 40. The top reads:
25 "I cannot recall who I spoke to about Claire's

1 future management at 5 pm, but I know I discussed
2 further drug options and decided to administer
3 intravenous sodium valproate as a further therapeutic
4 option. I believe this discussion may have been with
5 Dr Sands, but I cannot be certain."

6 I appreciate it's not determinative of the issue,
7 but it's perhaps worth juxtaposing that piece of
8 evidence with this part of the evidence that's being
9 elicited from Dr Sands to assist the inquiry.

10 MS ANYADIKE-DANES: That's very kind. I think we will find
11 it as well, but I think Dr Webb is specifically asked
12 whether there was any explanation or reason for why
13 there should be a delay in the administration of the
14 medication to 9.30, and his view is that there wasn't
15 any. I can give the reference for that. That is at
16 page 41, the next page to that.

17 I think it's (c) that we want to look at:

18 "I recommended that Claire receive cefotaxime and
19 acyclovir at 5 pm. I would have expected this to have
20 been started within an hour or two."

21 Then he talks about how the non-convulsive status
22 can arise or occur spontaneously.

23 So then he goes on. He says where his decision to
24 start treatment is recorded:

25 "There was no delay in the administration of

1 cefotaxime to Claire and I do not know why there was
2 a delay in administering the acyclovir."
3 THE CHAIRMAN: It's a bit unsatisfactory, isn't it? Because
4 Dr Webb is saying, I would have expected them to have
5 started within an hour or two, which is a bit -- seems
6 to me to be a bit loose. One of them is started within
7 half an hour, isn't it --
8 MS ANYADIKE-DANES: Yes.
9 THE CHAIRMAN: -- which is quicker than Dr Webb suggests,
10 and there is a delay which is not readily explained
11 in the acyclovir.
12 MS ANYADIKE-DANES: Yes. All that I was seeking to ask
13 Dr Sands is whether, given that there is no indication
14 on the medical notes and records that the acyclovir is
15 to start as late as 9.30, whether it was not his
16 responsibility to at least satisfy himself as to why it
17 was starting as late as that and see whether that was in
18 accordance with either Dr Webb's instructions or some
19 other problem, like we just didn't have access to the
20 medication. That's what I'm trying to find out, your
21 responsibility.
22 A. I think I would have liked to have known that, when it
23 was meant to be given, could it be given then, and if
24 not, why not.
25 Q. I understand that you said that you would have liked to

1 have known it. Was it your responsibility to have found
2 that out if you were there at that time as the most
3 senior doctor?

4 A. I think it would have been partly my responsibility,
5 yes.

6 Q. Thank you. Then I wonder if we might -- one question
7 I've been asked is when you looked -- at whatever stage
8 you did it -- at the drug sheet, which you would have to
9 look at to sign off that you were giving the sodium
10 valproate, whether you noticed any of the errors there
11 in relation to the phenytoin and in relation to the
12 midazolam.

13 A. The answer to that is no, and that sounds strange at
14 this stage because when you look at it in detail and
15 look at it now, it does look quite obvious, but the
16 answer is no.

17 Q. Do you think you should have?

18 A. Perhaps.

19 Q. Thank you. Then can I ask you about the handover and
20 shift and then it will take you slightly out of order,
21 and I apologise for that, but there are some other
22 matters that people wanted me specifically to raise with
23 you. I'm going to move now to the handover of the shift
24 and then go on to those matters.

25 Sorry, I think I had asked you this, but

1 if I haven't asked you that: the blood samples at
2 5 o'clock, I think I had asked you whether it was your
3 responsibility to chase those, see what had happened
4 about them if you didn't already have the results.
5 THE CHAIRMAN: He said yes. Dr Sands accepted he had some
6 responsibility for checking that these had been done.
7 MS ANYADIKE-DANES: I thought that had been the case, but
8 I wanted to make sure. Thank you.
9 Now the handover. When you had been answering
10 questions earlier, you said that the handover at the end
11 of the day was perhaps more important than the handover
12 at the beginning of the day; is that correct?
13 A. That's right.
14 Q. Is it something, however informally it was done, that
15 typically did happen?
16 A. Yes.
17 Q. Can you remember if you actually did effect a handover
18 on the 22nd?
19 A. I don't remember the details of the handover on this
20 occasion. I don't remember that.
21 THE CHAIRMAN: Do you remember the fact of a handover as
22 opposed to the details?
23 A. I don't have a recollection of the handover.
24 THE CHAIRMAN: Okay.
25 MS ANYADIKE-DANES: But doing the best you can, do you think

1 it's something that you would have wished to do?

2 A. Yes. I think that would have been very much my
3 practice.

4 Q. And that is a handover to Dr Bartholome?

5 A. Yes. Probably not just Dr Bartholome. I probably would
6 have tried to involve the SHOs as well. It may have
7 been done separately, so one may have talked to
8 Dr Stewart, who was going to be on from 10, as I now
9 understand, but had been there throughout the day.
10 Dr Hughes, who was coming on, I believe, at 5. So she
11 would have needed to be part of a handover. And
12 Dr Bartholome. I have also said in my witness statement
13 that I would have probably tried to find out if there
14 was neurology -- if the junior neurology staff had
15 anything they particularly wanted to add. I understand
16 now from the additional information that, in fact, the
17 registrar was on leave, Dr Jyothi(?), Asha Jyothi, was
18 on call that night. I think she was covering paediatric
19 ICU and children's Clarke Clinic, the cardiology ward.
20 She may have been involved in some discussion about
21 what was to happen with Claire.

22 Q. Can I ask actually how handovers work? Do all the new
23 incoming team congregate somewhere and have a meeting
24 and then disperse to their various stations? How does
25 it work in practice?

1 A. They do now and it's much better. It's formalised now.
2 There's a printed-out list of all of the patients and
3 they go through them one by one with individual issues
4 so there's time set aside to do that. In 1996, to the
5 best of my knowledge that didn't happen, it was a much
6 more informal affair, it was a case of: if I had access
7 to the SHOs, I would talk to them there in Allen Ward,
8 but I may have had to find Dr Hughes in Musgrave Ward,
9 although she may have been able to come down to
10 Allen Ward. I am very likely to have had to go and find
11 Dr Bartholome to give her advice about Claire, or indeed
12 other patients as well as Claire.

13 Q. So you're basically trying to seek each other out, if I
14 can put it that way?

15 A. Yes.

16 THE CHAIRMAN: How many wards is Dr Bartholome taking over
17 for the evening?

18 A. I think it's about 12 altogether.

19 THE CHAIRMAN: Tracking her down for a handover could
20 literally take an hour-and-a-half or two hours?

21 A. I would have had a pager, so I would have been able to
22 find her.

23 THE CHAIRMAN: Right. And join the queue?

24 A. Yes, but I wouldn't necessarily have expected her to
25 come to me. I may very well have had to go to her.

1 THE CHAIRMAN: When you said it was very much your practice
2 to do a handover, would that be for children who you
3 were as concerned about as you were about Claire rather
4 than the whole of Allen Ward?

5 A. Yes, not everybody. Not everybody, it would have been
6 restricted, I think, to those where you had a particular
7 concern or there was something still outstanding.

8 THE CHAIRMAN: Okay. Let's suppose for the sake of argument
9 that you found Dr Hughes, but Dr Bartholome's also up to
10 her neck with another child or Dr Stewart, I think, is
11 coming --

12 MS ANYADIKE-DANES: Later on.

13 THE CHAIRMAN: He was coming later on. If you were able to
14 do a handover, say to Dr Hughes, would you necessarily
15 wait to repeat that with Dr Bartholome?

16 A. I think I would have still have wanted to get some word
17 to her.

18 THE CHAIRMAN: You might have to go through Dr Hughes?

19 A. Possibly, but I think it more likely that I would at
20 least get her on the telephone if she was really tied
21 up. I suppose you could conceive of a situation where,
22 if she was extremely busy and unable to even take
23 a telephone call, you might have to ask somebody to
24 relay information to her.

25 THE CHAIRMAN: Thank you.

1 MS ANYADIKE-DANES: I think Dr Hughes was on call from
2 5 o'clock in the afternoon until 10, and then Dr Stewart
3 took over from 10 o'clock and thereafter.

4 A. Yes.

5 Q. I think Dr Webb is literally on call from 5 o'clock
6 together with Dr Bartholome throughout the night.

7 A. That's right, and I think then, as I understand it, then
8 the -- who I had originally called a specialties SHO.
9 It seems that the specialty SHO was more confined than
10 that. It was paediatric ICU plus children's Clarke
11 Clinic, the cardiology SHO. So not covering neurology
12 and children's haematology as they do now.

13 Q. Given that this is, in 1996, a far less formal business
14 than it is now in the sense that you don't all
15 congregate in one place and exchange information, if I
16 can put it that way, and you're going to have to go and
17 find people, does that mean that who you are really
18 looking for is somebody that you can impart information
19 to about the patients that you are really quite worried
20 about or something that they need to be particularly
21 alive to during the evening?

22 A. Yes, I think that's right. It wouldn't be a full list
23 of all the patients, I don't think.

24 Q. If it's that, one or the other, somebody that you're
25 really worried about or somebody who maybe had

1 outstanding results and you would just want to prompt
2 them that they should be looking for those, on either
3 basis, is Claire in that category of somebody you would
4 have wanted to --

5 THE CHAIRMAN: He said he would not do a handover for
6 everybody on Allen Ward, but he would certainly have
7 wanted to do one for Claire due to his concerns about
8 her condition.

9 MS ANYADIKE-DANES: And if you had a preference, who would
10 you have wanted to effect that handover with?

11 A. Dr Bartholome.

12 Q. I know that you can't actually remember doing it, but
13 what would you have been wanting to tell Dr Bartholome
14 at that stage?

15 A. Again, I would like to have given her some of the
16 happenings earlier in the day, a bit about Claire's
17 background, the fact that Dr Webb had been there and had
18 been involved and what the possible diagnosis was, what
19 had been done for Claire, what medications she had had.

20 Q. And would you have wanted to give Dr Bartholome an
21 indication of how unwell you regarded Claire to be at
22 that stage?

23 A. Yes.

24 Q. Would that have been any advance on "neurologically very
25 unwell"?

1 A. It may not have been. Again, I'm having to sort of try
2 and piece that together. But I would have given her my
3 honest appraisal of what I thought of Claire,
4 particularly as I was leaving, and that was that she was
5 still very unwell neurologically.

6 Q. Then in relation to the other children on the ward whose
7 care you have had during the day, where would you place
8 Claire?

9 A. I would have said at the top of the list in terms of
10 children who were unwell. That's to the best of my
11 knowledge, having looked at Claire's chart and looked at
12 some of the other patients -- bits of the other
13 patients' charts that we've seen.

14 Q. Given that your actual description of her hasn't changed
15 from when you first formed it after your ward round, so
16 far as you're concerned, was Claire actually the sickest
17 child on the ward throughout the day?

18 A. Again, looking back and having seen now the notes --
19 well, I suppose that's unfair because I haven't seen all
20 the notes from all the patients on the ward. That's my
21 impression.

22 Q. Throughout the day, she would have been the number one
23 concern out of all those children on the ward?

24 A. That's my impression from what I've been able to see in
25 terms of notes and so forth.

1 Q. I believe Dr Bartholome's evidence yesterday was that
2 Claire was the sickest child on the ward so far as she
3 was concerned, and would that fit with your view?
4 A. Yes.
5 THE CHAIRMAN: In fact, it actually doesn't matter whether
6 she's number one or number two on this unhappy list.
7 She is very unwell and needs to be particularly looked
8 after during the course of the evening.
9 A. Yes.
10 MS ANYADIKE-DANES: Yes, I didn't mean to put it in
11 a ranking way.
12 A. No, of course.
13 Q. If you are dealing with the sickest child on the ward,
14 maybe it's the child to whom you have to pay special
15 attention to?
16 A. Yes.
17 Q. If I might now pick up some points that others wish --
18 MR QUINN: Mr Chairman, I have marked it in the
19 transcript -- Dr Steen said on the 16th, I think it was,
20 that when she phoned the ward at teatime, she was ...
21 THE CHAIRMAN: Sorry, if she phoned the ward at teatime.
22 There's a lot of supposition on Tuesday's evidence. She
23 has no recollection of this. She was saying she would
24 have expected that she would have phoned the ward.
25 MR QUINN: It's day 45, page 19, line 8:

1 "I said yesterday I can't remember what was said on
2 the telephone call when I phoned the ward, when I phoned
3 the ward around teatime. Whatever was said, I was
4 reassured."

5 THE CHAIRMAN: I think this witness has said, first of all,
6 there's a fundamental starting point about whether
7 a phone call was made either way to start with. And the
8 second issue is, if she was accurately advised about
9 Claire's condition, she could not have been reassured.

10 MR QUINN: Yes, that's just what I want to make sure is on
11 the record. And what I want to ask, through you, is: is
12 there any way she could be reassured after what this
13 evidence has been?

14 THE CHAIRMAN: I thought Dr Sands had said a few moments ago
15 that there wasn't any way -- I think this is repetition,
16 but let's repeat this. Let's double-check it.

17 If it is correct that either Dr Steen was rung at
18 Cupar Street or that she rang from Cupar Street and
19 asked about Claire's condition, could it have been in
20 your view that she could have been reassured that ...
21 What was the wording?

22 MR QUINN: "I was reassured" in the context that she wasn't
23 coming back to the ward.

24 THE CHAIRMAN: Claire was not so unwell that it wasn't
25 necessary for Dr Steen to come back.

1 MR QUINN: Yes, that's correct.

2 THE CHAIRMAN: I think you have said you have difficulty
3 understanding how any such reassurance could have been
4 given.

5 A. I do, sir, unless Dr Steen -- and this is all
6 hypothetical -- believes that Dr Webb has taken
7 everything on board and is fully in control and is
8 content with the situation. That's the only way I could
9 construe that Dr Steen might feel somewhat reassured,
10 but not completely.

11 THE CHAIRMAN: Even if we step aside from the argument about
12 who's in control, Dr Webb wasn't content with the
13 situation as I understand it. At the very least, from
14 his 5 o'clock examination.

15 A. Yes.

16 THE CHAIRMAN: Thank you.

17 MS ANYADIKE-DANES: The fact that you considered her so
18 early in your examination of her, if I can put it that
19 way, to be neurologically very unwell, and that remained
20 with you as far as you were concerned, and that you
21 considered her to be that serious by comparison with the
22 other children on the ward, is any of that reflected in
23 the notes or instructions for the nurses?

24 A. I would need to go through all the notes and
25 instructions for the nurses, I suppose, to --

1 Q. Are you aware of having that recorded for the benefit of
2 the nurses so that when they change shift, they would
3 appreciate that this is the condition of the child whose
4 condition they are monitoring?

5 A. I'm not sure to what extent the nurses fully understood
6 the severity of Claire's condition. I can't be certain
7 of that.

8 Q. But should they have or should they have been helped to
9 understand that?

10 A. Yes, I take the point and I think the medical staff
11 should all have been feeding into that and making --
12 well, trying to make sure that the nursing staff were
13 aware that this was an unwell child, if they didn't know
14 already. Perhaps they did.

15 Q. Apart from the nursing staff, should the junior staff
16 have had impressed upon them how serious Claire's
17 condition was? Because I think Dr Stevenson didn't have
18 a full appreciation of how unwell Claire was. He was
19 doing what he was being asked to do in terms of adhering
20 to Dr Webb's prescriptions and so on, but I think his
21 evidence was that he really didn't understand how unwell
22 she was.

23 A. That may be so, perhaps he didn't and perhaps the SHOs
24 both didn't have a full appreciation. And maybe none of
25 us because we didn't understand exactly what was going

1 on, didn't really understand quite how sick Claire was,
2 even though we thought -- and I have always said that
3 I felt she was neurologically very unwell. I still may
4 not have understood and wouldn't have understood what
5 was around the corner for Claire.

6 Q. I understand that. You may not have understood the full
7 depths of it, you may not have understood all the things
8 that were causing that and what its likely progression
9 might be. But you at least had formed the view that she
10 was neurologically very unwell and you continued in that
11 view. All I'm asking you is that, given that you formed
12 that view as early as her ward round, did it not fall to
13 you at that stage, the most senior clinician there, to
14 ensure that the nursing staff and the junior staff, the
15 SHOs, knew that? They might not have understood the ins
16 and outs of how she came to be that way, but that was
17 her condition. Did it not fall to you to make sure they
18 understood that?

19 A. That's before Dr Webb's visit?

20 Q. Yes.

21 A. I think again I would have expressed my concerns to the
22 nursing staff and told them I thought that Claire was
23 very neurologically unwell and said we needed
24 a neurologist to see Claire because I'm not sure what's
25 going on here. I suspect this maybe, but I don't know.

1 Q. The problem, frankly put, from the nurses' point of
2 view -- and one can't speak for Dr Stewart, he hasn't
3 given his evidence yet -- their impression is that they
4 just didn't realise that Claire was as ill as that.
5 Now, for Dr Stevenson and the nurses, they are the touch
6 point or the contact point with the parents. So if they
7 don't fully understand it, absent yourself or Dr Webb
8 coming and specifically discussing it with the parents,
9 then it's difficult to see how the parents will be
10 accurately informed about the condition of their child.
11 Would you accept that?

12 A. I think there may have been that gap in understanding.

13 Q. And is that not a gap that you should have ensured
14 didn't open up?

15 A. I think I should have been part of that communication to
16 ensure that that gap didn't open up.

17 THE CHAIRMAN: In conjunction with Dr Webb, surely?

18 MS ANYADIKE-DANES: Yes. I'm only dealing at this stage
19 with what you would consider your responsibility to be.
20 You're not the only clinician there, we're aware of
21 that.

22 THE CHAIRMAN: Okay.

23 MS ANYADIKE-DANES: I am putting to you issues that people
24 have. If we stay with the nurses, when you formed that
25 view of encephalitis/encephalopathy, albeit contributed

1 to by your discussion with Dr Webb, did you think that
2 that ought to be recorded in the notes for the nurses
3 anywhere? You have recorded it here in her medical
4 notes and records, but should that have fed through to
5 the nurses for any kind of effect that should have had
6 on their care of Claire?

7 A. Again, those were only possible differential diagnoses.
8 I'm not sure that the nurses would have necessarily
9 adopted those in the nursing notes at that stage.

10 Q. I understand. And then, in relation to your views at
11 5 o'clock as to Claire's condition, do you think that
12 even if you had not done it before, that at that stage
13 you should have made sure that the nursing staff
14 understood that your view was that she was
15 neurologically very unwell and had been all day?

16 A. I'm not sure what discussion took place between me and
17 the nursing staff at that stage. It may have been
18 relatively limited, it may have been dependent again on
19 what Dr Webb had said to the nursing staff as well. I'm
20 not sure that I fully -- that I asked them if they
21 understood her to be a child who was neurologically very
22 unwell.

23 Q. What discussion do you think you should have had with
24 the nursing staff at that time before you went off duty?

25 A. As one of the clinicians there, I think I should have

1 been part of a discussion with the nursing staff to say
2 that this is a girl we are concerned about for these
3 reasons.

4 Q. And one of the reasons I'm being asked to put that to
5 you is that when Claire's parents are thinking of
6 leaving the hospital, it's the nursing station they go
7 to to say they're going to do that and to try and get
8 a sense of their child's condition. So this is the
9 significance of the question to you. If they have not
10 had impressed upon them what Claire's condition is, it'd
11 be very difficult for them to pass that on to the
12 parents who could make a decision as to what they wanted
13 to do about leaving for that evening; would you accept
14 that?

15 A. Yes.

16 Q. And you would appreciate that the most readily available
17 person, perhaps during the evening, for the parents
18 would be the nurses?

19 A. Yes.

20 Q. So if they were going to want to find out about their
21 child's condition and should they stay the night, should
22 they be making arrangements and so on, it's really the
23 nurses they're probably likely to look to in a busy ward
24 in the evening?

25 A. I think that's correct.

1 Q. Then can I ask you about a statement that you made
2 at the inquest? It comes in the answer session.
3 There's a formal bit which is typed up and then there's
4 a bit in manuscript. 091-009-059. It's almost exactly
5 halfway down:
6 "But I cannot be more exact. I probably examined
7 her late morning, but I cannot be more exact. What
8 I saw was outside my experience and then I contacted
9 Dr Webb."
10 Did you really regard Claire's presentation almost
11 throughout the day or at least whenever you were
12 engaging with her, if I can put it that way, as being
13 something that was just outside your knowledge, outside
14 your experience?
15 A. Yes, and by that I mean it's not something I could
16 countenance managing myself. It's not something that
17 I had experience of, so therefore it was outside of
18 experience that I'd had prior to this. That's what
19 I mean by "outside my experience".
20 Q. And absent the comfort of knowing that Dr Webb has
21 agreed to become on board and will see her, would you
22 have felt out of your depth? I don't mean that in
23 a pejorative way at all, but given your level of
24 experience and seniority at the time?
25 A. To some extent, yes. And by myself?

1 Q. Yes.

2 A. But again, I wasn't insofar as Dr Webb was there.

3 Q. Yes. When you take comfort from the fact that you had
4 brought Dr Webb in, who's prepared to come and give an
5 opinion and give guidance on her treatment, did you
6 think at the time that actually he was going to look at
7 Claire in the round, so not just to come and give
8 a discrete opinion, or are we talking about non-fitting
9 status or are we talking about encephalopathy and so
10 forth, and he was going to regard her in the round and
11 address her management in that way?

12 A. I think I considered Claire's problems to be
13 neurological and so I felt that Dr Webb was the person
14 to take that fully on board and manage that neurological
15 problem. As I said earlier, it may be that Dr Webb
16 actually, as well as being a paediatric neurologist, is
17 duly accredited as a paediatrician -- I don't know that
18 for sure -- but I would have felt him capable as well of
19 taking on board Claire's care in the round, if
20 necessary.

21 Q. Then let me ask you in this way. If that's the case, if
22 there were issues to do with her fluid regime, as to
23 whether that was the appropriate fluid regime or whether
24 it should be reviewed and so forth, this is during the
25 afternoon when he's coming to see her, is that something

1 that you would have thought was also within the spectrum
2 of the care that you believed that he was going to be
3 providing to Claire?

4 A. Yes, but equally I think the paediatric medical team
5 could have altered fluids too. I don't think one
6 clinician could or couldn't or should or shouldn't have.

7 Q. And if it was the paediatric medical team that was going
8 to do that, does that mean, because it's not entirely
9 clear where you were in the afternoon, effectively
10 Dr Stevenson?

11 A. Yes, if necessary, yes.

12 Q. And did you regard Dr Stevenson at that time in his
13 career, if I can put it that way, given what people were
14 beginning to regard as actually a very complex situation
15 with Claire -- did you regard him as sufficiently
16 experienced to be able to embark on managing her fluid
17 regime and even think about perhaps altering it?

18 A. I don't know if I thought about that at the time.
19 I would have expected Dr Stevenson to call, perhaps call
20 me for advice about that, if he was contemplating
21 a change, to run it by me.

22 Q. Would he even have had enough experience to know about
23 contemplating a change?

24 A. I'm not sure. He had done some adult medicine. I know
25 it was very early in his paediatric experience. He had

1 done some time as a medical SHO and would have
2 prescribed fluids, not for children, but -- I'm not sure
3 how I would have considered his ability or otherwise at
4 that stage.

5 Q. If you thought he was capable of -- or at least the
6 paediatric side also had some responsibility for the
7 fluid management element, and if he was capable of doing
8 that in the circumstances of her presentation, should
9 you not have turned your mind to it, either at 11-ish or
10 even at 5 o'clock, when you came back, and would have
11 realised that her fluid regime had remained the same all
12 afternoon?

13 A. Yes. With hindsight, yes, looking back, yes. I think
14 it would have been entirely appropriate, but that's
15 looking back 16 years. At the time, I think it would
16 have needed an instruction from somebody who had
17 a better idea of what was going on, or another U&E
18 result, perhaps showing that the sodium was falling,
19 which might have then prompted a change in fluids.

20 Q. The reason I pressed you on that is because when I was
21 suggesting to you that maybe the fluids might have been
22 something you thought were all part and parcel of what
23 Dr Webb was responsible for, you said, "Well, yes, but
24 also the paediatric team had some responsibility for
25 that". And I was really just trying to tease that out

1 because the paediatric team -- until you get back at
2 5 o'clock, or it would appear that you weren't there
3 until you arrive at 5 -- is really Dr Stewart and
4 Dr Stevenson, and Dr Stewart has even less experience
5 than Dr Stevenson.

6 And if you're thinking -- when I asked you, "Well,
7 couldn't you have done that at 5 o'clock", that's
8 something that you might have needed some instructions
9 from somewhere else, how is the paediatric team going to
10 independently address the issue of a review of Claire's
11 fluids if even you're not entirely comfortable doing it
12 at 5 o'clock?

13 A. I think that's fair. What I would suggest is that if
14 there had been a U&E result available, I think it would
15 have prompted an SHO to think about changing fluids,
16 perhaps after a discussion with myself or Dr Webb, or
17 Dr Steen even. In the absence of that, somebody would
18 have needed to have known what was potentially happening
19 to Claire in order to do that.

20 Q. And might that be a reason why, if you didn't see that
21 there was a serum sodium result at that stage, you might
22 have asked for one to be urgently sought?

23 A. Yes.

24 Q. And that would be something that would be added to
25 Claire's plan to be -- if your current team weren't able

1 to do it before they went on duty, something to be
2 referred to the incoming team to know that that's
3 something that ought to be done?

4 A. Handed over, yes.

5 Q. Yes. Did you ever have yourself a definite diagnosis of
6 Claire's condition?

7 A. In 1996?

8 Q. Yes.

9 A. Or before her death?

10 Q. Well, before her death, yes.

11 A. I don't think I did have a definite diagnosis, except to
12 say I would have believed Dr Webb's impression that she
13 did in fact have ongoing seizure activity because he was
14 the consultant neurologist and that seems to be his
15 feeling.

16 Q. Yes.

17 A. And I don't believe I heard anything that pushed me away
18 from that.

19 Q. But in all the time that you had contact, if I can put
20 it that way, between the clinician, the other clinicians
21 and the nurses, did you ever feel that anybody had
22 arrived at a definite diagnosis of Claire's condition as
23 opposed to a number of working possibilities, if I can
24 put it that way?

25 A. Not a very firm diagnosis, no.

1 Q. Just finally on this -- and if you can't answer this,
2 please say. Were you surprised that Claire didn't have
3 an inquest when you learned she had died?

4 A. I don't recall whether I was surprised or not. I can't
5 honestly answer that. I think as a registrar then,
6 I would have gone with, believed, left it, to the
7 consultants who were there at Claire's death to decide
8 whether or not Claire's death was referred to the
9 coroner. I'm quite sure I would have done that.

10 THE CHAIRMAN: And with the benefit of hindsight?

11 A. I think it should have been referred to the coroner.

12 MS ANYADIKE-DANES: Thank you. I think there's just one
13 final question, maybe two, that I've been asked to put
14 to you. Forgive me if you have answered this question,
15 but sometimes people don't always catch the answer that
16 they're looking for and they just want the question put
17 again in case. Forgive me if I have put it to you
18 before. When you spoke to Dr Steen, did you describe
19 her condition in the way that you have described it
20 today to the chairman, "neurologically very unwell"?

21 A. I don't remember what words I used. I can't remember
22 what words I used to Dr Steen on the telephone.

23 Q. If that was your view of her condition, is there any
24 reason why you wouldn't have described it to her like
25 that?

1 A. I think I would have used similar terminology. I can't
2 be more exact.

3 THE CHAIRMAN: And I think that when you were talking about
4 this earlier on, you said that the phrase
5 "neurologically very unwell" is a phrase which you would
6 use.

7 A. Yes.

8 THE CHAIRMAN: You're not recalling specifically using it to
9 Dr Steen, but it is a phrase which would have come from
10 your lips from time to time?

11 A. Yes.

12 MS ANYADIKE-DANES: There is just one final question.

13 I wonder if we could pull up 091-011-067, the last four
14 lines. I should say that this is the statement of
15 Dr Steen's at the inquest:

16 "My recollection is that when I contacted the ward
17 and told Dr Webb had seen her and had taken over her
18 management ..."

19 That's the bit that you're being asked. Is that how
20 you would have described it at the time?

21 A. Not unless I was sure that Dr Webb had in fact said that
22 or written it.

23 Q. And was it your impression that that is what had
24 happened at the time?

25 A. I think he was the consultant who was primarily guiding

1 treatment, prescribing treatment, had attended Claire.

2 Q. Yes.

3 A. And arguably de facto was the consultant who was leading
4 Claire's care. But I wouldn't have said Dr Webb was --
5 that he had taken over her care unless I had been told
6 that.

7 Q. Yes. And if that had happened, quite apart from being
8 told it, would you have expected that to be recorded
9 somewhere?

10 A. Again, this is one of the problems. It often wasn't
11 and, even until very recently, right up to almost the
12 present moment, it's not something that has been well
13 documented in notes. The shared care, as I said
14 earlier, can work well and you can get two consultants
15 or three consultants who manage a patient very well,
16 each talking to each other, and not write anything
17 in the notes about who's doing what. But if there's
18 a problem, it compounds the problem and it leads to
19 ambiguity, and it's something that I think needs to
20 change and arguably should have changed long ago.

21 As I say, I brought this up at the op group meeting
22 within the Children's Hospital in June, and it is
23 minuted. I brought this up in relation to a serious
24 adverse incident, that this is something that needs
25 clarified, particularly for junior staff, for nursing

1 staff and for consultants, that people know where they
2 stand and that there's a clear idea of who's doing what.

3 Q. Thank you, doctor. I think it's that word "management",
4 that was causing you to take some issue. Whatever
5 Dr Webb's involvement in Claire's care or guidance or
6 provision of opinions, it was that word "management"
7 I think that you thought didn't quite capture what his
8 role was. Would that be fair?

9 A. Well, "management" to me means that you're actively
10 doing something, you're managing it, you're ...

11 THE CHAIRMAN: You're in charge?

12 A. To some degree.

13 MS ANYADIKE-DANES: And you didn't think that's what
14 reflected Dr Webb's role at that time?

15 A. I think he was managing her care. In practical terms,
16 he was managing her care. Dr Steen wasn't.

17 Q. Yes, but not taking over her management?

18 A. You see, again, I think that's very difficult.

19 THE CHAIRMAN: Is this the area of ambiguity you are talking
20 about?

21 A. It's exactly it.

22 THE CHAIRMAN: Okay. When you had spoken to Dr Webb in the
23 morning, you'd asked him to become involved and to look
24 at Claire and you were glad that he was becoming
25 involved?

1 A. Absolutely.

2 THE CHAIRMAN: Your next possible involvement with Dr Webb
3 was at about 5 o'clock because we know you were on the
4 scene soon afterwards. You can't quite recall seeing
5 him. So if Dr Steen was told, if she made the phone
6 call, that Dr Webb had seen her, that would be accurate.
7 The question then is about the difficult phrase that he
8 had taken over her management. If that is done, is that
9 done consultant to consultant?

10 A. Yes.

11 THE CHAIRMAN: Have you known it to be done registrar to
12 consultant, with a registrar handing over management on
13 behalf of -- in this case, in other words, would you
14 hand over on behalf of Dr Steen management of Claire to
15 Dr Webb?

16 A. No.

17 MS ANYADIKE-DANES: At the time you think you spoke to
18 Dr Steen, which is sort of in the early part of the
19 afternoon and before Dr Webb had actually been there,
20 just so that we're clear, although you had asked Dr Webb
21 to come and see Claire and he had agreed that he would
22 do that --

23 A. Yes.

24 Q. -- nothing had happened at that stage, had it, to
25 suggest the extent to which he would become involved in

1 her care?

2 A. No.

3 Q. So if you were speaking to Dr Steen at that stage about
4 matters, you could not have been conveying to her any
5 suggestion that he was taking over the management of her
6 care irrespective of whether --

7 A. I think I'd have just given a description of what
8 Dr Webb had agreed to do, rather than make any
9 assumption about him taking over her care.

10 Q. Yes. So if she had got that impression from someone,
11 she wasn't getting it from you?

12 A. I don't believe so.

13 MS ANYADIKE-DANES: Thank you very much. I think that's it.

14 THE CHAIRMAN: Any questions? No? Mr McMillan?

15 MR McMILLAN: No, Mr Chairman.

16 THE CHAIRMAN: Dr Sands, thank you very much. Before you
17 leave the witness box, is there anything you want to
18 say?

19 A. I was wondering, Mr Chairman, if I may just say a word
20 to Mr and Mrs Roberts, with their permission as well.
21 I just wanted to say that I can't know what it has been
22 like for you these 16 years. I need to say that I can't
23 practice medicine without sharing a portion of the
24 sorrow that occurs when a patient dies, and particularly
25 when that's a child. And all I can offer to you is that

1 sorrow and my sincere sympathy. But, as I say, I can't
2 fully understand or appreciate how difficult these
3 16 years have been.

4 THE CHAIRMAN: Thank you very much indeed. You are free to
5 go, Dr Sands, thank you.

6 Ladies and gentlemen, that brings an end to a very
7 long week. We will not be sitting next week, as
8 you know, and we will resume on Monday week at 10.00.

9 (5.05 pm)

10 (The hearing adjourned until 10.00 am on Monday 29 October)

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