Wednesday, 17 October 2012

(10.00 am)

(Delay in proceedings)

(10.15 am)

DR HEATHER STEEN (continued)

Questions from MS ANYADIKE-DANES (continued)

MS ANYADIKE-DANES: Good morning, Dr Steen.

A. Good morning.

Q. Dr Steen, you don't have a recollection of Claire's admission at all, but you have always said in your evidence here to the chairman that you had the impression or you believed that you were there and that you have pointed us to certain aspects of other children's records in support of that view.

If you actually were there, can you think of any reason why you wouldn't be recorded as participating in any of the ward rounds? I'm not just talking about Claire's; in any of them.

A. I've always said that the ward round was running late. At the most, there were only five patients to be seen before Claire, and that something else must have been going on in the hospital that morning, that the ward round was not running normally, and that it may well be that I was somewhere else and popping in and out so that I was there for periods and not.

Q. Why do you say that at the most there were only five patients to be seen before Claire?
A. Because the ward held 17 patients plus -- and we know there was one in Cherry Tree and four cystic fibrosis patients, so the four cystic fibrosis patients would have been in four of the five side wards. So there was a patient in one of the side wards that may have been Allen Ward -- you're looking for your map?
Q. I'm listening to what you're saying.
A. There would have been a patient in one of the side wards that may have belonged to the Allen Ward team and there would have been four patients in room 6. From my understanding, Nurse Fields, when she was advised by Claire's parent that there were concerns about Claire's well-being, had to actually go into room 6 to draw Dr Sands' attention to Claire being unwell.
Q. We'll come to that in a minute. My tally is that there were seven of your patients who were the subject of a ward round.
A. Plus the other patients who would have belonged to the Allen Ward team.
Q. I beg your pardon, in fact there were eight of your patients who were subject to a ward round.
A. Plus the Allen Ward patients who would have belonged to the Allen Ward team.

Q. I understand that, but leaving aside that for the moment, I'm just trying to find out why you think there were only that number seen before Claire.
A. Because there were four CFs plus one in Cherry Tree, so that was four side wards used. If you start at the top of the ward, there are four side wards. Four have CF patients in it, so that leaves one. The next ward is the four-bedded ward, room 6.
Q. Yes, but do you know that the ward round was actually conducted in that way?
A. It's the way it is normally conducted unless someone else has taken -- has gone elsewhere. It normally starts at the beginning and works its way round unless there is a reason to go from one patient to another in a different way. It's quite a formal process to see all patients.
Q. There seemed to be an indication that you might see patients who you thought were more serious and required to be seen.
A. If that was highlighted at the handover at 8.45, 9 o'clock.
Q. But the reality is that you don't actually know how they conducted that ward round.
A. No, I don't.
THE CHAIRMAN: I had got the same impression as

Ms Anyadike-Danes has just said and I think you're correcting it. Unless your attention is drawn to a specific patient who needs to be seen urgently, the ward round follows a geographical route.

A. Yes, through the ward to the outliers and then intensive care.

THE CHAIRMAN: And that is the route which you would follow day in, day out, year in, year out, unless it's brought to your attention there's a child in room 6 or room 7 who needs to be seen urgently?

A. Yes.

MS ANYADIKE-DANES: And why do you think the ward round started late?

A. Because my understanding from reading the witnesses is that Nurse Fields returned from second coffee, and it was that stage Claire's parents arrived and identified to her that Claire was unwell. That was after 11 o'clock. And Nurse Fields actually went into room 6 to ask Dr Sands to see Claire. The diazepam, I think, was given about 12 o'clock. So therefore, Claire was being seen slightly ahead of what other children were in room 7, but it was some time between 11 and 12 o'clock, and the ward round should have been finished before then.

Q. It should have, according to you, unless of course there

needed to be more time taken with any given patient. Presumably, these things aren't entirely regimented in that way and you take the time you need to deal with the patient.

A. Yes.

Q. So depending on what was happening that day, if you started at 9 and you didn't necessarily start in the way that you had indicated, you might have been getting to Claire towards the end at 11 o'clock?

A. Yes.

Q. But in any event, the question I had asked you was why is there not any reference to you being involved in any of the ward rounds, and I think your answer was you are not entirely sure, but you think you might have been popping in and out.

A. Yes.

Q. But you don't know what else was happening?

A. No.

Q. And can we say that on the medical notes and records of the other children on the ward, there doesn't seem to be anything indicated there that would have occupied your time?

A. No.

Q. And there's certainly nothing recorded as showing that your time was being occupied.

A. Yes.
Q. That's correct, isn't it?
A. Yes.
Q. So if it was something that was occupying your time, it doesn't seem to have anything to do with the children on the ward?
A. No.
Q. And you've not been able to help with what else that might be.
A. No.
Q. You didn't have a scheduled clinic or anything of that sort.
A. No, there would have been no clinic and we have searched through looking for diaries, et cetera, and there's no information.
Q. Yes. So if you had been there in the way that you suggest and able to see the children that you say you saw, or at least interpret the records to indicate that, then there would be no reason why you wouldn't be involved in the care of one or other of those of your children who were on the ward in a way to have you recorded?
A. I'm sorry, you lost me.
Q. I beg your pardon. It was rather a convoluted way of asking the question. I am sorry about that. If you

were about in the way that you've indicated and able to see the -- I think it's at least two children who you say you saw that morning, or at least you say the records point to that --

A. Yes.

Q. -- then there's no reason why you couldn't have been involved in Claire's care.

A. No.

Q. No. In fact, I think you did indicate that Claire was a sick child and, all things being equal, you would have wanted to be involved in Claire's care.

A. Yes. And I'm unsure if Claire's condition was giving concerns before 11 o'clock or just after 11 o'clock.

Q. But even if Claire's condition was giving concern at 11 o'clock, according to you, although you don't remember it, your normal practice would have been to not leave the hospital before about 1.

A. Yes.

Q. So you would still have been there.

A. And I would still expect to have been spoken to.

Q. Yes. But even whether you'd have expected to have been spoken to, she was a new patient of yours, you're in and about the ward, you even say you were in the very bay where she was, which is a four-bay ward. So there would be absolutely no reason why you couldn't have seen

what was happening with Claire, introduce yourself to her parents or other family members who were there and just generally keep track of what was happening and, in that way, had yourself recorded.

A. I've no recollection. I can only tell you what my sense is of what has been happening and we -- there is no documentation to clarify it.

Q. My question to you is: if you were there in the way that you suggest and if you, more than that, were actually in the bay, there is no reason why you could not have yourself involved yourself in Claire's care.

A. That's correct.

Q. And if you had done that, you would expect that to be recorded.

A. Yes.

Q. And if the junior doctors weren't there to record something of significance, then you yourself could have added something to Claire's notes just as in the same way you added to the notes of -- I believe it is patient S8?

A. Yes.

Q. But that's not there.

A. No.

Q. I want to put to you something that Dr Sands has said, because he, after all, was carrying out most of the ward

rounds and certainly the ward round involving Claire. If we pull up his witness statement, 137/1 at page 19, and then if you bring page 20 up alongside it.

Really, if you go down to the bottom, you see it all is in response to question 10; do you see that?

A. Yes.

Q. And this is a statement that he had made. I believe that's from his deposition to the coroner:

"The paediatric consultant under whom Claire was admitted was unavailable, although I believe she was kept informed by telephone."

That's you who's being referred to.

A. Yes.

Q. If we look at (e), for example:

"Explain why the paediatric consultant under whom Claire was admitted was unavailable."

And he says he can't explain it, although:

"[His] understanding was that the consultant under whom Claire was admitted was not present in the hospital."

You are dealing with impressions, he's dealing with understandings. But so far as you're aware, how could he possibly have got an understanding like that?

A. I'm not sure because we -- whatever way it is taken, we do have some information, some evidence, something

written at the time, to suggest that I was in the ward that morning.

THE CHAIRMAN: Is his understanding correct for the afternoon?

A. It is.

THE CHAIRMAN: Okay.

A. And we don't know exactly what time.

THE CHAIRMAN: So the real question is what was happening in the morning. And we'll hear from Dr Sands hopefully later today about whether that understanding extends to the morning as well as to the afternoon. But that's the issue really, which arises from his statement.

A. And what part of the morning.

MS ANYADIKE-DANES: Let's look at (c). He was saying something about you were generally unavailable. So:

"State what you mean by unavailable and how and when you first became aware that the consultant was unavailable."

He says he doesn't remember where you were on the 22nd:

"But I believe she was not in the hospital, but was contactable by telephone."

I'm putting these things to you simply so that you have an opportunity to respond, but more to the point, because he's going to give his evidence, so that he

hears how you respond to these things. So it's really the same question. How is it that he could have formed the view that you weren't in the hospital and were only contactable by telephone?

A. I don't know how he could form that view. We do know from the records, albeit limited, that I was in the ward at some stage that morning.

THE CHAIRMAN: But then in fairness to you, Dr Steen, if you read on down, his answer to (d) is that he doesn't know for what period you were out of the hospital and not able to attend. And then he says, at (f), that his contact with you was at least once by telephone and he believes that was in the afternoon.

A. Yes.

THE CHAIRMAN: So if that's correct, then there is a certain logic to it because it's agreed you're not in the hospital in the afternoon. So if he does contact you in the afternoon, it has to be by phone.

A. It would be.

THE CHAIRMAN: We still have the missing period about the morning.

A. Yes.

MS ANYADIKE-DANES: Claire's parents will say that they were in hospital from about 9.30 in the morning of the Tuesday and they didn't see you at all. As I understand

their evidence, they didn't even know you were the consultant for their own child. But if you had been about, then one might expect them to have remembered that. They were looking for medical guidance as to what was happening with their daughter.

A. I think there's ... If you look through the different evidence, there's various times when the Roberts had felt they had arrived in the ward. I think if we go way back to Nicki Rooney's history ... Let me think. Mrs Roberts had said they arrived about midday in the ward and that's minuted, I think, in Nicki Rooney's minutes of the meeting that was held in 2004.

Q. We'll check that.

A. Yes. And then the nursing staff will give you maybe a clearer idea of when they think Mr and Mrs Roberts actually came to the ward. They certainly came at some stage that morning.

Q. Their evidence is, as I understand it, that they were there from 9.30 in the morning. We'll look at Nicki Rooney's minutes subsequently, but that's their evidence.

THE CHAIRMAN: Mr Quinn, am I right in understanding that the position of Mr and Mrs Roberts is that the first time they met Dr Steen was after they were called back into the hospital in the early hours of Wednesday

morning when her condition was irretrievable?

MR QUINN: That's correct. That's correct. They say two things on this point. In fact, I opened the case very carefully on this issue. They say they were there at 9, 9.30. They say they were not happy with Claire's appearance and that they told a nurse, who went off somewhere to carry that information somewhere else. And they say -- and Mrs Roberts will say this quite clearly -- that they actually knew and had got to know the parent of the other child who was in bay 7, and had Dr Steen been there, they'd have recalled this. Because of that connection, they have a clear recall of the other child, whom they know in these notes in bay 7, who we have asked them not to reveal, of course.

THE CHAIRMAN: Of course.

MS ANYADIKE-DANES: I have their witness statement. It's witness statement 253/1, and it's at page 6. At (a):

"Please state time at which you arrived in the hospital on the morning of Tuesday 22 October. Approximately 9.30 am."

And then, just to confirm by evidence, so it's not Mr Quinn giving evidence from the bar, there is a reference there to:

"Claire did not appear to be herself that morning."

And they expand upon that:

"When I arrived at the hospital on Tuesday morning, I expected to see an improvement in Claire's condition. Claire was still lethargic, drowsy and pale and her condition had not improved from the previous evening."

And then going on:

"Please state if you were present during the ward round on the morning of the 22nd. I was present during the ward round on the morning of 22 October."

And so on. I don't propose to go through the entire bit, but they are quite clear in their evidence.

So if you had been in that bay where they were with their daughter or if you had popped in and out at some point during the ward round at that stage when their daughter was being examined, their view is that you would have been obvious to them and they would have remembered that. And they don't.

A. No, they don't, and I'm not sure whether the timing, after all these years, is correct. There's a suggestion in 2004 it was slightly later that they arrived.

Q. We'll look at that in due course, I'm sure. Anyway, you can't help with the response that Dr Sands has so far given in his evidence as to why he should have that view.

A. No.

Q. I just want now to close off this evidence that you have

given in relation to what we call the 150 file. Clearly, this whole issue as to where you were and when you were is something that you have appreciated is of some significance and has always been important --

A. Yes.

Q. -- right from the outset.

A. Yes.

Q. Because you weren't able to assist the coroner really with any clear idea, except for: we've seen a reference when you are communicating with Mr Walby and you acknowledge that you didn't see Claire from the moment she was admitted until coning. I think that was the expression you used. Leaving aside that, that raised a question of why didn't you, where were you, so this is the issue that has been there for you from the outset really.

A. It has.

Q. Can I then ask: how did it come to be that you had the idea that you would look at other patients' records to try and see if that would assist and when did you have that idea?

A. We had been trying for years to --

Q. Can I just ask who "we" is?

A. Myself, the management team, the litigation team had been trying for years to try and have a clearer picture

of what had been happening that morning. I think a lot of the searches went on the ward diaries. I personally on at least three occasions went through admin filing in Cupar Street and Carlisle Centre, trying to find diaries relevant to that period, and I'd been through my own. There was constant discussion around what could we do, what could we find out, who else would have been in the ward, and I think everybody was focused on the ward diary and was searching for the ward diary. I was not aware that the IT system could be interrogated to identify which patients were admitted on a certain day, and I'm not sure the Trust did either because the inquiry asked the Trust -- I think it was in January -- how many beds were occupied in RBHSC on the night. I think there's a letter -- April -- a letter back from the Trust to say that the IT department had interrogated the system and found that -- I'm sorry, don't quote me -- there were about eight beds occupied.

I certainly personally didn't know that the IT system could even be interrogated at this stage to deliver that, and if that had been shared with myself or indeed Mrs Pollock or any of the other staff, we would have been aware that that's not true, there's no way there were just eight beds occupied. But it would also have given us an opportunity to discuss if there were

any other ways we could do things with IT.

My understanding is a colleague was doing a clinical audit where he was going back over an issue and discovered that you could actually interrogate the IT system to identify who was admitted on a certain day. Hoping to help me, and without understanding the full repercussions, he asked for all the charts for the children who were admitted on 21 and 22 October.

Q. How did he know that was an issue?

A. Everybody knew it was an issue.

Q. For you?

A. For me, for Mrs Pollock, for all the nurses, the medical staff, what was happening that day. It is a discussion point within RBHSC about trying to find out what was happening that day.

Q. And you said that this was also something that management were concerned about, obviously, from their point of view?

A. Yes.

Q. Then if he had found a way to do that, that's, one might say, problem solved. Why didn't he take it to management and say, "You can deal with this".

MR FORTUNE: Sir, this is not a proper question for this witness.

THE CHAIRMAN: If she doesn't know the answer, she will say

she doesn't know the answer.

A. I don't know why he didn't take them. What he did was he left them with my secretary on the Monday afternoon.

MS ANYADIKE-DANES: You mean without discussing with you that he had found a way to address the problem, he just did that?

A. He brought the charts to my office and he left them on a Monday afternoon and informed me what had happened. I did not get a chance to look at anything until the Wednesday. I was having a consult with my legal team on the Wednesday, I didn't know what to do with the information, I wasn't sure whether it was admissible, what was appropriate, so I took copies of some of the records, redacted them so the children weren't obvious, and took that with me to my legal consult to ask for legal advice about the way forward with what we did with this information.

Q. Have you ever had to look at files for research purposes?

A. Yes. But you normally look under -- if we are auditing, we audit to condition, so I know I could ask, "Could I have all the charts of children with asthma, with empyema?", which is a chest infection, and they would recognise ... I knew you could search under diagnosis. I didn't know you could search back to find out all the

children who were admitted on a certain day.

Q. What did you know about how you could search? You could search under consultant, did you know that?

A. No. The PAS system, as far as I am concerned, is -- a clinician stores all the outpatient attendances and the inpatient attendances of the patients. So if you had a patient identifier, a number or a name or a date of birth, you could go in and find out about that patient. You could find out in advance what patients were booked for your clinic, but after your clinic's been over, maybe a few weeks, that information is lost and what you just then have is being able to identify each patient. And I would know that you can go in under diagnosis to find out how many children were admitted with a certain diagnosis and who those children were. But not -- and obviously neither did the IT department know this that in --

Q. Leaving what the IT department knew to one side for the moment, but when you were trying to work out where you were and what you were doing and you say this was a matter that you, other clinicians, the management team and so forth, were all exercised about, and you knew for perfectly proper research purposes and clinical purposes that you could look at data in a certain way, did you ever raise with them, you not being an IT person, "Is

there not some way that you can search that system and find out?". Did you ever raise that issue?

A. I think Peter Walby sent me an e-mail, towards the end of January.

Q. No. Did you ever raise that issue, "Is there not some way in which the files can be searched to see where I was and Angela Pollock and others and what was happening on the 21st?"

A. I cannot recollect. I do know I had a conversation with Peter Walby following an e-mail he sent in January about my whereabouts, and I think it was also about my job description. And at that time, I identified to him all the steps that I had taken to try to discover where I was, going through the diaries, discussing with people, looking at various options, and his advice at that time was to wait until all the witness statements came in because it might help to clarify the issue.

Q. What I'm trying to get at is: I think your earlier evidence was this was something of some concern and you and others had been trying to do this for some time.

A. Yes.

Q. Don't worry about what Peter Walby's e-mail was to you. The question I'm seeking to have you address is just: if it was something that was very important, which you have accepted it was, and you've been trying to do it for

some time, did you ever ask, "Is there not a way where the files can be interrogated, looked at, searched to try and find the very thing that is of concern to us, which is: where were we and what were we doing?"

A. I can't be sure whether I asked or not.

Q. You see, the impression that I got when this matter first arose is that that is something that you believe you had been asking to do. You didn't personally know whether it could be done, but you were asking whether that could be done, to answer the question.

A. I can't -- I'm sorry. I cannot clearly tell you a date or time or person that I would have asked that question to.

MR QUINN: Mr Chairman, the witness has mentioned diaries. I took it to understand that there were no diaries.

THE CHAIRMAN: That's what our understanding is. In fact, we have been specifically told that the ward diaries from that time have long been destroyed.

MR QUINN: We specifically asked for them three months ago, all diaries, anything at all. I would like to know what they were and where they are and how we can get a look at them.

THE CHAIRMAN: What is your understanding about ward diaries?

A. My understanding is that there has been extensive

searching over a period of time throughout the hospital and I personally, through community paediatric admin systems, trying to identify the diaries and no diaries have been found.

THE CHAIRMAN: What different sorts of diaries could you be talking about?

A. There's my personal diary, which would have been held in the Cupar Street clinic by my secretary. There is the clinic diaries, which would have been held in Cupar Street, which would have identified when clinics were being held, who was running them and which patients had been booked to attend. They were manual records, they weren't IT. There was the ward diary, which was the ward round diary.

THE CHAIRMAN: Sorry, like Allen Ward or Musgrave Ward?

A. Yes, Allen Ward -- and I'm not sure the system that Musgrave Ward had. Allen Ward had its diary. There would have been a diary, probably another ward diary, where you put in your booked admissions and any other things that were going on in the ward. And then there were my personal diaries that I may have kept at home.

THE CHAIRMAN: So far as your personal diary is concerned, have you made efforts to find that?

A. Yes, I've been through the house repeatedly.

THE CHAIRMAN: Okay. And the ward diary, there are two

possible different sorts of ward diaries within the Children's Hospital: the Allen Ward and another ward diary for booked admissions, et cetera.

A. Mm-hm.

THE CHAIRMAN: What is your understanding about those diaries?

A. They have been disposed of, they cannot be found and there have been extensive attempts made to try to find them.

THE CHAIRMAN: Okay. And the Cupar Street diaries, are they less likely to show where you were or what you were doing on the --

A. No, they were my eight-sessions-a-week diary. They reflected what I did most of the time.

THE CHAIRMAN: How would they help with finding out what you were doing on the morning of the 22nd when you weren't at Cupar Street?

A. If it had been anything other than being in Children's, that would have been noted in the diary. It would have noted where I was, but it would have noted if there were any clinics or anything else running.

THE CHAIRMAN: And what's the position about those in the Cupar Street --

A. I searched for those in 2004 and couldn't find them. Cupar Street then -- the majority of community

paediatrics moved to Carlisle Centre about 2007, I can't be sure, and we had an opportunity then to go through a big admin storage area, myself and one of the secretaries went through trying to find the diaries. Then finally Cupar Street was decommissioned in June 2011 and myself and my secretary again went through any documents left for any aspect of community paediatrics to make sure that the diaries weren't there, but also to make sure that confidential documents were disposed of appropriately.

THE CHAIRMAN: Okay. Let's move on.

MS ANYADIKE-DANES: I think when your counsel was explaining how these initial documents came into his possession, which led ultimately to the application that the inquiry made to see them all, there was a discussion then between your counsel and the chairman as to the route B. If there was no ward diary, what was the route B? What other way might there have been to try and assist answering the question? In particular, when you needed to answer it, which was when you received your first request for a witness statement from the inquiry.

I think the answer is that trying to answer that question and what the route Bs might be is something that was the subject of discussion between you and the management; would that be fair?

A. Yes.

Q. Well, that's exactly the point, because the inquiry asked the Directorate of Legal Services about that, just so that we were clear. In fact, that correspondence, I think, has been provided. It starts at 302-133-001. That's the question:

"The chairman has directed the Trust be in a position to provide him with details of any and all enquiries and efforts made to discover the whereabouts and movements of Dr Steen between 9 am and 5 pm on 22 October."

There was a follow-up to that.

THE CHAIRMAN: "Any enquiries and efforts made either by Dr Steen or by the Trust."

MS ANYADIKE-DANES: Yes. Exactly. I beg your pardon, Mr Chairman.

That's either in relation to the inquest or since then for the purpose of responding to the requests made by the inquiry. After that, there's a letter on page 134-001. So that's an extension of that:

"... whether Dr Steen made any requests orally or in writing or by e-mail to clarify whether she was present in the hospital and/or in the ward or contactable on Tuesday 22 October and confirm what steps the Trust took."

Then the answer comes back as 302-135-001. It's really the second paragraph:

"In relation to the requests contained in your letter, we are instructed by our client that it has undertaken a thorough search of all relevant paper and computer records and it can find no evidence of Dr Steen having ever asked the Trust's litigation office to clarify whether, on Tuesday 22 October 1996, she was present in the hospital and/or in the ward and/or contactable."

Then it goes on to say:

"We have examined the Brangam Bagnall/MSC Daly file [which is the solicitor's file] relating to Claire Roberts' inquest and we can see no evidence of any such request having been made of the litigation office via Gary Daly or Brangam Bagnall."

And then in addition:

"We have received instructions from Mr Peter Walby that Dr Steen had two clinical sessions in the former Royal Hospitals Trust in 1996 and the rest of her employment was with the North and West Belfast Trust. She had ward duties in Allen Ward on a Tuesday morning and duties in Cupar Street [which we now know] on a Tuesday afternoon. Mr Walby raised the issue of her non-attendance at the Tuesday morning ward round on

22 October 1996 in an e-mail sent on 27 January 2012 [which might be the e-mail you were referring to] at 12.40."

A. Yes.

Q. And then just over the page from that, 002:

"Mr Walby has advised us that Dr Steen did not make any requests to him concerning whether she was present in the hospital or ward or contactable on Tuesday 22 October 1996.

"As regards whether the Trust undertook any investigation or interrogation of the computer systems in the hospital, Mr Walby instructed us that he did not think of doing this on behalf of the Trust as Dr Steen's Tuesday morning ward round, whether performed or not, would not have been registered on the Royal Hospital computers."

So he goes on about the PAS system. Perhaps if we go to 135-003, we can see the e-mail that has been referred to. This is an e-mail that Peter Walby sends directly to you. He says:

"Personnel have had the old files trawled in McConnell's storage and your file is not there, unfortunately. So we cannot trace a copy of your job description."

Which was one of the things being requested:

"Current at the time of Claire's admission."

Then he asks you whether you could look for it at home:

"I know it is a long time ago, but would you have not kept it with other contract documents, et cetera, which would have had relevance to the development of your CVs?"

Just so that we are clear: do you have any documents at home that relate to your period of involvement with Claire?

A. Not that I can find.

Q. Thank you. And then he refers to the questions that have been asked which would be relevant for such a search. Then he says:

"It is going to be awkward if you are not able to explain why you did not do your normal Tuesday ward round as one of your two RBHSC sessions, isn't it?"

And then he adds a postscript to that:

"The inquiry want an answer today as to why your statement is late. What do you want me to say to them, please?"

So it is very clear, the difficulties posed by not having the information. It's very clear that at that stage, which is January 2012, you don't appear to have any explanation or answer for what you might have been

doing. But it also seems to be the case -- and this is what I'm inviting your comment on -- from the DLS correspondence and Mr Walby's correspondence that this matter was not the subject of discussion or request from you.

A. I'm very clear that I had a discussion with Peter Walby in his office following that e-mail in January 2012, and I can't tell you exactly the date. It was within a few days because I was going back over to try to get my statement finished. And that conversation focussed around what I had been doing to try to identify where I was that morning. And his advice to me at that time was to wait until the rest of the witness statements came through because they may have helped identify what was happening.

THE CHAIRMAN: Okay. Well, the rest of the witness statements came through and they don't really help to identify what's happening.

A. No.

THE CHAIRMAN: So this remains an issue of great concern to you personally.

A. Of course.

THE CHAIRMAN: And it should also be an issue of great concern to the Trust.

A. Yes.

THE CHAIRMAN: Because on the face of the record, apart from your own interest, the Trust should be concerned that one of its consultants does not appear to have been where she might be expected to be on the morning of the 22nd. When the statements all came in, the Trust would have known about the statements because the Trust coordinated the responses which we received for most of these statements.

A. Yes.

THE CHAIRMAN: When that was done, did you yourself take any further steps to raise this issue, in other words go back to Mr Walby who had previously said, "Hold off until the statements comment in"? Did you then come back to him?

A. I had several conversations with Peter Walby over the period of time until my statement went in and I can't remember them all.

THE CHAIRMAN: I asked you something slightly different. He said, "When all the statements come in, let's see if they throw light on your whereabouts", effectively.

A. I'm not sure that he or I said that the witness statements didn't help.

THE CHAIRMAN: Yes, but if you're going to him and recognising that there is a problem, that the records aren't available to show where you were, and his

response is, "Look, let's wait and, when all the witness statements come in, see if they throw light on it", and the witness statements come in and they don't throw light on it. At what point did you then pick up with Mr Walby and say," This hasn't helped, what can we do next?"

A. I'm not sure I went back to him particularly around the witness statements.

THE CHAIRMAN: It's around the issue that there's still no information about where you were.

A. He wasn't able -- whenever we had the conversation, he wasn't able to suggest anything else. The Trust were trying to interrogate the PAS system to get further information. I didn't realise that was going on. And they were having difficulty getting information out of it. And I think simply, without any other things, simply people had not realised that you could go into the system -- so simply under date of admission -- to identify the patients. Because if we did, it would have made everybody's life easier and it would have saved so much delay and so much difficulty. It sounds very simple. I don't know how our IT department didn't know what to do. I'm not IT, I use PAS as a clinician, I didn't know. Peter Walby uses PAS as a clinician, he also knows a certain amount around litigation. I don't

think either he or I knew that we could interrogate PAS in this way to direct the IT department to do it.

THE CHAIRMAN: The person who did uncover this, is that -- I don't want the name. Is that person a doctor --

A. Yes.

THE CHAIRMAN: -- who's connected to the Children's Hospital?

A. Yes.

THE CHAIRMAN: Right. So we've got a doctor connected to the Children's Hospital who knows the system can be interrogated in that way. We have you not knowing that. We have Dr Walby whose position was what, at the time?

A. Assistant --

THE CHAIRMAN: He's in a senior position in any event. And we have the IT system you say you now understand was being asked to interrogate the system. And I'm being told today that, fortuitously, a doctor, who's nothing to do with the inquiry, who was doing some other research, trips over this?

A. Could I ask you to put the word "audit" in rather than "research", simply because there are governance issues around? It was an audit and, yes, for some reason -- and I have not spoken to him because once I had the documents with my solicitor, I was advised not to speak to him about it any further, so I don't know exactly

what the audit he was doing or whatever it is was, but whatever it did, it required to be able to identify patients on the day of admission.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Just one final question then. Your view, really. Is it not an extraordinary thing if you haven't specifically requested it, for when the doctor tripped over it by accident that you could do this, that he then takes it upon himself to -- did he bring the files to you or photocopy them?

A. He brought the files and left them in my office.

Q. Having identified these files, and these files are files that might be relevant to assist you, he then goes and finds those files. I presume they would be in storage somewhere given the length --

A. Yes.

Q. So he has to go and request them from storage, where they'd be kept, because we're talking about 1996, get them back and go and put them in your office, all without any exchange between you and he.

A. Yes.

THE CHAIRMAN: or between him and the hospital management?

MS ANYADIKE-DANES: That was going to be the next point.

A. I can't answer because I have not spoken to him about it

because I've been advised not to.

Q. How many files did he leave in your office?

A. The Trust will know because the Trust removed the files from the office.

Q. Yes, but you had them and looked at them. So how many files did he leave in your office?

A. There's the number of charts ... You're asking me for details which I find difficult for numbers, et cetera. I find real difficulty remembering this type of detail. There were seven to nine different patients as far as I know.

Q. All yours?

A. I can't remember. There must be documentation around somewhere about this. I would need to refresh my mind about exactly -- you're asking me to give detail that I can no longer give.

THE CHAIRMAN: Are we right in understanding that the Trust then took or somebody in the Trust then took these documents and files out of your office?

A. On the Tuesday, whenever my legal team brought it to your attention, the Trust removed the charts from my office that evening. I was not in the Trust on the Wednesday, but I was in on the Thursday.

THE CHAIRMAN: Sorry, I think it was on a Monday.

A. Was it the Monday?

THE CHAIRMAN: This was raised here on a Monday and when Mr Simpson, one of the Trust's counsel, was back here on Tuesday, he said the Trust had taken the files from your office.

A. Yes. In fact, they hadn't taken all the files. There were three left and I took those up to the clinical director's office, and said, "Those need to go somewhere, those are being requested as part of the inquiry, I don't want to know any more, those need to be taken to one side".

MS ANYADIKE-DANES: When the files were originally left in your office, were they left with a note of some sort?

A. I can't remember. He had spoken to me in the afternoon. I think we were both doing clinics in the afternoon.

Q. And he spoke to you and said that's what he had done?

A. Yes.

Q. What was your response to that?

A. I didn't know what to do. I didn't know what to do with this information. I didn't know whether it was going to be relevant or whether it was going to be admissible.

Q. Leaving aside relevance and admissibility, what was your response as a senior clinician? You after all have been assistant medical director, I think, at some stage.

A. Yes.

Q. So a senior clinician and in management at that. What

was your response to the fact that apparently you had in your office unsolicited medical notes and records of children?

A. I ... The issue about it being unsolicited I don't think came -- or my thoughts I think were --

Q. Then the medical notes and records of other children.

A. My thoughts were: gosh, this might help, it might be a negative, it might be a positive, what are we going to do about it?

Q. Were not your immediate thoughts: isn't that a breach of somebody's confidentiality?

A. I'm sorry. It wasn't my immediate thought and it should have been.

Q. Given that that now was the answer to the question that you, according to you, your evidence, had been pursuing with the Trust, did you immediately tell the Trust: there's a way of doing this, not just for me but for Angela Pollock and everybody else we've been searching for?

A. No, I went to my legal team and asked for legal advice about the best way forward of what to do with the information that was now received. My legal advice was no longer with the trust.

Q. Sorry, I wasn't talking for legal advice, I meant to the management, but anyway I think you've answered the

point.

I wonder if now I can take you to some of the events that are recorded in Claire's witness statements and put to you some of what the experts have said so that, as I had said I would do, have an opportunity to respond.

I think that the inquiry's expert, Dr MacFaul, would be of the view that if you thought you were not going to be available for any reason at all, then you should have handed over to another consultant paediatrician; would you accept that?

A. Yes.

Q. And if you thought you were going to be present, but perhaps not available for the ward round, you should have deferred the ward round until later on; would you accept that?

A. If that was feasible, yes.

Q. And --

A. Sorry, can I just add an issue there? If you defer it for too long you're actually not getting children seen and sorted.

Q. I'm sure there's a judgment call on that.

A. Yes.

Q. And if you are going to do that or if for reasons you come to the conclusion that you can't defer it in a way that would accommodate you and satisfy the needs of the

patients, then in either case, you should be notifying your registrar, because either he has to re-arrange matters so that he can accompany you on a deferred ward round, or he or she is going to have to conduct the ward round?

A. Yes.

Q. Would you accept that?

A. Yes.

Q. It seems that Dr Sands actually conducted the ward round.

A. Yes.

Q. Is there any documentation that you can see that has identified any kind of communication, alerting him to the fact that that's what he's going to be doing that morning?

A. No.

Q. In your practice, was it your practice that you would carry out the ward rounds and for him to be -- or "her" if it's another SHO -- to be carrying it out is not routine or a regular thing?

A. Post take [sic], I would have tried to carry out my own ward rounds. If I knew in advance that I would not be available, I would have tried to change the night on-call with my colleague so that she was there, she was doing the ward round, and if I wasn't able to attend at

all and she was available, I would have asked her to keep an eye on the ward.

Q. So do I understand that to mean that you regularly carried out your ward rounds?

A. Yes.

Q. Then if we go a little bit behind that to the actual admission time and deal with the fluids that Claire was prescribed and administered. Professor Neville has said in his expert report -- I don't think we need to pull it up, but for reference 232-002-004 -- that the use of Solution No. 18 in a drowsy child should have been at least with a warning for an urgent review and it would have been appropriate in those circumstances to use restricted fluids; would you accept that?

A. Yes.

Q. And MacFaul says that:

"In the context of a possible encephalopathy, the ideal or high-quality practice was to use an IV fluid with a higher sodium concentration and therefore, obviously, not Solution No. 18."

Would you accept that?

A. Yes, but I -- we also have, I think Dr Scott-Jupp suggested the awareness of needing to reduce fluids or ... I don't like quoting things that I vaguely remember without the documents.

THE CHAIRMAN: We can bring up Dr Scott-Jupp's report. If you can summarise the point and, if we need to, we'll look at the precise details of what he said.

A. I think Dr Scott-Jupp did also say that the awareness of needing to change to higher sodium solution or to reduce fluids was maybe not ... There wasn't a lot of awareness at that time.

MS ANYADIKE-DANES: Did you have such an awareness?

A. I can't remember. We're going back to 1996. I can't remember. There has been so much happened in between that how practice has changed -- I certainly know that by 2000 any child with an acute neurological condition was maintained on two-thirds maintenance when they came in, no matter what their sodium was.

Q. Leaving aside whether that would be the appropriate fluid to start her on -- and just for reference's sake, the reference for MacFaul was 238-002-018 and the reference for Dr Scott-Jupp is 234-002-002 at (c). I think he also refers to it at 005.

THE CHAIRMAN: Is this your point at the bottom, Dr Steen?

A. And I think -- yes, does it go on? I think he answers several questions.

MS ANYADIKE-DANES: If we pull up 234-002-005. Let's have that alongside.

THE CHAIRMAN: Is it paragraph (d), doctor, on the

right-hand page? Just take your time.

A. Yes. I think he covers it -- I think there's a lot in his brief around IV fluids, around the time, and what was appropriate and what, generally, paediatricians would have understood, including when the U&Es should have been repeated.

MS ANYADIKE-DANES: We see his view as to whether it would have been common to start on that, but the circumstances in which you keep that under review and possibly change it, and particularly he deals with that at (d), whether continuing the IV fluid therapy was appropriate. He says:

"I believe the electrolytes should have been checked again, in which case Solution No. 18 may have been changed to a more concentrated solution."

A. Yes.

Q. And of course, there is a very significant issue about that around 11.30 in the evening of the 22nd. But I'm at the evening of the 21st and the morning of the 22nd.

When Dr O'Hare is prescribing the IV fluids, she prescribes them and recommends -- and we saw that in the medical notes and records yesterday -- that there is a reassessment. She sees Claire again at midnight and it's round about that time or thereabouts, there is the serum sodium level, which is below the range, and she

again says that Claire ought to be reassessed.

So irrespective of what was the usual fluid regime, you have a registrar indicating reassessment and you have Claire continuing to be on IV fluids, and the fact of whether that was the appropriate fluid regime does not, according to Dr Stevenson, appear to have been the subject of any reassessment. So I'm putting to you that in those circumstances, would you accept that there should have been some consideration given to changing her fluid regime?

A. I think there should have been. In the afternoon, there should have been another U&E, which would have helped everybody, and a clinical reassessment and a reassessment of her fluids as well as her overall condition. I think if the U&E had been done around lunchtime, early afternoon, and the fluids reassessed -- that's what should have happened around the fluid reassessment.

Q. Why do you think she should not have had her bloods taken and tests done following the morning ward round?

A. The morning ward round, I think, was still going on right up until towards lunchtime and that's normally -- if you look at the timings ... I mean if Claire was only going to be seen after 11 o'clock, there were still other patients to be seen.

Q. Just for the practicalities of it, if you'd reached the view that she had a slightly low sodium result, we certainly need to get that checked, is there any reason why, then and there, the bloods couldn't have been taken and dispatched?
A. No. Normally, the ward round would have been over long before this and the U&E would be despatched before lunchtime.
Q. Yes, but even if it wasn't, even if she was being seen at 11 o'clock, which is when her parents recall, is there any reason why then and there her bloods couldn't have been taken for that purpose and despatched?
A. Not that I'm aware of.
Q. And they could have, could they not, requested an urgent response?
A. Yes.
Q. And that could have led to the reassessment that you were talking about happening towards the afternoon. That could have brought that forward and you could have been having a reassessment before lunchtime.
A. Yes.
Q. In fact, on your evidence, if you're about, you could have been having a reassessment while you were still in the hospital and while you were still potentially able to assist and guide that reassessment.

A. Yes.
Q. I think when you were first giving evidence, you made some comments about the standard of record keeping, which, in fairness to you, you also made that as a self-criticism. You didn't think that your own record keeping had been up to standard, if I can put it that way. Would that be fair comment in what you said?
A. Yes.
Q. What is it that you thought was lacking in Dr Stevenson's ward round note? Let's pull it up, just to help you. It's to be found at 090-022-052. If we can pull up the next page as well, 053. There we are. So his ward round note starts at the bottom, and you have seen this many times before, I'm sure. It carries on to the next page.
So you have criticised the note keeping. What was wrong with that?
A. It's not timed.
Q. Okay.
A. I'm not sure it's signed.
MR FORTUNE: It's not.
A. The time of the U&E -- and there's a blood glucose of 6.6. It's not timed when that U&E was done and of course that has been a concern. And then Dr Sands has felt, after speaking to Dr Webb, he needed to add

something more to it.

MS ANYADIKE-DANES: We'll come to that bit in a moment. But just as it stands as a note that Dr Stevenson made, that's the criticism?

A. Yes.

Q. So if he had timed it, if he had included the time when the bloods were taken and perhaps also when the U&E results were received, and if he'd signed it, that would have passed muster for you in 1996?

A. It's not a bad note, no. I think that's reasonable.

Q. When you did see Claire at 4 o'clock in the morning of the Wednesday, the 23rd, you wrote up your own history.

A. Yes.

Q. I think you said you looked at the medical notes and records at that stage.

A. Yes.

Q. You'd have had had to inform yourself of what was happening.

A. Yes.

Q. It might not have been your pressing concern at that stage, but later on, as part of what you have said is the importance of teaching and so forth, did you ever go back to some of these things that you think are not quite up to par and deal with that as a learning point with Dr Stevenson?

A. We would have been feeding back all the time to junior staff on ward rounds and it was part of our normal process to feed back about different things. From Claire's perspective, my belief is her medical records went to pathology at the time of her post-mortem and therefore wouldn't have been back in the ward to go through with Dr Stevenson.

Q. No, but you looked at them in the morning --

A. Yes.

Q. -- and you would have formed a view as to whether, as you are looking at them, they're particularly helpful notes to you trying to figure out the path of her treatment and deterioration.

A. Yes.

Q. Leaving aside what might have been discussed in the ward round but not recorded, which you wouldn't be in a position to know, you would have known this is an untimed, undated ward round note and I don't see when those the bloods were taken or the results received.

A. Yes.

Q. Just by looking at it, you could tell that. So you don't have to have the whole set of notes come back at some point in time, but this is something that you, presumably with your experienced eye, could see. Did you think that you would use these things as learning

points with the SHO?

A. I can't remember what actually happened around this case. It would have been normal practice to feed back to the juniors on a continuous basis around note taking, prescribing, differential diagnoses, investigations, why things were being done. There would have been a lot of discussion, none of which is documented, the morning after Claire's arrest and transfer to PICU. I have no doubt there was a lot of discussion between clinical staff and nursing staff about what happened, what could have been done better, just basically reviewing the situation. But I have no recollection of any of that.

THE CHAIRMAN: Sorry, let me get this right then. Is it your best guess that there would have been a lot of that discussion on the 23rd October, but you can't remember?

A. Yes. For something to have happened -- any child to collapse on the ward always evokes discussion.

THE CHAIRMAN: Apart from being in the hospital from about 3 or 4 in the morning after being called in because Claire had arrested and then doing a brainstem test later on that day, you weren't actually in the hospital that day?

A. I would have been at the clinic in Cupar Street all day and then back in the evening.

THE CHAIRMAN: Yes. So if there was any extensive discussion with the doctors and nurses who'd been

involved the day before with Claire, you were largely absent because you had other responsibilities that day?

A. Yes.

THE CHAIRMAN: So you would not have been part of that?

A. No.

THE CHAIRMAN: Then who would have led it?

A. I would expect that Dr Sands, Dr Bartholome, Dr Stewart, the nurses in the ward, Sister Pollock, if she had been on duty, would all have discussed it.

THE CHAIRMAN: But do you know if that actually happened?

A. I've no recollection, no.

THE CHAIRMAN: I think the agreement with Dr Steen today is we're going to try and get through one hour sessions of evidence from the doctor, because after today she can't be recalled until Monday week.

MS ANYADIKE-DANES: I understand. Mr Chairman, I wonder if I might ask one question that's just been passed up to me?

THE CHAIRMAN: I just want to break in the next few minutes. If we can get two more hours of evidence from the doctor today, we might be able to make a lot of progress.

MS ANYADIKE-DANES: It will be that, just one very quick question, and that is: you have been self-critical about your own record keeping. Am I to understand that that might extend to the patient at S8? Do you remember when

you go in and you add something to the prescription in relation to the inhalers; do you remember that?

A. Yes.

Q. It's initialled, but it's not timed --

A. No.

Q. -- and it's not dated.

A. No.

Q. That's a similar sort of error.

A. It's in on the 22nd October, but it's not dated. It's in the time slot, it's --

Q. But it's not dated. It could have been an addition after the 22nd.

A. It could have been, but it's most unlikely.

Q. It's not dated and it's not timed.

A. No.

Q. This is definitely dated 22nd --

A. Yes.

Q. -- and your criticism is it's not timed.

A. Or signed.

THE CHAIRMAN: We'll break for ten minutes.

(11.20 am)

(A short break)

(11.38 am)

MS ANYADIKE-DANES: Dr Steen, when we were looking at the medical notes and records, I was asking you about the

ward round, and you quite properly pointed out the "encephalitis/encephalopathy" addition. When you were criticising the ward round, I asked you to leave that to one side for the moment. Do you have a criticism about the way that's entered?

A. Simply --

Q. Sorry, let's bring it up. 090-022-053.

A. Simply, again, it's not dated and timed when that was entered. And it's not signed, but it's in a different hand.

THE CHAIRMAN: To be fair to Dr Stevenson, we know from the other ward rounds that he did that he generally signed the notes.

A. Yes.

THE CHAIRMAN: So that's an omission here which is not typical of him.

A. No.

THE CHAIRMAN: I don't think he generally has timed the ward round.

A. No.

THE CHAIRMAN: So that's a failing, but isn't it a rather less significant failing than adding two more potential diagnoses for Claire and not leaving people who come afterwards with a record of when they were added or why, or in fact who added them? This looks more serious,

doesn't it?

A. Well, I suppose it reflects what I'd done with one of the patients, where I had added in something in the midst rather than at the end of a note. So when did I add that? That was dated and timed. And when was it relevant? And this person has done the same as I did. I initialled mine, but I didn't time it.

THE CHAIRMAN: Sorry, your intervention was about the type of inhaler that an asthmatic child should get.

A. Yes.

THE CHAIRMAN: This, in Claire's case, is a more significant intervention, isn't it?

A. Yes.

THE CHAIRMAN: Because it's moving away from a diagnosis of non-fitting status to other quite different diagnoses.

A. It opens up the differential diagnosis, the possible diagnoses, quite a bit.

THE CHAIRMAN: So to the extent you say that your own note is open to some criticism, it's on a less significant point than the addition to this note, I suggest.

A. It is a possibility, yes.

MS ANYADIKE-DANES: And what, to you, are the implications of the differential diagnoses now being non-fitting status, epilepticus and encephalopathy? What do those two add?

A. The encephalitis introduces the idea of infection. We already had infection as the possibility with the virus because we had the raised white cell count, it was felt there was a viral illness, and that raises the possibility that the virus has now affected the brain with all the complications that will arise will that. So that's quite important. The encephalopathy opens up another differential group of diagnoses about other causes of encephalopathy, global brain dysfunction, which could be due to seizures, seizures cause encephalopathy, but so do other conditions.

Q. And encephalopathy causes seizures?

A. Yes. And both cause inappropriate ADH.

Q. Exactly. So you don't know whether, at this stage, you're dealing with cause or effect at the moment?

A. Yes.

Q. And in terms of your reference to the infection, the referral letter at 090-011-013, just quickly if we pull that up -- we can see under the "Known allergies", there are a number of queries there. This is the doctor referring Claire.

A. Mm-hm.

Q. "Further fit" is a query. "Underlying infection" is a query. So it's been a query and a possibility right from the outset.

A. It has.
Q. If then you'd been alive to that being added as a differential diagnosis at some point, which we don't know when it was, what difference would that have made to your handling or the way that you would have wished Claire's care to be handled?
A. I would have wished Dr Webb was being involved and I would have wished the CNS obs to start and Dr Webb to see her as soon as possible to guide us on any further changes. If I had been at a district general hospital with Claire and her position had presented in this way, I wouldn't have been phoning the paediatrician in the Royal, I would have been phoning the neurologist in the Royal for advice, and if the neurologist had wanted to see the child, the child would have been transferred to neurology. So certainly around this time I am extremely anxious that the neurologist sees and advises on further managements because this is significant diagnosis or possible diagnosis.
Q. And when you saw that non-fitting status, did it occur to you that this child should have an EEG?
A. A non-fitting status -- I've only ever seen a -- I personally have seen and diagnosed one case in all my experience, and the diagnosis was made with the EEG and diazepam. And that was my understanding: an EEG would

be required to make that diagnosis. It could be suspected clinically, but to be diagnosed, you needed an EEG.

Q. And given that in your experience you'd only seen one case of it, did you not perhaps think that maybe more investigation ought to be carried out before one even had it as a differential diagnosis, because it's a fairly rare condition, is it not?

A. I hadn't even seen the case. I was discussing this in 1996; the case I was discussing was subsequent to that. It is a rare condition, it's one of the reasons why somebody becomes quite vacant -- besides me being vacant and unresponsive -- becomes quite vacant and unresponsive and like an automatic thing and it is one of the differentials. And in a child where you don't have any other underlying causes, it's very important to rule it out.

Q. Yes. And the previous medical history is significant in that, isn't it?

A. Well, it is, yes, because certainly my understanding is that if you've had seizures as a child, even though you've done very well, you're always at an increased risk of seizures in the future. And I certainly never give any of my patients a cast-iron guarantee that they'll never have another seizure.

Q. Because you have now referred to the fact that you yourself would have wanted Dr Webb involved if you'd been there, you might have got him involved a little earlier if you'd had an opportunity to do that, is it your view that if you had been about that you should have been contacted by your registrar and been involved in that decision to refer?
A. Yes, and I think we've said this before during my evidence, that I would have expected to have been informed and for it to be discussed with me.
Q. Thank you. Then if we perhaps just turn to the medications. Would you have wished Claire to have been starting on something to address a virus or possible bacterium before the 5 o'clock where one of those medications was started?
A. I think once you have a differential diagnosis of encephalitis, which is more likely viral than bacterial, then it's important to thing about herpes encephalitis, which is the one thing we can treat with acyclovir.
Q. Is that a yes?
A. Yes.
Q. Then can I ask you now about liaising with Dr Webb? I think it was yesterday in your evidence that I think you conceded that you yourself could have contacted Dr Webb.

A. Yes.
Q. You also, I think, thought that Dr Webb might have contacted you --
A. That's correct.
Q. -- with that level of involvement with a patient that was, after all, yours?
A. Yes.
Q. Who did you regard as actually having the responsibility for Claire's care?
A. I was the named consultant and she remained under me as the named consultant, but her neurological condition on that Tuesday afternoon was such that, as a general paediatrician, I couldn't manage it. Therefore, as far as I would have been concerned, and looking back over the notes, as far as I'm concerned, Dr Webb was the key player around any of her neurological status, the medications, what advice would be given in her treatment plan because it was outside my realms. And again, using the scenario of if she had been admitted to another hospital and transferred in, she wouldn't have been transferred into paediatrics. So I really feel around her neurological condition and the management of those symptoms, Dr Webb very much was taking a lead.
Q. On that side yes, but that wasn't the only possibility for Claire's condition or presenting condition. There

were other things which may have been more in the domain of the general paediatrician, and you were her paediatrician. Is it not a case that the two of you should have been actually working together?

A. Yes.

Q. And so although Dr Sands had, from your perspective, quite properly brought in a specialist view in relation to the neurological concerns he had -- and in any event the concern was there about some sort of underlying infection -- once he had added that "encephalopathy/encephalitis", that was something that may be he might have been looking to you to guide him on how to deal with these other differentials?

A. The other differentials fall into neurology, encephalitis/encephalopathy fall into neurology.

Q. Yes. But I think you've said, though, that it was something that the two of you could have been working on together.

A. Yes.

Q. You have also something to bring to this.

A. Yes.

Q. Yes. But you didn't, so far as it's recorded.

A. No.

Q. Because of the way things have transpired, would you accept that it's possible that some of the junior

doctors, and maybe even the nurses, were left in an unhappy state of confusion or lack of clarity as to exactly who the lead consultant was?

A. I think you need to ask them. I'm not sure there was any lack of clarity in the minds of the nursing and medical staff, because they would have known, as I was the named consultant, to phone me, and in fact when things were difficult, they phoned me. It may have been reasonable to think that Dr Webb also should have been informed because he was looking after her neurological condition, but when anybody needed phoned, the nurses phoned me straightaway or the doctors or whoever did phone me.

THE CHAIRMAN: Do you mean in the early hours of Wednesday morning?

A. Yes. So I can't answer for others. I'm not sure if they were confused or not.

MS ANYADIKE-DANES: Well, what had you done to make it clear?

A. I was the named consultant and that hadn't changed.

Q. Were you here yesterday in the afternoon?

A. Not in the afternoon, no.

Q. Dr Stevenson's evidence would suggest that he wasn't entirely clear. In fact, I think he regarded the position as that the person he was now looking to was

Dr Webb, and even, I think he used the word, bypassing the hierarchy, his registrar, Dr Sands, and it was Dr Webb that he was looking to.

A. He certainly would have been looking and I would have been looking to Dr Webb for guidance on any of the neurological information.

Q. As you have already conceded, the neurological information is not the only element of Claire's care.

A. Yes.

Q. If we pull up 310-005-001, which is a schedule that I put to him. This is a schedule that we compiled, bringing together the various answers to this very question that I'm putting to you.

If you see one of your answers, this is the reference -- not to be pulled up -- 091-011-067. You said that you were aware that Claire was on the ward, you couldn't recall if you examined Claire before that time.

A. Sorry, would you just give me a moment to find out where we are? Okay.

Q. I had taken you to that passage before, I think, the first day of your evidence:

"She recalled that when she contacted the ward, she was told that Dr Webb had seen Claire and taken over her management."

What did that mean to you?

A. To me, that meant Dr Webb was managing her neurological condition. We hadn't done any formal handover other than that, there wasn't any formal transfer into neurology at that time. But Dr Webb was managing her neurological condition, which seemed to be the dominant problem at that time.

Q. It doesn't say that. It says "taken over her management".

A. Yes.

THE CHAIRMAN: Can you tell me, what does a formal transfer require?

A. We've just got documentation round of what a formal transfer should be. In 1996, it was usually very informal. The consultants discussed or the registrars and consultants, if the consultants couldn't be in -- it may seem strange, but quite often consultants could not be in the same place at the same time because of all the commitments both inside and outside the hospital. A discussion would have been carried out at registrar level to say who would take over the lead. So if we had a cardiology case in where are child had come in breathless and had a heart murmur, they would have come in under the paediatricians, we would have asked the cardiologists to see it the next day. If it turned out

to be a cardiology case, the cardiologists would then have then taken the lead, but the documentation on the computer or anything like that wouldn't have changed. The child may well have remained on the medical ward and the medical registrar and SHOs, the ward staff, looked after the child, not the cardiology junior doctors.

THE CHAIRMAN: So if there had been a formal transfer of Claire's case from you to Dr Webb in October 1996, what at that time would we expect to see in the records?

A. There might have been nothing in the records.

THE CHAIRMAN: So you say the absence of any specific reference in the records doesn't actually indicate at all who was in charge?

A. No.

THE CHAIRMAN: So the fact that you were still the named lead consultant doesn't help us with identifying you as the person who's still in charge?

A. I'm still the person at the head of the bed, I'm still the person on the chart, I'm still the person --

THE CHAIRMAN: What I have understood you just to say to me is that you could have a formal transfer in keeping with the practice in 1996, which didn't involve any formal record or note being put on any file.

A. Yes.

THE CHAIRMAN: So the fact that you're still the named lead

consultant on the records does not appear, on what you have just told me, to confirm that you are in fact the lead consultant.

A. Yes. I see what you mean. How do the staff know who's taken over the management?

THE CHAIRMAN: This is the point. Because if in 1996 you say there was no formal process or the formal transfer process was, in fact, an informal process, which may not be documented anywhere, and the staff see Dr Webb, they know that he's seen Claire three times on Tuesday afternoon, they know that he's prescribing drugs for her. So if they're asked who's in charge of Claire, how do they know it's you, not Dr Webb or Dr Webb and not you?

A. I don't know. You might ask them. They would have -- the default position would be to phone either of us. It doesn't matter who they phone as long as they phone a consultant. If Dr Webb felt it was in the paediatric realm, paediatric medicine, he'd have said, "Look, would you also phone Dr Steen". If I had felt it was in the neurological one, I'd have said, "Look, could we discuss it with Dr Webb? Do you have his number? I might even give him a call".

THE CHAIRMAN: To what extent did it matter?

A. I'm not sure it did matter. Unless the witnesses are

saying it did, I'm not sure it did because the important thing was: was there someone contactable out of hours, who would have dealt with any situation or know how to deal with any situation? And I would suggest that be it Dr Webb or myself, although I wasn't on duty, if we were contacted, we would have been dealing with a situation and ensuring that the right person was involved.

THE CHAIRMAN: Okay. Thank you.

MR LAVERY: Mr Chairman, it might be of some assistance if Dr Steen was asked whether or not, at that time, the name of the consultant would have been written above the bed, which I think is common practice nowadays.

THE CHAIRMAN: Was that the position?

A. [Inaudible: no microphone] of the bed.

THE STENOGRAPHER: Sorry, I didn't get that.

THE CHAIRMAN: The witness said: yes, she has already said her name was above the bed.

But I thought the point that you've just made to me -- and this is why I was asking you about it -- was that the lead consultant can change without any change in documentation.

A. In 1996, yes.

THE CHAIRMAN: With respect to Mr Lavery's point, the fact that your name is still above the bed does not mean that you're still the lead consultant.

A. No.
THE CHAIRMAN: The fact that there's no entry in Claire's notes to say that Dr Webb has taken over doesn't mean that he hasn't taken over.
A. No. But then you took it a step further to say what was the relevance.
THE CHAIRMAN: Yes.
MS ANYADIKE-DANES: Whoever is the child's consultant is the consultant who has ultimate responsibility for that child's care.
A. Yes.
Q. Is that not relevant to know who that is?
A. It may not affect the actual management of the child.
Q. Well, that will depend on who people think that they're referring to, if I can put it that way.
A. Yes, but --
Q. And it might be relevant for the parents to know whether they are actually talking to somebody who has the ultimate responsibility for the care of their child.
A. Yes.
Q. Would it not also have been appropriate, whatever Dr Webb was going to be managing and assisting on, to know what taking over management is, or at least what his role is? Because if he is of the view that actually what he's being asked to do is to come in and to give an

opinion on certain neurological aspects, and that's what he's doing and that he's not taking on board the general care of that child, but dealing with matters in a very specific way, is that not relevant for people to understand that?

A. I think Dr Webb's involvement that afternoon was more than giving an opinion. He had been very proactive in the management of Claire, giving guidance on what needed to be done, and his concerns were such that he came back on two occasions. So I think he not only gave an opinion, but he was directing her care that afternoon. I know Dr Webb feels that the IV fluid administration did not fall within his remit and remained with paediatricians.

Q. Yes.

A. I think there's a debate about who actually writes up the fluids and who was in the best position to advise that fluids should be reduced or changed or repeat bloods should be done.

Q. But there shouldn't have to be a debate. It should be clear who has responsibility for that.

A. I think it's a question. I think it may not be clear especially if there is shared care --

Q. Should it not have been clear at the time?

A. It probably should have been documented what Dr Webb was

taking over, yes.

Q. Yes, because if Dr Webb thinks "I'm dealing with essentially the CNS issue here, so I want to know what's happening to her GCS score, I want to know when her anticonvulsant medication is being administered and things that will affect that, that's what I'm going to give you some guidance on and I would like to know what happens as a result of that", but all these other issues to do with the fluid regime she's on, if that is his view, that that is not something that he is giving any guidance on at all, that would be very important to know, because anybody therefore wanting to seek guidance on that knows not to talk to Dr Webb, but actually needing to contact Dr Steen about that.

A. I think it would have been very helpful for all of us to know because Dr Webb was in an ideal position to say that an acute neurology situation like this may produce inappropriate ADH and so you need to monitor your fluids more carefully.

Q. Yes, but you, as you have just said, remained her consultant --

A. Yes.

Q. -- you remained responsible for her care --

A. Yes.

Q. -- should you therefore not have ensured that it was

absolutely clear who people were looking to and for what purpose?

A. Yes.

Q. And that was a failing?

A. Yes.

Q. And should you not certainly have been very clear about that at around 5 o'clock when you were effectively going off duty? You say you're still contactable, you're going off duty, but you have a night staff coming in, who will have a number of children to look after, may not be at all familiar with Allen Ward. It's really important that if anything goes on during the evening that they know who they're looking to and for what purpose.

A. Yes, and I have said that I cannot remember what I was informed by telephone when I phoned the ward, but whatever it was, it reassured me.

Q. No, if I may correct you on that. What you were being reassured about was Claire's condition, not to clarify who people should look to for various aspects as to her care.

A. I don't recollect what we were clarifying on the telephone. I can just say Dr Webb ... I remembered back ... that's an old reference, the taking over her management. Is that back to 2004? I don't know.

Q. That's the inquest.
A. Yes. So that was taken over at that time. I don't know what else was clarified on that. I certainly would have expected, when I phoned, to know that there was a management plan for Claire in place going forward over the evening.
Q. And who should be looked to for what element of that management plan?
A. Yes.
Q. But there's no record of any of that in her documents?
A. No, there's no record. We've never debated that there was a record.
Q. Is that not something you should have ensured was clear and documented?
A. Yes.
MR GREEN: Sir, before we move on, I wonder if, in fairness, both to Dr Steen and Dr Sands, if Dr Sands' position on the communications between him and Dr Steen on the afternoon of the 22nd and about Dr Webb's involvement could be put? It's witness statement 137/1, page 17. You see at the bottom, sir:

"The request to ask for Dr Webb's help would have been discussed on the ward round. I believe Dr Steen was informed of this after I had spoken with Dr Webb."

Then over the page to 18, please. The first answer

there:

"Dr Steen would therefore have been aware of Dr Webb's involvement in Claire's case."

Then if we move over to page 20 --

MR FORTUNE: Before you do that, can I ask you to look at (iii)?

MR GREEN: All I'm doing is identifying for Ms Anyadike-Danes the points that I wish to be put so that she can put them globally rather than me standing up and then sitting down and it becoming a game of ping-pong. At page 20, under (f):

"My recollection is that Dr Steen was contacted at least once by telephone by myself in relation to Claire. I believe this was on the afternoon of 22 October 1996. I believe I advised of Claire's condition and Dr Webb's involvement. However, I cannot recall specific detail. I am unable to recall the time or whether additional contacts with Dr Steen were made by myself or other members of the ward team."

Then over to page 21. Under (l):

"I believe that I felt that Dr Steen was responsible for Claire's care until the time I asked for Dr Webb's advice. Therefore, I would have felt that Claire was under joint management with increasing responsibility being passed to the neurology team, given the nature of

Claire's condition. However, I believe I would have expected Dr Steen to retain an interest in Claire's case throughout the time she was in hospital. This approach of shared care would, I believe, have been appropriate to this situation with one team, either formally or informally, taking over eventual care."

Then once again at page 22, under (o)(i):

"I had no contact with Dr Steen before 22 October. I recall at least one telephone conversation with Dr Steen. I believe this took place after my contact with Dr Webb. This was on 22 October 1996. I believe it was at the earliest opportunity, likely in the afternoon."

Next answer:

"This communication was by telephone."

If we skip down to (iv):

"I do not recall the details of what information was given to Dr Steen. However, I recall advising that Dr Webb was helping with Claire's management."

Then finally on page 23, I simply draw Ms Anyadike-Danes' attention to the answer under (q). I rise at this stage so it can be dealt with without my learned friend having to jump about and without her having to sweep up afterwards whenever I pass her a note about it, particularly given constraints of time which

we're working under with Dr Steen.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: That's very kind of you. I'm not sure whether the question is what her comments are about that.

MR GREEN: I leave it to Ms Anyadike-Danes to take her own course. I simply ask that Dr Sands' position be put to Dr Steen so that she can indicate whether she agrees with it, can't remember, or what her comment is.

MS ANYADIKE-DANES: I'm very grateful to you for that. I had, to some extent, started it when I had put to her the page 19 and 20, particularly the (f) point. I had done that. You're right to mention it and I was actually going to come on to the part in the schedule, which includes much of that. Maybe if we have that to one side of there, one can see at 310-005-002 --

MR GREEN: As I say, I leave it entirely to my friend as to what forensic mechanics are employed. I just wanted it putting.

MS ANYADIKE-DANES: I'm very grateful.

What can be seen under that schedule is actually a collection of the points that Dr Sands is making about who he thought was the consultant with responsibility for Claire's management and treatment. But in any event, you've had where they originate from, which was

the original source in his witness statements.

The upshot of it is threefold, really. One, he is of the view that you were kept informed that Dr Webb was involved. It's not entirely clear when that happened, but there seems to be some evidence that it was in the afternoon rather than any time earlier. That's one.

The second is that there was effectively joint care between you and Dr Webb, although it's not entirely clear what are the elements that it was believed that the paediatric team would retain responsibility for.

The third point was, I suppose, that if there was joint care, that you still retained an involvement and that you still should have been contacted for your assistance.

I think those are the three things one draws out of that; would you accept that?

A. Yes. I can't remember Dr Sands' phone call. I have no doubt it would have happened. Dr Sands has always said it happened. I can't recall it. I have no doubt he would have kept me informed.

Q. Yes. I think some of that was raised on the first day of your evidence when the chairman was telling you that if Dr Sands had contacted you and told you anything about what was happening in relation to Claire, he would have been telling you the information that we see

recorded on that timeline, and if he had told you any of that, what your impression would have been. And I think your view was that you would have regarded her as being very ill.

A. Yes.

Q. And you might well have wanted to come back after your Cupar Street clinic to see her at 5, as you have done in previous times to see other patients.

A. Yes.

Q. But where I really was wishing to take you to is -- and it's nicely encapsulated in a way by Dr Sands believing that he had two masters, as it were, that there were two consultants involved, and I think you have already addressed the point. It should have been clear exactly which parts of Claire's care, if I can put it that way, the paediatric team, and therefore you, were clinical lead on, and your guidance should have been sought about those particular issues, even if Dr Webb is being asked to assist with certain other things.

A. Yes, and I think it's a fair criticism to say that both consultants should have made it clear their areas of responsibility.

THE CHAIRMAN: Does that mean that, in essence, insofar as Mr Green has taken us through these extracts and insofar as you see them summarised in this document, that you

agree with the position or the evidence which Dr Sands has put forward in his written statements?

A. I can't remember all that Dr Sands has put forward. We have a summary here of his --

THE CHAIRMAN: What I'm trying to avoid is taking you through everything point by point. You will obviously have read Dr Sands' statements as part of your preparation for giving evidence.

A. Mm-hm.

THE CHAIRMAN: Mr Green, on his behalf, has taken you through some of the major issues about the joint care and contact with you. And Ms Anyadike-Danes and the inquiry team has prepared this document, which is on screen in front of you.

Is there anything which you disagree with?

A. No, I think Dr Sands has given a very balanced approach to it.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Hindsight is a wonderful thing. And everybody accepts that. But doing the best you can, do you get the sense that there was a failure of you, as the clinical lead, to actually establish the paediatric lead, if you like, in relation to Claire's care?

A. Sorry, could you rephrase?

Q. It's quite clear that Dr Webb was coming in and out on

three occasions and we are quite clear what he was doing. There is a note of what he was doing and what his suggestions were. I think the very first time he frames them as suggestions. Then he helps to develop a plan. But it's quite clear what he's doing because all that is recorded. What I'm not clear on is exactly where the guidance was from the paediatric side, recognising, as you do, that what had actually happened was a situation of joint care, if you like. Do you feel that you failed to establish the position of the paediatric side and a lead in that respect?

A. I think that we've already said that I should have made it clear what my responsibilities were and Dr Webb's responsibilities were, made it clear to all the staff what I, as the paediatric consultant, was taking responsibility for, what he as the neurologist was taking responsibility for, make sure it was documented and make sure staff were aware of that.

Q. Yes, I'm taking it a little bit further than that. Because whether there was de facto shared care, you were actually the clinical lead. And where I'm trying to explore with you is whether there is a sense that what was missing is some sort of overarching concept of the direction of her care.

A. I can't recall that.

Q. Do you see any evidence of that?
A. I don't see a lot of evidence because the documentation's not that strong, but I --
THE CHAIRMAN: I think the point that is being made to you is this: we do have a fairly clear idea about what Dr Webb was doing.
A. Yes.
THE CHAIRMAN: And insofar as it's recorded in the medical notes and records and the nursing records, the nursing staff had a fairly good idea of what he was doing as well.
A. Yes.
THE CHAIRMAN: What appears to be absent is any clear idea of what you were doing or what the junior paediatricians working under you were doing.
A. Yes, and I think that's a fair enough criticism.
MS ANYADIKE-DANES: So where I was taking that is what may have been missing is some overall guiding hand to draw all these things together, apart from any other thing, to be able to explain in the round what was going on for the benefit of Claire's parents.
A. Yes.
Q. I wonder if I can turn now to something different and move on to the conduct of the brainstem tests. If we go to 090-045-148. The first of these was conducted at

6 o'clock in the morning on the Wednesday --
A. Yes.
Q. -- the 23rd. The second is conducted at 6.25 that same day, but in the evening.
A. Yes.
Q. Did you consider Claire was hyponatraemic at the time the first test was taken? Let's pull up the result. Did you consider she was?
A. I can only go back through the documentation to work out what has happened in and around that time. From the information provided to me, my understanding is we took a -- as is the protocol, there's a very definite protocol for brainstem testing. We took a U&E sample in and around the time of carrying out the brainstem tests. It was put through the blood gas analyser in PICU and my understanding is the sodium on that was 133. But because we didn't quite trust the blood gas analyser and because this was important, it was also sent to the laboratory. And the laboratory test, which would have come back after 0600, was a 129 ... Was it?
I don't ...
MR FORTUNE: That's 090-022-060. Five lines up from the bottom.
A. There's results somewhere from the analyser which showed the analyser result was 133.

MR FORTUNE: On the previous page, 059, about ten lines up from the bottom.

A. So when we actually did the brainstem results, the first set, our understanding that her sodium at that time had improved to 133 -- which would have been a level so as not to cause any significant problems. Hyponatraemia, I believe, at 1996, was defined as below 130. And I refer to one of the expert witnesses on that.

So we did that and we did the brainstem tests on that. The 129 would have come back after that, and I can only think that there is a discussion between Dr Webb and I -- and indeed maybe Dr McKaigue but not necessarily -- on whether that was still acceptable for those brainstem tests to stand or whether they needed to be repeated again.

MS ANYADIKE-DANES: Well, I think when you first started you said that because you weren't quite confident about the blood gas analyser, you had the tests done again through the laboratory.

A. Yes.

Q. So if you weren't confident, why did you move forward on the brainstem test without waiting for the result for the laboratory?

A. If the laboratory result came back grossly different, we could have just stopped and said: those don't stand,

we have to do it again.

Q. But why do it all until you have the laboratory results?

A. I can't recollect, but it was obviously felt at that time it was an appropriate time to start doing brainstem tests.

Q. You're the consultant there too.

A. Yes.

Q. You're just as well able to express a view as to whether you think it's appropriate to move forward on a blood gas analysis of her serum sodium level or whether you would wait and get the lab result, given the significance of ensuring where these results are in terms of normal values for the purposes of the brainstem test. So why didn't you just wait until you got the lab result? In fact, the lab result would have told you it was significantly lower. 129 would be hyponatraemic.

A. It would be hyponatraemic, but not enough to cause a cessation of breathing.

Q. Well, are you saying that in 1996 it was acceptable to have proceeded on with the brainstem test with a result of 129?

A. I'm saying that it would have been discussed with Dr Webb and I must have decided it was, yes. Otherwise we would have repeated them.

THE CHAIRMAN: On reflection, do you think that was the

right decision?

A. I think on reflection, with where we are today, we would ... I can't put myself back to 1996. There's been so much done about blood analysers and hyponatraemia, it's very hard to say what you would have done then, compared to now, because there's been so much about it in the last six years.

THE CHAIRMAN: Okay.

A. Eight years.

MS ANYADIKE-DANES: Well, I don't know if you've had an opportunity to read the transcripts of the earlier case of Adam Strain.

A. Just parts of it, not a lot.

Q. Because the inquiry's expert consultant paediatric anaesthetist gave evidence on that occasion. He produced the 1998 code of practice for the diagnosis of brainstem death. It's at 306-035-001. The flow chart is at 306-035-021. He explained the absolute, in his evidence -- and the transcript is of 3 May 2012. I think it starts at page 106.

THE CHAIRMAN: Do you want to bring that up or not?

MS ANYADIKE-DANES: I don't think we need to bring it up. I can take an extract from it. He says:

"The third step in the flowchart states exclusion of hyponatraemia, intoxication, sedative drugs,

neuromuscular --

A. Sorry, hypothermia.

Q. "... hypothermia, intoxication, sedative drugs, neuromuscular blocking agents, severe electrolyte, acid-base or endocrine abnormalities as causative."

In the course of that case, he referred to Adam as being hyponatraemic at the time his brainstem tests were carried out, and he felt that in accordance with the code of practice, active steps should have been taken to normalise over a period of hours the concentration of sodium in his blood.

So 129 would not have been regarded as a normal serum sodium level.

A. I'm not sure what Adam's was.

Q. But 129 would not have been considered as a normal serum sodium level.

A. No.

Q. No, it wouldn't. So what I'm asking you is, given the significance of a brainstem test and the care with which one has to approach it, was there any thought that you should actually try and bring her serum sodium levels up to within the normal range?

A. And I have no recollection.

Q. Well, thinking about it now, do you regard that that would have been an appropriate thing to do?

A. But I was asked to think about it in light -- in 1996. I can't because things have moved on and things have changed. I'm not sure the awareness of a 129 in 1996 would have evoked a repeat brainstem because a 129 would not have caused her symptoms. We have children coming into hospital perfectly well with a bit of vomiting, diarrhoea and sodiums of 122. So I know we're dealing with absolute figures and I understand we're dealing with absolute figures, but I'm not sure millimoles, small shifts in amounts, are of significance, and the expert witnesses may be able to advise better than myself.

THE CHAIRMAN: You said to me that when the lab result came back, you think you and Dr Webb and possibly Dr McKaigue might have discussed whether the first test should stand in light of the lower sodium reading; right?

A. Yes, but I don't know whether it happened or not. I'm just saying that what's may have happened. We should have discussed it because we sent it to get that back and it is Dr McKaigue that has documented it.

THE CHAIRMAN: So there is a degree of supposition in this? But if we suppose that that conversation did take place, do you further suppose that the decision was: well, the reading is 129, that's barely below the definition of hyponatraemia at 130, and it's not sufficiently below

for us to scrap the first result and start again?

A. I can only assume that's what happened because we didn't do it, but I'm also aware Dr Webb has made comment on this in his evidence and I don't know how, having read that, it has affected my thinking.

MS ANYADIKE-DANES: What about the influence of drugs on her system? Was there any sense that maybe that should be recorded or maybe one should postpone a little bit the brainstem tests until you felt that the possible sedative effects of those drugs might be out of her system?

A. The midazolam had been stopped for some hours. The phenytoin level had been repeated, I think. It was back at 19.

Q. Well, the particular question -- if I just take you to the question that you're dealing with -- is 1(c):

"Could other drugs affecting ventilation or level of consciousness be responsible for her condition?"

That's what's actually on the tests. And you answer in the negative.

A. Yes. So I need to know what drugs they were because I don't remember. I know there was phenytoin and the phenytoin was now within the normal therapeutic range at something, and the midazolam, which has a short half-life, had been stopped, and I think the diazepam

had been given at 12 midday. Was the only other drug the valproate? I'm sorry, I can't remember.

MR FORTUNE: The reference for the phenytoin is 090-031-101. The test result was vetted at 4.38 on the Wednesday. It was 19.2 milligrams per litre, which is inside the tariff, the range.

MS ANYADIKE-DANES: So your view is that you could safely answer that question in the negative because there were no drugs that could be having an effect on her system?

A. That were beyond the therapeutic margin --

Q. Yes.

A. -- if you follow me.

Q. Well, beyond the therapeutic margin for the particular drug in question. That doesn't tell you what happens as to a combination of drugs, does it?

A. No. But the diazepam was given --

Q. Let me pull up this timeline we keep going to. The only reason I do that is because it has them all in one place. It's 301-001-001. The diazepam, yes. You see when that is given.

A. 12 midday.

Q. Then you have the phenytoin, then you have midazolam. Just looking along the top, that stat dose of midazolam, possibly 3.30-ish. Then you have the 400 milligrams of sodium valproate, 600 milligrams of cefotaxime, and

there's more cefotaxime administered later on in the evening. This is the same evening when she suffers her collapse.

If you see along the bottom, there's an infusion of midazolam. It's not entirely clear -- and that is an issue that we have to resolve -- when that stopped. It might have stopped at 3, it might have stopped slightly later than that. But in any event, whenever that infusion stopped, if we say 3, then three hours after that you are carrying out the first brainstem test. If we say more like 3.30 to 4, perhaps when she gets to PICU and you're there, it's two hours after that. So is any thought given when you are completing that part of the brainstem test that although she might be out of the therapeutic range of some of these taken on their own, what might be the effect of them in combination?

A. I assume we had that conversation. I don't know. I have no recollection. But we went through the brainstem guidance carefully. The midazolam had been stopped, it's got a very short half-life. The phenytoin was within therapeutic range, and this is me trying to interpret what is written 16 years on. The valproate had been given at 5 o'clock. So the only two that were probably interacting -- and I do appreciate that

diazepam has a long half-life, but in fact within 4 to 6 hours, anyone who's been given diazepam is usually awake and it doesn't affect the sedation. The two interactions would have been between phenytoin and sodium valproate.

Q. Let's pull up what Dr Aronson says, who's the inquiry's expert. 237-002-008 and alongside that 009. If we look there at (f):

"Please explain within what period of time you would have expected IV phenytoin to take effect. The onset of action of phenytoin after intravenous dose is 30 to 60 minutes and the effect lasts for up to 24 hours."

A. Yes.

Q. That's the phenytoin. And then he goes on to say the effect of that -- hold on a second. So we don't have his view on the half-life of midazolam. That is something that we're going to have to take up with him. But he has the effects of the phenytoin itself lasting for up to 24 hours. The phenytoin is given at 2.30 in the afternoon.

A. And we have a blood level at 9.30, which was slightly above the therapeutic range, and a blood level around 4.30 in the morning, which was within the therapeutic range.

Q. What do you mean by "the therapeutic range"?

A. We don't use phenytoin this way any more.
Q. But what do you mean by "therapeutic range"?
A. If you had a patient on phenytoin to control seizures, at that stage you try to have the dose within a certain margin, as advised by the blood level. And so once you have got to the top of that dose, the risk of side effects is such that you don't really want to put the dose up. But if you were within that margin it would have been assumed that the patient was tolerating the drug, wasn't necessarily very drowsy, it was therapeutic without causing significant side effects.
Q. How is the therapeutic range established for any given child?
A. It's established for the drug. The drug is -- it's established for the drug. So somewhere, pharmacy has determined through research that for phenytoin in 1996, to have enough in the blood to get a response, but not enough to cause too many side effects, you need the blood range as it is.
Q. And within the therapeutic range, does that mean the drug is having an effect?
A. Yes. If it's too low you may not be having an effect. If it's too high, the risk of side effects is significant.
Q. So if when you do the blood test, you discover that the

levels of that particular drug are within the therapeutic range, does it mean that the drug is having an effect?

A. Yes.

Q. So when you got your blood test results, that meant that that drug was having an effect?

A. And unlikely to be toxic and unlikely to be causing adverse problems. After 20, it was above the therapeutic range, so there was a risk it could have increased her drowsiness. I suppose it's semantics about where you go between 19 and 20.

Q. I accept that, but whatever it is, it is having some sort of effect?

A. Yes.

Q. Otherwise, it wouldn't be within the therapeutic range. It would be below the scale if it was having no effect whatsoever?

A. Yes, effect on managing seizures.

Q. Yes. It's doing something?

A. Yes.

Q. And that you know just in isolation of that drug?

A. Yes.

Q. So whether if you combined the amount of midazolam that she had been receiving continuously over a period of time, leaving aside the stat dose, you have no idea what

that would have done?

A. I'm sorry, but I honestly think the reason why your midazolam is by infusion is because it has a really short half-life and, as you say, maybe that can be clarified. But that's why if you give a drug by infusion it's because it's getting washed out of the system very quickly and you need to giving it ... I think midazolam literally has maybe a half-life of -- I don't know. But it's very short and we know that when we use it now because we use it first line in various things in the wards.

Q. So if you add the therapeutic effect that was still in her system and doing something of the phenytoin, you add maybe something for midazolam, I don't know what it does in combination, if you have the two, and if you add whatever residual effects there might have been of the diazepam. So that particular cocktail, over and above whatever might be in her system, you don't know what effect that's having on her presentation?

A. Yes, and I'm not sure -- maybe the experts do, but I'm not sure anybody --

Q. But don't you need to know in order to answer no?

A. Well, it may not be possible to know. What you can just know is you have not given any drugs in a way that will knowingly affect her level of consciousness and ability

to breathe. You haven't got so many -- so if her phenytoin level had not come back at 19 and it had come back at 23, we couldn't have answered "no" because it's very clear that that is beyond the therapeutic range and may have increased the drowsiness. Maybe not enough to stop her breathing, but it would have increased the drowsiness.

Q. I understand. But in any event, you can't remember whether you had that kind of discussion or, for that matter, received that level of reassurance from Dr Webb?

A. Yes.

Q. Can I be clear about that? This element of what the interaction might be between those drugs, which are to a large extent anticonvulsant drugs, is it that you would be looking to Dr Webb to guide on you that as to whether it was appropriate to answer that question as "no" or would you have sufficient knowledge of your own to be able, with confidence, to answer that question?

A. I would not have used an intravenous anticonvulsant regime like this before that time, so I was looking to Dr Webb for his advice around the anticonvulsants. That was a regime that I wouldn't have used.

Q. That's a prescription and administration. This is a slightly different question. In order to answer the question that you have to answer to be able to proceed,

which is that there isn't anything, if I can put it that way, in her system that's likely to have a sedative effect or any of the other indications that are listed there, would you be able to do that on your own independent knowledge of these matters or would you be looking to Dr Webb to assist you or guide you?

A. I would be looking for some advice from Dr Webb. I would have had some knowledge around some of the drugs.

Q. But not sufficient to answer this question?

A. I don't know. I don't know what our level of knowledge was in 1996 or what discussion we had.

Q. When the second brainstem test was carried out, Claire was hypernatraemic at that stage?

A. Yes.

Q. Is that something you think should have affected whether you pursued it?

A. I think you're again left with the situation of: does the high sodium affect her ability to breathe and the different brainstem tests that we do. Because ultimately, what we're looking for is her ability to respond to certain stimulations and ability to breathe when we stop the ventilation, and would a sodium of that level have caused her not to breathe, not to respond to icy water, et cetera? And the answer would be no.

Q. So despite the fact that she was hypernatraemic, I think she was at 152 --
A. Yes.
Q. -- that's not something that you felt would have affected the way either you completed that form or continued on with the second brainstem test?
A. No, because it would not have affected her responses to the specific tests that we did.
Q. Would you do that now?
A. Um ... I think ... I haven't had to do brainstem tests for quite a while. I think there would be a discussion. Firstly, there's a discussion about whether we can actually get the blood level normal.
Q. Yes.
A. When the child is changing the situation like this ... The inquiry will know from looking at the results, we sort of swung from one position to another, went from too low to too high, and you'd to bring it back down again. So I think there would be a lot of discussion around -- there's always a lot of discussion around sodium. I think there would be a lot of discussion now about when we could actually do it, and we may actually seek coroner's advice now. We tend to go to the coroner if there's any question around sodium levels in children and we're trying to work out what to

do.

Q. What has brought about that change in practice?

A. The entire awareness since -- well, 2002 was the first awareness, wasn't it? There has been building awareness throughout medicine. In 2002 we had the very clear direction from the Department of Health for Northern Ireland. We have the 2004, we have the NPSA, we had RQIA. There were shifts going on anyway in the background, but I think in Northern Ireland -- I think that Northern Ireland, unfortunately because of the identified cases, has led the rest of the UK and maybe, in fact, other countries as well in identifying and managing sodium much better than before.

Q. Now would you have thought maybe about the drugs and maybe taken some guidance on that?

A. Well, the guidance would be more readily available because there's pharmacists now --

Q. Would you do it?

A. Probably, yes.

Q. Thank you. If I can then turn to -- this leads on to communications with the family, really.

THE CHAIRMAN: Let's look at our time. The doctor has been giving evidence for her second hour now. How are we going to work through the rest of today? It was agreed beforehand, Mr Fortune, that Dr Steen could give us

three sessions of approximately one hour each today. We have reached the second hour or finished the second hour. It's a question of how much further we can get with the doctor, at what point do we break. Does the doctor need a break now?

Why don't I rise for a couple of minutes? We obviously want to make as much progress as we can with Dr Steen. If her evidence doesn't finish, I understand that, for various reasons, tomorrow and Friday are not options, so we're back into the following Monday. But we'll then be running into governance after that, so it'll be a question of whether we recall Dr Steen to finish any ungiven clinical evidence as part of governance or whether we have to, if we need to, ask her to come back for another session in clinical.

MR FORTUNE: Sir, would you give my solicitor and myself leave to talk to Dr Steen?

THE CHAIRMAN: On this issue.

MR FORTUNE: Yes, on the issue of her health.

THE CHAIRMAN: Yes. There's then a knock-on effect because we want to get Dr Sands' evidence started today and then to continue and finish, if at all possible, Dr Sands on Friday.

MR FORTUNE: If you give us a few moments, we can talk to Dr Steen. My learned friend can assess her position and

we can have a conversation.

THE CHAIRMAN: Yes. I will come back in at 12.50 and we can work out, if possible -- I'm quite happy to sit on and we'll take a late lunch or we can stop a bit early for lunch and take an early and slightly abbreviated lunch. All of these options are available.

(12.44 pm)

(A short break)

(12.56 pm)

MR FORTUNE: I see leading counsel is not here.

THE CHAIRMAN: She'll be here in a moment. Let me just tell you as we start that a difficulty has emerged, which means that Dr Volprecht is not available to us on Friday afternoon. I suspect that that is going to work in our favour because I think that means that Dr Sands is available on Friday, isn't he?

MR GREEN: Yes.

THE CHAIRMAN: And Dr Hughes is available on Friday. We have overrun a bit. If we lose Dr Volprecht, who was to be the video link on Friday afternoon, and we get Dr Sands started today, we can resume Dr Sands on Friday and still do Dr Hughes, I hope.

I'm not going to rush anybody through any evidence because we have some important witnesses this week, so I'm not going to curtail any questioning which has to be

taken. I'm just looking at the moment for the best format through the rest of today and into Friday.

What's Dr Steen's position, Mr Fortune?

MR FORTUNE: Well, sir, originally we took instructions on the basis of a short break and then another hour. Dr Steen was content to do that. It may well be, however, that your preference is to take the midday adjournment.

THE CHAIRMAN: Look, if it's easier on Dr Steen, I will take a break now until 1.15 and we'll go on until 2-ish if that suits. Let's forget about everybody getting their lunch; we can get over that for one day.

MR FORTUNE: The bottom line is simply this: Dr Steen would, if possible, like to finish today, and complete her evidence. We are in the hands, obviously, of my learned friend. It is likely there will be some suggestions or questions to be fed into my learned friend from other members of the Bar. No doubt they will be considered by my learned friend and put, if appropriate.

THE CHAIRMAN: Yes.

MR FORTUNE: But we are very much in the hands of my learned friend as to the length of time these questions take.

THE CHAIRMAN: Okay. If we started again at 1.15, Ms Anyadike-Danes, can we make progress on a number of issues until about 2-ish?

MS ANYADIKE-DANES: We can.

THE CHAIRMAN: Where would that leave us at your best estimate with Dr Steen's evidence?

MS ANYADIKE-DANES: The main issues that I wish to address still with Dr Steen are what I had just indicated I wanted to start with, which was the communications with the family, then the cause of death and the autopsy request form. Those are the remaining three issues. They are interrelated, of course, but there is quite a bit in that, and it trails back into something of her understanding of the medical notes and records.

Although it seems slightly out of sync, and I was asked to do it and it seemed sensible to deal with the brainstem test form, which is a slightly more technical thing, and one can then go into these matters. That's why it was done that way, but I don't want to suggest that we could complete all of that in the time that you have indicated. I'm afraid there is a bit more on that and we are now into the territory where there is direct communication and relationship between Dr Steen and Claire's family and, of course, Claire herself, although at that stage she was terminally ill.

THE CHAIRMAN: Okay. I think the unfortunate reality, doctor, is we're not going to entirely finish your evidence today.

A. Sorry, I have said that if the lunch break -- everybody's blood sugars are essential. If the lunch break is required and we need to do two hours, an hour and an hour this afternoon, I'll have a go at that. I can't tell you how well I'll be, how my thought processes will be as fatigue kicks in, but I'll have a go at it. I know we need to get a flow in the evidence and that is helpful to everybody. So if we want a short lunch break and then an hour and an hour, I'll have a go at it.

THE CHAIRMAN: Is that the best option?

MR FORTUNE: Rather than negotiate on the floor, can I suggest that we take the midday adjournment and come back at 1.50?

THE CHAIRMAN: Let's try to start again at 1.45. Let's take up Dr Steen's offer and we'll make as much progress as we can. Thank you.

(1.03 pm)

(The Short Adjournment)

(1.45 pm)

MS ANYADIKE-DANES: Good afternoon, Dr Steen. When do you recall, if you do, speaking to Claire's family when you returned to the hospital?

A. I don't have any recollection of it. I only have what the documentation is.

Q. Which is that you spoke to them when they arrived in the early hours of the morning?
A. Yes.
Q. By the time you were speaking to them, what did you have available to you?
A. I would most likely have had her medical and nursing records, I would have had information from the medical and nursing staff in PICU of what had been happening since her admission. I may have been able to have a conversation with Dr Bartholome to identify what exactly had been happening. I don't know, I might have had some information from the nursing staff on the ward of what the parents had been told and what they'd been made aware of.
Q. When you say that, is that because that's what would be logical?
A. Yes. That's what would normally happen when you come into a situation like that. You're trying to rapidly find out what has happened in the preceding few hours and you're trying to also find out what has happened and what has been informed to the parents because the parents are about to have a very difficult conversation with staff.
Q. You were in paediatric intensive care because that's where Claire was?

A. Yes.
Q. So when you say you would have informed yourself about Claire's condition or treatment prior to that, with a conversation perhaps with the nursing staff, maybe with any junior doctors who were on duty over the evening, I'm just trying to see when that would have happened. Because you're coming into a crisis situation --
A. Yes.
Q. -- and she has not very long been transferred across from the ward to paediatric intensive care. So what's the priority at that stage?
A. The priority at that stage for me to rapidly assess what as happening with the child, what needs done immediately, and then what further information is required or what else needs to be done. So there's the immediate situation, but I believe Dr McKaigue --
Q. That's what I'm trying to disentangle. If we can just focus on the bits that relate to you at the moment. I mean, what other people do obviously bears on what you do. But you come in and I think the first note you make is at 4 am.
A. Yes.
Q. So you're coming in, it's a crisis that's happened.
A. Yes.

Q. And the parents have been asked to come to the hospital as well rather rapidly. When you come there, you have a child there, there has been a collapse and she's in PICU. So some medical things have to be done to see if you can alleviate that crisis, I presume.
A. Yes.
Q. So you have at your disposal anybody who -- well, McKaigue, if he was there, as the consultant intensive care paediatrician, you have whichever nurses brought her across.
A. Well, probably the nurse who had been allocated to her in PICU; the nurse who had brought her from the ward would probably be back on the ward. She may not have been, but it was probable she would have gone back to the ward.
Q. At that stage, although her notes, I'm sure, would have travelled with her, you don't actually at that stage have access to anybody who would have been treating her during the evening.
A. Unless Dr Bartholome or the SHO were still in PICU.
Q. Yes. But unless they were, you've got McKaigue, and you have the PICU nurse; is that right?
A. The PICU nurses, who would have had a handover from the ward nurses.
Q. From them and her notes, you're trying to get a sense of

where things stand; yes?

A. Yes.

Q. And her immediate treatment?

A. Yes.

Q. Before trying to find out: how did we get to this situation? Presumably, that's a slightly secondary matter, maybe.

A. Yes.

Q. In fact, we have your note, which is at 090-022-057, if we pull that up. So this is your note. If we just pull up to the left-hand side of it, the preceding page, 056. That's just to have the thing in its context. So you can see that the notes run, there's an 11.30 note, then a 3 am note and then there's your note.

A. Yes.

Q. In fact, there's not really very much more that goes before that. You're then into the afternoon and Dr Webb's notes really. Okay, so this is what you have and this is what you do with it, if I can put it that way. And part of this will inform what you're going to tell the parents, I presume.

A. Yes.

Q. That responsibility is yours, is it?

A. It's mine and Dr Webb was also coming in at this stage to talk and to assess Claire and to talk to them as

well.

Q. We see Dr Webb's note just below. His note is written a little later than that.

A. Yes.

Q. Is it obvious from this whether you've spoken to him before you write your note?

A. I can't remember, but I suspect when I got the phone call I've asked: did you also phone Dr Webb? And would have asked the staff to make sure Dr Webb was informed. I think the parents came in by the time they got in and we spoke to them. Dr Webb and I were both present.

Q. This information, the preceding note that goes before it and any of the other notes and records, this is the information upon which you base your plan, if I can put it that way.

A. Yes, my initial plan. This is for the -- the information, tried to put it succinctly, quickly, again -- didn't try to put succinctly -- to put in place a plan.

Q. Yes. As you are doing that and you're reviewing the notes, even if you went no further than the note of 11.30, you would have seen that she had a sodium level of 121.

A. Yes.

Q. And you would have seen there what the action was taken

in relation to that and what the concerns were.

A. Yes.

Q. And immediately below that, there's a query over hyponatraemia. There's a query over fluid overload and low-sodium fluids and SIADH. Then there is a query over the need to increase the sodium content in the fluids. So all of that is Dr Stewart's view.

A. Yes.

Q. Then we have the fact that he discussed that with the registrar, with Dr Bartholome, and the result of that is to reduce the fluids to two-thirds of their present value and to reduce the rate to 41 ml an hour --

A. Yes.

Q. -- and then to send a urine.

A. Yes.

Q. When you looked at that, did you consider that an appropriate action at that stage?

A. To reduce the fluids to two-thirds maintenance was the first step that was routine in Children's, RBHSC, at that time, if you considered it to be SIADH. I would have liked the urinary U&E and osmolality and I would have liked it sent ASAP and there is a question that the U&E needed repeated just in case it was an artefact, an abnormality. With her condition, subsequently when I saw her, it was most unlikely to be abnormal, that it

was a true result, a true reading.

Q. Yes, but did it -- well, firstly, is there any written guideline as to what you have just indicated there?

A. I don't think there was any written guidelines in Children's at that time.

Q. So how did people know that's what to do?

A. Well, they would have known from given textbooks and given teaching at that time.

Q. Am I to understand you saying that the guidance that Dr Stewart got when he contacted the registrar is actually what you might have advised if you had been contacted?

A. That would have been my first step, but I'd have wanted a clinical assessment. If I'd been called, I'd also have wanted to come and see her to try and get an overall picture because when you look at the overall picture, her condition had deteriorated to such a degree that there would have been a question that further intervention was required.

Q. Dr Scott-Jupp is of the view -- and I think actually all the inquiry's experts are of the view -- that far more severe fluid restriction should have been imposed. I'm not going to ask for it to be pulled up, but just for reference's sake, 234-002-008. He is of the view -- and that is shared by the other expert witnesses of the

inquiry -- that it might have been appropriate to stop the IV fluids completely and it would have been advisable to check the blood osmolality, as you said, as well as the urine.

So his view is that something more stringent, if I can put it that way, ought to have happened at 11.30. Professor Neville takes it further and says that Dr Stewart's classification of the problem was appropriate at Dr Stewart's level, it was right to go and seek further advice, and that what should have happened then is that there should have been an attempt to induce diuresis by mannitol and to ventilate Claire to reduce intracranial pressure. You haven't said any of that; would you accept that?

A. I don't know what was in all the textbooks. I think the experts have tried to relate it back to all the textbooks. I know the understanding at this stage in 1996 was to reduce the fluids to two-thirds, reassess, find out what's going on and then take it from there. We cannot take the U&E on its own out of context with Claire's condition. I've said earlier, it just is what happens. We get children coming in with very low sodiums who aren't unconscious, don't have an altered level of consciousness and just have a primary viral illness or something like that. I think the key thing

about Claire is not only her U&E, but her overall condition. Was this sodium affecting her and, if so, what needed to be done? And I think if you take that from a clinical assessment with her Glasgow Coma Scales, et cetera, I think the consultants should have been informed and there were further things to be carried out. But if you look just at the U&E per se, I know the first line of treatment was to reduce fluids to two-thirds maintenance and check.

Q. Well, firstly, it wouldn't be a matter of Dr Bartholome, or Dr Stewart for that matter, looking just at this as a snapshot in time of her U&E results because, in fact, almost 24 hours earlier, you'd had a slightly low sodium result and all that had happened is that it started at 132 and it is now 121, despite all that may or may not have been done in the intervening period. So it's not a snapshot in time entirely. But the point I'm asking you is: the inquiry's experts are of the view -- and I don't think it is correct to characterise that as them just looking at textbooks; they are giving their expert view as to what the appropriate action ought to have been in 1996. And their view is that at least one of the things that should have been considered is to stop all further fluids.

A. And I can only answer that my understanding is that was

not the clinical practice in RBHSC at the time. It might have -- maybe it should have been, but my understanding is that it wasn't.

Q. Then when you saw this result, and the other things you'd have had, presumably, would have been her fluid balance sheet where you would have seen she'd been on --

A. Yes.

Q. -- IV fluids almost from the outset, if you like. And given her presentation over the time and the way that deteriorated, was there any thought, when you saw that, that Dr Stewart may actually have a point, there may be an issue to do with fluid overdose or overload here. That may actually be part of this child's condition. Did you think that?

A. I have no recollection of what I thought.

Q. Well --

A. I can only go on what the documentation was and I know that we primarily were thinking of inappropriate ADH secretion with water retention.

Q. As you look at it now, do you think that that conclusion of hyponatraemia, attributing it to possibly -- that's a query -- to fluid overload and low sodium fluids, is that an appropriate characterisation of what might be happening?

A. I think it could be a contribution, but it doesn't take

away from the underlying condition.

Q. Which was as far as you were concerned?

A. Viral illness with encephalitis and possible seizures.

Q. How did you know that? How did you know, at that stage, that that was the underlying illness?

A. Because her -- at the time of admission, she had been vomiting, her temperature was up slightly, her white cell count was elevated, she had been seen by Dr Webb, who had agreed that encephalitis or encephalopathy was maybe part of it. He had asked for certain investigations to be done and some investigations had been present from when she was a baby looking at causes of metabolic encephalopathy, so there had been steps taken to try and exclude it. Sorry, you need to take me back to your question.

Q. It was your statement. You said that hyponatraemia wouldn't necessarily explain the underlying cause of her condition, which was a viral infection, I think you said.

A. Yes, because when she came into the hospital with a sodium of 132, a sodium of 132 would not be symptomatic, you would not be having a decreased level of consciousness with a sodium of 132. A low sodium per se could not explain the entire picture prior to this --

Q. No, but it wasn't actually that that I was querying you about. You had, if you like, identified what the cause of her underlying condition was and I think you had identified that as something viral, encephalitis, encephalopathy, and I'm simply asking how you were able to reach that view, because you had had no real contact with Claire until you come now at 4 o'clock to be looking at her notes and you're giving that view that you thought that might be the problem. I'm simply asking you how you were able to reach that view.

A. By reviewing her notes, her observations and what had already been found.

Q. You might like to consider your witness statement, 143/1, page 82. It's in answer to (f). This is a series of questions going back to question 53, which is:

"At the time, I thought she died from cerebral oedema due to neurological causes."

So that is a statement that you make in your deposition. And these are a series of questions which flow from that, if I can put it that way. And then (f) is:

"State whether, how and when the fluids administered to Claire caused or contributed to the SIADH."

And you say:

"In 1996, the fluids were not felt to have contributed."

A. Yes.

Q. I think you just indicated that you thought that they might have contributed.

A. I think, looking back, we do know that the fact that she was on a lower salt solution will have increased the hyponatraemia due to the inappropriate ADH. But in 1996 -- and even when we went to the inquest, there was a query around how much the fifth-normal contributed as to the other underlying condition. And also whether in 1996, despite the Arieff paper, despite Children's being aware of Adam Strain, there was an awareness among paediatricians that fifth-normal would contribute to hyponatraemia.

Q. Yes, I accept that --

THE CHAIRMAN: Just one second, sorry.

When you said, "Whether in 1996, despite the Arieff paper and despite Children's being aware of Adam Strain" -- who was aware of Adam Strain?

A. The Trust then. We are aware that --

THE CHAIRMAN: So when you say the Trust was aware of Adam Strain, who was aware of Adam Strain?

A. Well, who knows, but --

THE CHAIRMAN: That's exactly the point.

A. It had not been ... I am not aware that that information had ...

THE CHAIRMAN: Had gone out beyond the very, very small circle which did not include you?

A. I believe -- yes.

THE CHAIRMAN: That's the very point.

A. Yes. At this point in time, I am aware that the inquiry has concerns that information was not disseminated. So what I'm saying is that even with all of that, in RBHSC, we were not made aware or we did not feel that at that time the hyponatraemia was significantly contributed to by the fifth-normal.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Yes, but Dr Stewart has reached that as a possible view, so does that mean when you read that note of Dr Stewart's, you thought: that's an interesting note from the SHO, but I just don't think there's any basis for that?

A. I might well have added up her total volume of fluids to see if she had had additional fluids above and beyond her maintenance, I don't know, to see if she was overloaded, if she had extra fluid above and beyond what would be maintenance. I don't know if I did.

Q. I appreciate you don't know, and that's part of the difficulty.

A. Yes.
Q. But trying to deal with that difficulty as best we can, what we do have is a note made by an SHO, who wasn't very long in that particular position, and irrespective of what is said to have been in common knowledge at the Children's Hospital in relation to low-sodium fluids, hyponatraemia, SIADH, this is a junior doctor who is nonetheless able in examining Claire and presumably looking at Claire's medical notes and records to actually identify hyponatraemia as a possible cause, identify fluid overload as a possible cause for the hyponatraemia and the low-sodium fluids, and query whether what we're seeing here is anything to do with SIADH. So that particular doctor was able to be prompted by Claire's condition and what he found on examination to reach that view.
A. Well, the hyponatraemia, I think, is a description of the low sodium --
Q. Exactly.
A. -- rather than an overall description -- Dr Stewart can answer this -- of Claire's condition. And he's saying: is the hyponatraemia due to fluid overload with low sodium fluids or to SIADH? And he queried the need for increased sodium content in the fluids. What I'm saying is that he may have been aware of that, he had

done -- it may it would be more obvious through the experience he had had as a houseman before he came to that. But I certainly do not feel that myself or others were aware that unless you gave more than maintenance of fifth-normal saline, you would induce hyponatraemia per se on its own.

Q. So on that basis, you're saying he actually may have been rather better informed about these directions than you?

A. He may have had a better differential diagnosis of hyponatraemia, the causes of hyponatraemia.

Q. Is it not something that you should have at least considered that that junior doctor may have been right about that and, before it was excluded, reached a basis upon which you could say, "Well, I've seen that, but I've not included that for this reason or that reason"?

A. I have no doubt it was considered and discussed.

Q. And then on what basis, from the evidence in Claire's medical notes and records, would you have excluded that as a possible cause?

A. I think, as Claire's condition deteriorated and she died, and we then got the post-mortem result -- because we were working through probable diagnoses, what we thought would happen. The ultimate confirmation of what we felt was happening was through the limited

post-mortem report. I think -- I'm sure because it's the inquest and it is in witness statements that the feeling at that time from the clinicians involved in her care was that the primary problem was a viral encephalitis with seizures, perhaps cerebral oedema, secondary to inappropriate ADH.

Q. I appreciate that. What I'm trying to ask you is, since you seem to have, in that formulation, excluded an alternative cause that -- well, he doesn't know at this stage that Claire is not going to survive, so what he's dealing with is a differential diagnosis, effectively.

A. Yes.

Q. Since you seem to have excluded that, what I'm asking you is: what did you see to form a basis for excluding that?

A. And I can't tell you what my thoughts were at the time. I can only tell you, looking at statements, et cetera -- in other words what seems to have been the understanding.

Q. I understand that. If we leave the statements out of it and we look at the actual medical notes and records, so the contemporaneous record and account of what was happening with Claire, what do you see there to enable you to exclude hyponatraemia caused in that way, potentially relating to SIADH, to exclude all of that

later on? What do you see in her medical notes and records?

A. I see the child most likely had a viral infection. I see the child had encephalopathy, query encephalitis. I see the --

Q. Sorry, can I pause you there. When you say "you see the child" --

A. You asked me to say what I see in the notes --

Q. Yes, but you have already acknowledged that those things were differential diagnoses. Nobody has actually confirmed the diagnosis of encephalopathy or encephalitis.

A. No, they are working --

Q. That's a differential diagnosis.

A. They are working diagnoses.

Q. Exactly.

A. They are working diagnoses. They were based on clinical signs as well as laboratory investigations.

Q. Yes. So how do those working diagnoses, which at the stage in which you're at, have neither been proven nor confirmed, how do they help you to exclude another one?

A. Because at that stage we did not think that maintenance fifth-normal saline significantly contributed to hyponatraemia.

Q. So that must mean at that stage you thought that that

suggestion from the SHO, Dr Stewart, must be wrong.
A. Well, it's the overload. Was there overload, was there excessive? We know now with practice that it was excessive because, in an acute neurological disease, we would automatically restrict the fluid input and we do that automatically now. But at that time, as far as I can ascertain from reviewing all the notes, we did not feel that the fifth-normal -- the volume of fluid she received as fifth-normal significantly contributed to her hyponatraemia.
Q. I understand that. What I'm saying, and maybe you are saying "yes", but in a different way -- that must mean that you thought that Dr Stewart was wrong.
A. As regards the overload, yes --
Q. Yes.
A. -- based on the idea of maintenance rather than a maintenance plus extra.
Q. He was wrong about that, as that being a mechanism that had led to her hyponatraemia, which could be explaining her presentation in part? He was wrong about that?
A. I can only say -- I can't say definitely whether we thought he was wrong or not. I can only look back and say: did we think fifth-normal in maintenance caused problems? And I don't think we did. He says fluid overload. Did we discuss what fluid overload meant or

whatever? I don't know.

Q. If you thought it was a possibility, and therefore not excluding it as incorrect, if you thought it was a possibility, you would have had that as another possibility?

A. Yes.

Q. Even one to be established later on.

A. Yes.

Q. "Let's have a series of working hypotheses --

A. Yes.

Q. -- this might be one."

A. Yes.

Q. Because at that stage, when you're starting to think about these things, you haven't had the post-mortem results, you don't actually know these things.

A. No.

Q. So these are a series of hypotheses as to what might have been happening and what contribution they might have made to her condition and her eventual collapse and death.

A. Yes.

Q. But you did not include that.

A. No. I don't know whether we ... I do not know what conversations were had because I do not recollect to include or exclude possible mechanisms. I can only

interpret what has happened over the period of time and what has been put forward in statements.

Q. Well, can I ask it slightly in this way: were you aware that an acute neurological illness could put Claire at risk of SIADH?

A. I can't be sure I was aware of it. I think I probably was.

Q. Then I think earlier today, when I asked you, you realised that there was a --

A. There is, yes.

Q. -- a pattern to these things.

A. Yes.

Q. And if you had realised all that, you shouldn't really, in terms of an alternative hypothesis, have been excluding hyponatraemia.

A. As a complication of the --

Q. A contribution. As a contribution.

A. A complication or contribution? I'm ...

Q. Because it is cyclical in that way. You shouldn't --

A. You've got a nice diagram, actually.

Q. We have got a diagram of it and I'm trying to find it to help with this.

A. Is it easier just to maybe say that we knew -- that my understanding would have been that the low sodium would have exacerbated the cerebral oedema, which would have

exacerbated the seizures, which would have exacerbated the inappropriate ADH secretion, which would have exacerbated the hyponatraemia.

MR FORTUNE: The reference is 310-014-001.

A. Yes.

MS ANYADIKE-DANES: Thank you. There we are.

A. The vicious circle that has been set up.

Q. Exactly. So that you can see along the bottom, those were the differential diagnoses that might have led to the brain swelling and the fatal cerebral oedema.

A. Yes.

Q. But you can also see, quite apart from that, there is its own little cycle with SIADH, the hypotonic fluids, retention of free water, hyponatraemia, which in turn would exacerbate the cerebral oedema. And that is a cyclical cause, if I can put it that way, that could be independent of or contributing to whatever was being produced by those three differential diagnoses along the bottom.

A. And the only other thing that I would add to that is those diagnoses cause cerebral oedema, but they also cause inappropriate ADH.

Q. Yes.

A. So you have the cerebral oedema leading to inappropriate ADH, but you have the encephalitis leading to

inappropriate ADH, the status epilepticus going to inappropriate ADH and encephalopathy. So it is a very complex vicious cycle.

Q. Precisely so. And so recognising that complexity, that's not something, if you were looking at your hypotheses -- because that's the stage that you're at, trying to work out what had happened -- you should be leaving hyponatraemia out of it if you look at it like that --

A. As a consequence of the encephalitis --

Q. -- and then --

(Intervention by the stenographer re overspeaking)

MS ANYADIKE-DANES: I'm very sorry.

Flowing through to exacerbating the cerebral oedema and so on, producing that cyclical effect.

A. Yes.

Q. So that should have been in there really.

A. As a consequence, yes.

Q. And in fact, the prompter to have that in there, if you hadn't already thought of it yourself, was something that your own SHO had thought of.

A. But the hypotonic fluids, how much that contributed to it, is the question. And that's where I think there was discussions, and I believe there definitely were discussions around the contribution, and I think there

continues to be discussions around the contribution of that to the vicious cycle.

Q. And those discussions at the time are not recorded anywhere?

A. No.

Q. And if one was trying to look back from a learning point of view or even from some sort of an investigation to learn what had happened to Claire, one wouldn't be able to see the thought process as to why certain things have been excluded or included?

A. No.

THE CHAIRMAN: Do you think it's likely that Dr Neil Stewart was not spoken to after Claire's death about his analysis or view of what was wrong with her at 11.30?

A. I don't know. I'm sorry, chairman, I just don't know. I don't recollect. It's possible. He would have been working the next day, but we were quite tied up in intensive care the next day.

MS ANYADIKE-DANES: So given what you have just said now about hyponatraemia, do you think that was something that was mentioned to Claire's family or not?

A. I think the low sodium was mentioned to Claire's family. We didn't use the word "hyponatraemia", and we don't particularly now. We talk about hyperkalaemia, high potassium, the potassium's abnormal, and we still tend

to talk about the sodium being abnormal on a day-to-day clinical basis and we wouldn't use a term like that with the parents.

Q. Did you tell Claire's parents that her sodium was abnormally low?

A. Yes, and I believe I did because I believe that's what triggered their memory when the UTV programme came on, to say: could that be our Claire?

Q. And if you told them that, would you have told them what you thought the implications of that might be?

A. That it would have added to the cerebral oedema?

Q. Well, I don't know, I am asking you.

A. I can only go by what is in the counselling record and what's been written in the notes. But I certainly think -- looking at those, I feel I would have said to the parents: this low sodium will not have helped, it's a result of these complications and the coning.

Q. So that must have meant that you recognised that -- let's forget about hyponatraemia and concentrate on low sodium -- that low sodium had a part to play?

A. Yes.

Q. Although when I was asking you about your hypotheses, you weren't including that there?

A. But the low sodium was a consequence, as far as my understanding going through the documentation over

time -- that the low sodium was a consequence of the inappropriate ADH secretion rather than the fifth-normal.

Q. And did you think that the low sodium, as a consequence in that way, could have been present or allowed to remain low as a result of poor fluid management?

A. The fact that -- yes, the fact that her U&E wasn't repeated and her fluids monitored more closely contributed to that low sodium, which contributed to her cerebral oedema. And there's no doubt about that.

Q. Yes. And did you explain to Claire's family that not only were Claire's sodium levels abnormally low, but the fact that they were abnormally low and remained abnormally low is a matter of poor fluid management?

A. I don't think we did cover that because subsequently, if you look at the information coming back in 2004, et cetera, the parents appreciated the low sodium, but we certainly didn't seem to have informed them that it was due to poor fluid management. And I'm not sure that at the time we actually did know that -- we did contribute poor fluid management to it. It was only when we went back and looked in detail at 2004 to 2006 that we appreciated how significant the fluid management had been in contributing to it.

Q. What did you see in 2004 that you wouldn't have seen in

1 1996?
2 A. Well, we were preparing the case in detail, going
3 through every single detail. We had greater awareness
4 of hyponatraemia and fifth-normal by then. So when
5 we were reviewing the case, we were actually then
6 looking with different eyes than when we had looked in
7 1996.
8 Q. But what did you see when you looked at the case in
9 2004?
10 A. I can't tell what I saw other than what I have
11 documented in 2004. But my understanding is that when
12 we went back through, when I look at the documentation,
13 we appreciated without a doubt the U&E should have been
14 done sooner, and if the U&E had been done sooner, plus
15 or minus an EEG, plus or minus a CT scan, her management
16 would have been very different and the outcome would
17 have been very different.
18 Q. But your evidence earlier was that if you had been
19 involved -- this is this sort of parallel universe one
20 gets into, ie what might you have done and what would
21 the significance of that have been. But if you had been
22 involved, I think your evidence was that there should
23 have been an earlier testing of Claire's serum sodium
24 levels.
25 A. Yes.

Q. Sorry, bear with me. So that was your evidence, that there should have been?
A. Yes.
Q. And the fact that there wasn't, and therefore you didn't actually know what her serum sodium levels were at any point during that day, you don't need to get to 2004 to see that that's poor fluid management. You can work that out in 1996 because you knew that you would have wanted her U&Es to be tested.
A. But her sodium -- yes, but is that ... How much is a complication of her underlying clinical condition and how much is a complication of the fifth-normal solution? And I do know that with some of the expert witnesses they do debate this themselves.
Q. I had put it to you in slightly different terms. The terms that you had accepted, that the low sodium, which you had characterised at that time as a consequence, if I can put it that way, of the SIADH, but you also recognised that for it to remain low, it could in turn have been an exacerbating factor --
A. Yes.
Q. -- and therefore have contributed to her condition in that way.
A. Yes.
Q. And you had recognised that and you recognised that that

was the case in 1996. And what I was putting to you is: for her serum sodium levels to remain low, undetected, is a matter of poor fluid management.

A. And I would accept that because we discussed -- and I've said frequently that the U&E should have been done earlier and then actions taken depending on the result of that.

Q. I accept that.

A. However, at the time, I do not believe that that was our thought processes or understanding.

Q. You sort of slide off into a different point. The point that I would like you to address is: you have accepted not to do her U&Es and not to know what the true status of her serum sodium level was was poor. You would have wanted that to be done, you would have wanted to know that.

A. Yes. In retrospect, looking back.

Q. But even then -- I have asked you and you have told me -- even in 1996 you would have known you wanted to know that.

A. Yes.

Q. So what I am putting to you therefore is: you could have, in 1996, explained to Claire's family, although we don't have the full picture here, we know that she's got low sodium, and I'm afraid to say that some of that is

down to our poor fluid management. It wouldn't have given the full picture because you don't have the full picture at that stage, but you knew enough to know that they had not managed the testing of her sodium levels in the way that you would have wanted them to. That's poor fluid management.

A. From my documentation, I do not think my thought processes took that additional step.

Q. Well, could you have worked that out, that it was poor fluid management?

A. As a contributory factor, given time, probably, yes. But at that time, we were working under the diagnosis of inappropriate ADH and water retention. There was no doubt her U&Es should have been done earlier and no doubt she should have been seen by senior staff earlier.

Q. Did you tell the Roberts any of that?

A. I don't know, I have no recollection. And the counselling record is limited, the nurse counselling record. There's two entries, but then nothing after, I think, 6 am or 6.30.

MR SEPHTON: Sorry to interrupt, I wonder if my learned friend could adduce on this point, that when she refers to "we", who "we" is, first in 1996 and, secondly, in 2004.

MS ANYADIKE-DANES: Who is "we" in 1996?

A. In 1996, Dr Webb was with me, and therefore with the "we", I'm putting Dr Webb because Dr Webb was managing this case. We were together in ICU and we were covering this case right through from 4.40 right through until her ultimate death. So the "we" in 1996 is Dr Webb and myself.

In 2004, we had got Dr Sands reviewing the notes, myself reviewing the notes, and the medical director had also asked Professor Young to review the notes, her records, around the sodium and the hyponatraemia. Dr Webb, of course, was not in Belfast any longer at that time.

Q. When you were saying what you had access to before you spoke to the family, we've talked about the medical notes and records and we have seen the note that you made. The note, I don't think, makes any reference to the point that Dr Stewart had raised. Did you have, when you were speaking to Claire's family, the PICU coding form at any stage? I'll pull it up for you, 090-055-203. Did you have that?

A. No, that was done on the 23rd.

Q. Which was the day you were speaking to Claire's parents.

A. No.

MR QUINN: Mr Chairman, the doctor's already given evidence back in the transcript that she had got that PICU note.

That was part of the file she had before she spoke with the parents.

A. I don't know if this was in the chart or where it was in the chart.

MR QUINN: She said it was in the chart earlier.

THE CHAIRMAN: Earlier this afternoon, Mr Quinn?

MR QUINN: Yes, just about half an hour ago. I've taken a note of it. I can't exactly say where it is on the transcript.

THE CHAIRMAN: Okay, wait one second. (Pause).

MR QUINN: The context was when we started off on contact with the family. My learned friend asked:

"What did you have?"

And she said:

"I had the usual medical records nursing records, PICU, and perhaps I had a chat with Dr Bartholome."

A. Yes, but I'm not sure when that coding form was written. It's not -- it's dated, but I don't know when that ...

THE CHAIRMAN: This is --

A. She had died by this stage, so I don't know if this was written at 7 o'clock in the evening. I don't know when that was written.

MS ANYADIKE-DANES: It's signed off by Dr McKaigue and Dr McKaigue is one of the people you say that you had access to in terms of not only writing up your note, but

generally understanding what had happened, isn't that right? He is one?

A. Yes.

Q. So this is signed off by Dr McKaigue, as I understand it. If you see there, hyponatraemia is included --

THE CHAIRMAN: Sorry, just a second. If you look, apart from the point that the note says "died", about five lines further up above that it says:

"Brainstem tests times 2."

If that means the brainstem test had been carried out, then she couldn't have had that note. The doctor could not have had that note at about 4 am. If it means that brainstem tests were to be carried out, then the doctor may have had it, but it looks a bit -- this looks to me, subject to anything the doctor says, as a note which was made later because it refers to brainstem tests and --

MR FORTUNE: Look at the last line, sir.

THE CHAIRMAN: "Died." Your client's already said that, Mr Fortune.

A. And "hypernatraemia", which happened during the day of the 23rd --

THE CHAIRMAN: Well, hypernatraemia is the later result from the file that we were looking at before lunch.

A. Yes. So I think -- and Dr McKaigue may be able to

help -- that this was written at the end of Claire's time in PICU.

THE CHAIRMAN: Right. So you did have access to whatever notes were in the paediatric intensive care unit, but for the reasons you've just summarised, you doubt whether that was a document which would have been drawn up by 3.30, 4 am on the 23rd?

A. Yes.

THE CHAIRMAN: Okay.

MR FORTUNE: Sir, for the avoidance of doubt, I understood my learned friend to be talking about the first meeting between Dr Steen and the parents.

THE CHAIRMAN: She was.

MS ANYADIKE-DANES: There are, in fact, two meetings, are there not?

A. There's two documented meetings in the nurse counselling records. There were other meetings, but I had asked if there was another page from the nurse counselling because there doesn't seem to be any other nursing reference to communications with the parents or indeed discussions around organ donation or anything else.

There's one page from nurse counselling, but that finishes really after the first set of brainstem results as far as I can recollect.

Q. The second brainstem death tests are then taken at

6 o'clock in the evening.

A. Yes.

Q. And you speak to the parents after that.

A. And I believe Dr Webb was with me. Yes, I speak to the parents after that.

Q. So at that stage, would you consider that she had died at that stage?

A. Oh yes.

Q. And did you speak to them after ventilatory support was finally removed?

A. I can't recollect.

Q. Did you speak to them again after the brainstem test, the second one?

A. I would normally stay in PICU until the child had died, and the parents had been with the child. I also was doing some documentation around that time, so I would have remained in the unit.

Q. Yes. So all the time you're in PICU, do you have access to Dr McKaigue?

A. The consultants change during the day. Dr Crean was on at one stage, Dr Taylor came on in the evening. So the consultants changed, PICU consultants changed, during the day. Dr McKaigue was on in the early hours of the morning until probably 9 o'clock. Then I think Dr Crean took over for daytime, Wednesday.

Q. Let's pull up 090-022-061. So if you see the first -- 18.25.

A. Yes.

Q. That's a diagnosis of brainstem death protocol completed. So that's the second brainstem test done.

A. Yes.

Q. And then you see:

"Discussed and parents agree that ventilation should be withdrawn."

Do you see that?

A. Yes.

Q. And you sign that?

A. Yes.

Q. And then the 23rd, so carrying on on that day, but just a little bit later on, 18.45. So ventilation is discontinued and that's signed by Dr McKaigue.

A. Yes.

Q. And then immediately after that:

"Death certificate is issued. Cerebral oedema secondary to status epilepticus."

A. Yes.

Q. And is that you writing that?

A. Yes.

Q. You don't sign that?

A. No.

Q. But it is you?
A. Yes.
Q. Yes. Can we go back to the brainstem form that we had up previously? 090-055-203. Just put that alongside maybe. Thank you.
So at that stage, there is a reference in this PICU coding form, signed off by Dr McKaigue, as to hyponatraemia.
A. Yes.
Q. But that's not something that appears in any of your notes.
A. No, I refer to low sodium in various places, but not that term.
Q. Not that term. Then having seen how the notes fall on the left-hand side, do you think therefore that you might have had that or access to the information on that PICU coding form at the time you spoke to Claire's parents on the second occasion?
A. No.
Q. Or access to the information on it?
A. Well, the information would have been what we had been discussing in PICU about her management.
Q. Yes.
A. So we'd have known her sodium had been low and gone high and that her potassium had gone low as well.

Q. So why is it you think that in a PICU coding form, hyponatraemia is included there, and yet it's not something that you're including in your notation?
A. I don't know how the PICU coding progresses. I think Dr McKaigue could probably answer that for you. I don't know how PICU code their episodes. This is very much a PICU coding form done by the intensivist anaesthetist.
Q. So do you think clinical coding could be differently in PICU than in the rest of the Children's Hospital?
A. I think their --
MR FORTUNE: Dr Steen says she didn't know. Just ask her.
MS ANYADIKE-DANES: I'm only ask you if you think that it might be different.
A. I think the things highlighted at this stage -- and I don't know if these actually were coded under PAS -- such as the intubation, the art line, the central line, IV infusion of inotropes. That is not normally something that we would have written in the coding area of the discharge letter in the medical wards.
Q. Let me put it a different way: if you had been asked to do the coding, which you might have done apart from the fact that she actually died in PICU, would you have included hyponatraemia?
A. As the word "hyponatraemia"? No.
Q. Would you have included low sodium?

A. Most likely, yes, because I included it in my clinical summary.
Q. Then can we pull up the discharge summary to see whether you had access to this at any time when you were speaking to Claire's family? 090-009-011. It's a very poor copy. I don't know if there is ...
MR FORTUNE: Is this a fair excise bearing in mind how poor the copy is?
THE CHAIRMAN: Let's see how far we can get, Mr Fortune. There's no need to cut it off at the start.
MS ANYADIKE-DANES: I think we actually have the originals here. That might assist.
Are you able to -- that seems slightly better pulled up like that.
"Admitted to PICU from Allen Ward because of respiratory difficulties and Cheyne-Stokes breathing. Intubated and ventilated. Pupils fixed and dilated."
A. I think that's probably "CT scan" or "CT brain".
Q. "Severe diffuse ...
A. -- hemispheric swelling --
Q. -- with complex effacement of basal cisterns. Brainstem tests performed with a diagnosis of brain death. Ventilation withdrawn after discussion with parents at 1845 hours."
A. And it's dated the 29th and I don't know who's signed

it.
Q. And where would the information for that have come from?
A. That would have come from presumably records or somewhere, I don't know.
Q. Would have you had access to that when you -- that was my original question.
A. This is 29 October that this has been completed, and it's purely the PICU component of her admission.
Q. I saw that as the date. I'm not sure that's when it's actually completed. I think you gave evidence before that sometimes these things are completed earlier than they are actually signed.
A. Yes. If you go right up, this says that she was admitted under Dr Crean.
Q. Let's go up to the top. Yes.
A. Yes.
Q. Well, if we pull the whole document -- it is very bad. I think you can see the diagnosis, though. If you work your way down from "ward", there's a principal diagnosis, which is the cerebral oedema.
A. Yes.
Q. Then "other diagnoses".
A. "Status epilepticus --
Q. "Status epilepticus --
A. -- and hyponatraemia."

Q. -- and hyponatraemia."
A. Yes.
Q. So there we have two other documents that have included the hyponatraemia, but not any of yours.
A. No. I have documents at the same time, showing "low sodium", but not the word "hyponatraemia".
Q. Then that is what you had available to you when you were discussing with Claire's family. Now --
A. Not --
Q. Sorry, I have been taking you through and asking you questions about what you might have had available to you when you were discussing with Claire's family.
A. This document is the 29th and Dr McKaigue's document was the evening, at least, of the 23rd.
Q. Yes.
A. So on the first conversations with Claire's family, Dr Webb and I did not have those documents.
Q. Yes. You had the information from which those --
A. Yes.
Q. -- matters were distilled?
A. Yes.
Q. And then, leaving aside whenever this was actually completed, can I ask you what you then discussed or what you consider it would have been appropriate, in the light of the information that you had available to you,

to have discussed on the first occasion, then you would have had or might have had less information to you, and when you discussed with them on the second occasion.

THE CHAIRMAN: Let's take it bit by bit.

MS ANYADIKE-DANES: Let's take the first occasion first.

A. The first occasion is -- had she gone for a CT scan at this stage?

Q. After the first brainstem test.

A. We had spoken to the parents already.

Q. Yes. I'm just asking you, at that point --

A. So we'd already had a conversation with the parents.

Q. That's what I'm asking you. When you have that first conversation with them, what do you think was appropriate for you to discuss with them?

A. Was it not before the brainstem tests? Was it when Claire was going for CT?

MR SEPHTON: I can help my learned friend.

Page 090-022-057.

THE CHAIRMAN: Thank you.

MR FORTUNE: Also the counselling record, 090-028-088.

MR SEPHTON: At 057, you have Dr Webb's note at 4.40, which mentions SIADH, hyponatraemia, hypoosmolality and cerebral oedema. Then it says, "For CT scan". And on the next page, we can see the CT scan report at 0530 hours. So that gives you the time of the scan.

MS ANYADIKE-DANES: That's very kind. Can we go back to that previous page? It's one of those other documents I meant to put and I apologise for not putting it to you in order.

You have said what you and Dr Webb were discussing and you were particularly asked by Dr Webb's counsel about who the "we" was when you were attributing certain things to a joint position, if I can put it that way.

A. Yes.

Q. And you said that that "we" included Dr Webb. But Dr Webb has recorded there SIADH, hyponatraemia and so forth, going on to cerebral oedema and coning.

A. Yes.

Q. So he has a progression, which includes hyponatraemia.

A. Yes, based on SIADH rather than the contribution of fifth-normal solution.

Q. Exactly so. But nonetheless, hyponatraemia, which some may consider to be a matter of fluid management, at least if it continues on to have those sort of fatal effects, is a matter of poor fluid management. He has that in his narrative, if I can put it that way, as to what is happening with Claire.

A. Yes.

Q. And the point about fluid management is fluid management is something that is within the control of the

clinicians, and if you have poor fluid management there's a suggestion that the clinicians have not provided adequate care. And that's the point. And what I was trying to explore with you was whether there was any suggestion of that passed on to Claire's parents so that at that stage -- well, at whichever stage you're talking to them -- to recognise, if I can put it that way, the possible culpability of the clinicians in Claire's death.

A. And I think my answer was that, looking back at the documentation, I do not believe my thought process had taken that step, that the contribution of the fluid management at that time was of such significance. Because if it was, it would have changed the whole -- if that it had been the thought processes of myself or any of the other consultants, it would have changed the whole process of what happened after her death.

Q. Well, that rather depends.

A. If we think she died because of something we did do, then there's no death certificate that can be issued; it is a coroner's case. So the fact that a death certificate was issued means that myself and, I would suggest, Dr Webb felt that her death was from explained natural causes rather than a contributory factor from mismanagement of IV fluids.

Q. If I may I say so, that is exactly the point.
A. Of course that is the point.
Q. The point is precisely the extent to which the treating clinicians could have understood that there was culpability in Claire's death, and therefore it was completely and utterly inappropriate not to have a coroner's inquest. That is exactly one of the points.
A. I accept that's exactly one of the points and what I'm saying is: as we did not move to that step and looking at what was done, the significance of the hyponatraemic solutions, the fifth-normal, was not appreciated at that time.
THE CHAIRMAN: Well, do you now, looking back on it, agree that that was wrong?
A. Yes. I think the minute we looked back at the case in 2004, in light of what we knew by 2004, it became very obvious that fluid mismanagement was a contributory factor to her underlying condition.
MS ANYADIKE-DANES: So I suppose the point you're making is, because you did not report the matter to the coroner, it means it was not a matter to be reported to the coroner.
A. That it was not something that we had realised as a significant contributory factor that would have affected her unfortunate death.
Q. That might lead to a bit of a circular argument. In any

event --

A. Well, I have, but, I mean, it is --

THE CHAIRMAN: We're going back over ground, but it depends on what you knew in 1996 about hyponatraemia compared to what you knew in 2004 about hyponatraemia. It also depends on what you should have known in 1996, after Adam Strain's death, or even without the event of Adam Strain's death.

A. Yes.

MS ANYADIKE-DANES: Thank you.

So I was asking you to help us with what you think you should have been raising with the Roberts family at any time. It actually turns out that you had three sets of conversations with Claire's family: one, as you identified, was before the CT scan -- I'm not asking it to be pulled up, but I'm doing it for record purposes, 096-001-004; one after the CT scan, 096-001-004; and one after the second death test, that is 090-023-061.

So there were three. I think you've tried to help us perhaps a little bit with before the CT scan when I suppose you have the least information because the CT scan is going to inform you better. So what do you think you should have been discussing with them after the CT scan?

THE CHAIRMAN: Sorry. Just clarify the question, please.

What do you think that you should have been discussing in light of her knowledge in 1996?

MS ANYADIKE-DANES: I beg your pardon, that's absolutely right.

A. The CT scan confirmed the cerebral oedema and her clinical condition in those few hours in PICU would have indicated that her brainstem had coned and was damaged and she couldn't breathe. So therefore, the additional information with the CT scan would have, I feel, meant that I discussed with the parents that our concerns, our fears, were true. We now had X-ray confirmation that the brain was swollen, that the brainstem had been damaged and that that was affecting her ability to breathe, and that -- I don't know whether I used at this stage or what stage or whether Dr Webb used at this stage -- she would have been brain-dead.

Q. And what are you advising or guiding them or helping them with at that stage that, in 1996, you would have considered appropriate?

A. I think any parent getting that -- it's absolutely horrendous. I think the amount of information they absorb is extremely limited, which is why you try to have the nurse there as well, so that when the parents are asking more questions, they can ask. I would have advised them what that we would do during the day is

monitor Claire, try to keep everything going, try to normalise the sodium, but we'd have to do it slowly, try to see what would happen during the day, but this is after -- have we done the first set of brainstems? Sorry, is this after the first set?

THE CHAIRMAN: This is after the CT scan.

A. Okay. So after the CT scan, what we then would have been talking about -- if we'd got her through to ... We'd talk to the parents about thinking that the brain had been -- especially the breathing part of the brain -- irrevocably damaged and what we needed now to do was to start a process in place to confirm whether that was actually true, and that included brainstem testing. Dr Webb and I should have informed them what the brainstem testing included, not necessarily the ins and outs of every single test, but that they would be done 12 hours apart, and during that period we would continue to monitor Claire's condition, correct anything we could correct, do all we could to try to stabilise her, but that we would be very concerned that this was irrevocable and it wasn't going to settle.

I would ask them had they anyone else to come in, to be with them, or someone else, because quite often, in situations like this, it's good to have somebody who's not a parent because they can take on board a lot of the

information and a lot of the questions. And I would have said that we would have been available, where possible, to answer any of the questions that they had.

MS ANYADIKE-DANES: You would have been personally?

A. I would have been as long as I could have been, until 9, and then later on in the evening, yes. I believe Dr Webb was actually in the hospital all day, but I cannot say whether Dr Webb said he would be available or not.

Q. Since you are Claire's consultant, were they going to be able to have access to you during the day? I think you said you would have left just before 9 o'clock.

A. Yes. They wouldn't have been able to have access except if I'd been available to return if they needed me between say 9 and 5, roughly. I wouldn't have been in the hospital, but Dr Webb would have been in the hospital.

Q. Did you give them any other paediatrician who had had the charge of her care who they might speak to?

A. I don't know if I did or not.

Q. Sorry, I framed that wrongly, because you can't remember that. Would you have considered that appropriate if you knew that you were going off, just before 9 o'clock, to another clinic? This is left in a halfway house in a way. They have had the devastating news, they have

had the first brainstem-death test carried out. It has proved what you feared it might, but formally there is another brainstem-death test to be carried out and there are various decisions to be taken consequent on whatever might be the result of that. So it's a very difficult position --

A. It is.

Q. -- to leave them in while they wait all that day. It must be the longest wait for the next one. Would you have thought it appropriate to indicate to them that you personally will not be in the hospital and what arrangements are made for them to speak to a paediatrician as opposed to Dr Webb?

A. No, I wouldn't have involved another paediatrician at that time because Dr Webb was there and was going to be there all day. And I know that the parents -- these are very ... These parents think of others quite a lot and they had actually brought up the issue, according to the records, of organ donation. And I know -- I think it's in the nurse counselling one -- there are actually -- Dr Webb was to come back and talk to them at 10 am. So Dr Webb was going to be back to talk to them at 10 am and would have been in the hospital all day. Dr Webb had met them and had been part of the discussion with them on the -- on Claire's condition and the

complications. Dr Webb also had had the opportunity to meet Mrs Roberts on the 22nd.

Q. Do you think you would have indicated to them, as appropriate, that you would be back in time for the second brainstem test?

A. I would have, yes. I think I would have indicated that to them because it would have been my intention to do those.

Q. Let's look at what the Roberts say that you relayed to them.

MR FORTUNE: Before we do that, can I correct one matter so far as Dr Steen is concerned? She referred to the nurse counselling records dealing with organ donation. The entry is in fact in Dr McKaigue's writing. It's at 090-022-060. And it refers in this way:

"Dr Webb and Dr Steen have discussed Claire's clinical condition with her parents. They initially appear to be giving consent for organ donation, but Dr Webb will speak again to both parents at or about 10 o'clock."

MS ANYADIKE-DANES: Thank you.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Can we go to 253/1 at page 14? If you look under (c), (d) and (e), starting at (b), that's the bit about the CT scan. It's you who advised them that

Claire was brainstem dead, it's you who advised them that nothing could be done to save her. At (c), (d) and (e), some more specific questions are asked:

"Please describe any discussions that Dr Steen and Dr Webb had with you at that time."

And then you see the answer to (c):

"Dr Steen explained that the virus from Claire's stomach had spread and travelled into Claire's brain and caused a build-up of fluid. I recall asking Dr Steen if it was possible for any type of surgery or to drill into Claire's skull to drain the fluid or relieve the pressure build-up. Dr Steen informed me that that was not possible. I asked if everything possible had been done for Claire and if anything else could have been done. Dr Steen informed me that everything possible had been done for Claire and nothing more could be done."

Just pausing there, there's no mention of low sodium there.

A. No. These are the parents' recollections and they're obviously very relevant. They are after a period of time and there are always problems with recollection and memory, especially when you're trying to recall something like this, frequently. There are words there I wouldn't have used, but it is what the parents remember.

Q. But you don't have any recollection yourself.
A. No, but there's words I just wouldn't --
Q. Which are?
A. That everything had been done; I would have said everything was being done. Dr Webb would have been discussing -- I would have been asking Dr Webb to take the lead around the neurological condition because that was his area.
Q. And the first correction you made, that you wouldn't have said that everything possible had been done, you'd have said that everything possible was being done, is that because you couldn't say that because, in your view, everything possible had not been done?
A. I wouldn't normally say that because when you're going into an acute situation like that, you haven't had time to go back and analyse everything. So I don't normally, in any of that situation, say at that time, "Everything had been done". I would be saying that we're doing everything we can to maintain or keep her going, there's nothing more we can do at this point in time, especially as there was discussion around surgery or drilling in to try to release the pressure.
Q. But you wouldn't, would you, from what I understand your evidence to have been so far, you wouldn't have said that everything possible had been done anyway --

A. No.
Q. -- because you don't think everything possible had been done [OVERSPEAKING]. No, if you just bear with me, with the question. And that is because you think that there were errors in her treatment.
A. No, I think I would not have said that because I couldn't -- I just don't use those words in this scenario because I will not have had time to debrief with everybody. So all I can say is that everything possible was being done at that time.
Q. With hindsight, you couldn't have said that.
A. Sorry?
Q. With hindsight, it would not be accurate to say everything possible had been done.
A. Yes, that is correct.
Q. Thank you. Then:

"Please describe the conduct and/or behaviour of Dr Steen and Dr Webb during your meetings with them after your arrival on the morning of 23rd. I do recall meeting Dr Steen and Dr Webb in a counselling room. My wife had gone to the ladies, so I entered the room. Both doctors seemed animated, particularly Dr Steen. I sensed from their mannerisms that they were going to tell me some devastating news."

Then (e):

"Please state if you were told at any time during Claire's admission to the Children's Hospital in October 1996 or prior to 2004 that Claire's of serum sodium levels ['low sodium' I presume] or her having hyponatraemia or this likely being caused by SIADH."

No to 1, no to 2.

So nowhere there do the parents recall, if we leave aside the term hyponatraemia, you saying anything about low sodium.

A. And I believe the parents were aware of the low sodium at the time, and that's what, when the UTV programme came on, made them think again about Claire.

Q. We will hear their evidence about that.

THE CHAIRMAN: Your supposition about this is that if they didn't know about low sodium from you, then when Ulster Television broadcast its documentary in October 2004, they would not have made the connection?

A. Yes.

THE CHAIRMAN: But if Mr and Mr Roberts say -- sorry.

A. It's recollections. It's trying to work out what people remember and what's written down. It's not easy.

MR QUINN: Mr Chairman, can I come in here at one point and ask you to refer to witness statement 143/1 at page 66 and 67? Because that sets out Dr Steen's clear

recollection when she made her statement. If those two pages could be put up together. Question 38 at the bottom of the left-hand page. I'll leave my learned friend to take over.

MS ANYADIKE-DANES: Thank you very much.

Claire's parents do have, according to them, a clear recollection of what was said. I suppose it's one of those moments that might be etched in their mind, but in any event they do have a clear recollection. You were asked in your witness statement request about what was discussed with them in relation to Claire's condition. In fact, it comes from your own initial statement:

"Dr Webb and myself discussed Claire's condition with her parents, emphasising that we felt she had cerebral oedema, as confirmed by her CT scan, which had resulted in coning of her brain and brainstem death. We also discussed the possibility of organ donation."

And arising out of that, you were asked a series of questions. You answer them in this way:

"I have no recollection of the events, but the relative counselling record indicates that Dr Webb and I discussed Claire's condition before and after the CT scan. Those conversations would have taken place in PICU."

Over the page, you are asked about whether you

discussed the cause of the cerebral oedema with Claire's parents and what you told them about it:

"I have no recollection of events and so cannot comment further than what is in the notes."

And then you are asked again about whether you informed Claire's parents of her abnormal serum sodium results. The term hyponatraemia was not used. In fact, it is a term that you use -- the abnormality of her results. And you say:

"I have no recollection of events and so cannot comment further than what is in the notes."

So you don't have any recollection at all when you were being asked to give that statement to the inquiry. What you're now doing trying to reconstruct perhaps some argument as to what you might have told them, but you don't remember that.

A. I don't have a recollection --

THE CHAIRMAN: Sorry, doctor. But she was asked to reconstruct.

A. That's what I was going to say. I have no recollection, but you have been trying to look at all possibilities of things that had happened throughout Claire's time. And what all the possibilities were and you have been doing that very carefully. So my reconstruction, my belief -- and perhaps other witnesses can say this or not -- was

that the low sodium was known to the family by whoever, but it was known to the family at the time, but there'd been no attempt to cover up the fact that her salt level, her sodium level, had been low and indeed high at one stage, because we'd also, I think, in 2004, explained to the parents -- and that was 2004, okay? -- that the sodium level had to be changed slowly, we couldn't do it quickly. That was 2004.

MR QUINN: This point is vexing the parents very severely because it is a point of a test of memory, and before we leave the point, I don't want to waste time by going back into this point later on. Could I ask the inquiry to look at the reference at the bottom of page 66, which is the counselling record? 090-028-088. What the parents want to know in relation to this is, if that's what Dr Steen's recollection is constructed from, where does it say in that document what we've been asking about in the last 15 minutes, that is that there was a fluid overload, and there was hyponatraemia discussed. The parents' recollection -- and this is clear -- is they were told throughout this exercise that she died of a virus and that appears in the very last line of the right-hand column of that document.

MS ANYADIKE-DANES: And just for ease of those:

"Asked why her brain had swollen. It was explained

it was probably caused by a virus."

A. Can we just go back to say the date is wrong if we're going through this? The date is the 22nd --

THE CHAIRMAN: Yes.

A. -- and it has to be the 23rd.

MS ANYADIKE-DANES: Yes.

A. So the date is wrong. We have two nurses, we think, three nurses maybe. I don't know whose writing's on the right-hand side and I don't know who they are. They're discussing two of the meetings that we had before and after the CT scan. It clarifies what we had been saying at that stage, that the underlying problem we felt was the virus that had made her brain swell. And that was what we were saying to them and that's what we always said: that she had, primarily, a viral infection, which may have caused encephalitis, depending on what the neuropathologist decides, that may have caused seizures, that resulted in cerebral oedema, inappropriate ADH secretion, hyponatraemia, a vicious circle. And that my understanding in talking to the parents at that time was based on the primary problem being the virus. And until 2004, that's what I said.

I don't know why there's not any other relative counselling documents --

Q. I understand that point, Dr Steen --

A. -- and I don't know whether there are any more or whether they go in any detail or what other information we gave to the parents.
Q. I understand. I think the point from the parents' perspective is you have now been given evidence about how it was recognised known that there was low sodium.
A. Yes.
Q. Because it is in the notes and in fact Dr Webb has specifically identified, as has Dr Stewart. You appreciated that, but you then have formed the view -- because I asked you -- as to what is the information that you believe you would have been given, even though you have no independent recollection. You formed the view that in those circumstances, you would have told them, and did tell them, about the low sodium. And all that is being asked for is where you see any kind of pointer or evidence to the fact that that is something that you would or even did tell the parents.
A. There isn't in the documentation, and there's no pointer to lots of the other things that I would have said to the parents.
Q. So your belief that that is what you might have said, as the chairman indicated earlier, is because they were able to identify Claire as a case that might be similar to those children in the UTV documentary?

A. Yes.
Q. And if they could do that, they'd only be doing that if they knew about Claire's low sodium? Otherwise, they wouldn't be able to make the connection.
A. Yes.
Q. Is that the logic of your argument?
A. That is the logic because there's no other information, unless any of the other witnesses can give additional information.
THE CHAIRMAN: Okay. We'll take a break for 15 minutes and we'll come back with Dr Steen.
MR FORTUNE: Sir, once again, can I ask, in the presence of my solicitor, how Dr Steen is?
THE CHAIRMAN: I have no difficulty with you speaking to Dr Steen, after I rise, on that issue.
(3.16 pm)
(A short break)
(3.34 pm)
THE CHAIRMAN: Mr McCrea?
MR McCREA: Just as a point of clarification, the doctor surmised that the reason Claire's father and mother, after watching the television programme, returned to the Royal Victoria Hospital [sic] was in relation to this issue of knowledge of low sodium. That's not in fact the case. What dropped the penny in their particular

box was the mention of fluid management and in fact the word "fluid", and in particular, Mr Chairman, the association that they took from the fluid management in the UTV programme and the explanation of fluid and the build-up of fluid around Claire's brain. That was the stimulus.

THE CHAIRMAN: Is that an independent piece of thinking on the Roberts' part or does that mean that they recall something about Claire's fluid management being raised with them at some point in the discussions?

MR McCREA: It was the use of the word "fluid" -- fluid itself -- being used in the programme.

THE CHAIRMAN: So that means that during their discussions in the Royal on the 23rd/24th October, thereabouts, they recall some reference to fluid?

MR McCREA: Fluid, build-up of fluid around Claire's brain.

THE CHAIRMAN: Right.

MR McCREA: Build-up of fluid.

Sorry, Mr Chairman, if you want that clarified by way of a formal statement, that can be done.

THE CHAIRMAN: They will be giving evidence, which is rather different from Dr Webb's unhappy position at the moment, which is why I'm content to take it like that, because I know that Mr and Mrs Roberts will be coming to give evidence after next week's break.

MS ANYADIKE-DANES: Thank you. Mr Chairman, there are two other points that I was asked to take up, which are matters that Dr Steen has said.

One is a reference to a second coffee break, I think, in relation to Nurse Field. A search was --

THE CHAIRMAN: Do you remember you mentioned that this morning? You mentioned this morning that you thought --

A. That Nurse Field, yes --

THE CHAIRMAN: -- had come back from her second coffee break --

A. Well, it's from second coffee. It was her first, but a group of nurses usually go about 10, and another group at 10.30.

MS ANYADIKE-DANES: Where did you get that from?

A. I don't know where I ... That's communication. That has been there over the years. I don't know. There has been a lot of discussion and I don't know how ...

Q. Where is that identified that Nurse Field did anything in relation to a second coffee break? In the papers, I mean.

A. It's not in the papers; it's my understanding.

THE CHAIRMAN: I think the question is: how would you know which coffee break Nurse Field was on because, subject to correction, it doesn't appear to be in our papers.

A. Because there has been a lot of discussion over the last

year to 18 months about what happened to Claire, what didn't happen, who remembered what, what could we remember.

THE CHAIRMAN: Within the Royal, you mean?

A. Yes, within the Children's Hospital.

Q. There is no reference in any of your inquiry witness statements to a second coffee break.

A. I'm not sure anyone has actually asked me. It depends what I'm asked and what I responded to. So I'm not sure anybody asked me about Nurse Field at all.

Q. Does that mean that's something you remember independently?

A. No, it's something that has been discussed.

Q. I beg your pardon, I framed that incorrectly. Are you saying therefore that you remember discussions which have given rise to the fact that something happened in relation to Nurse Field's second coffee break?

A. Yes, I remember ... Nurse Field will be in a position to clarify it, as will others, whose memory might be better than mine -- is that Nurse Field had returned from a coffee break and then she had been alerted about Claire's condition and she had gone to get Dr Sands.

Q. The reason I ask you that is because you've been very fair in referring to the failings of your memory and I'm not saying that you are saying that you remember this

contemporaneously from 1996.

A. No.

Q. But you certainly seem to be saying that you remember it from some stage since then. And yet you have informed the inquiry that you have real difficulties with your memory. That is why I'm trying to see if there is any particular reason why you'd be able to remember this kind of conversation or the fact that there was some sort of discussion like that.

A. I think it focuses on the desire of everybody to try and clarify what had happened that day and the discussions that ...

THE CHAIRMAN: Doctor, do I understand you to be saying, when you're talking about people talking about this a lot in the Children's Hospital, is that talking about this recently because the inquiry was coming up as opposed to talking about it in 1996?

A. Yes, I have no recollection of what was being discussed in 1996.

THE CHAIRMAN: Right. So when you say that there has been some discussion, which leads you to believe that Nurse Field was on the second coffee break at 10.30 rather than the first one at 10 am, that belief is based on what has been discussed much more recently in the Children's Hospital rather than what was discussed in

1 1996?
2 A. Yes. And you'd asked me about what efforts I had made
3 to clarify what was happening that morning, including my
4 own whereabouts. Part of that is asking and discussing
5 and looking for documentation.
6 THE CHAIRMAN: Okay. So in essence you are relaying to us
7 what other people remember or think they remember from
8 1996, not what you yourself remember from 1996?
9 A. No. But you can clarify, rightly or wrongly.
10 THE CHAIRMAN: Yes.
11 MS ANYADIKE-DANES: There was another point that I was asked
12 to take up with you, which is to do with when Claire's
13 parents arrived in the hospital on the 22nd. That's
14 what you were trying to assist us with. The other point
15 that you gained some sort of assistance from was
16 Nichola Rooney's note, which you thought indicated that
17 they had come in the afternoon --
18 A. Yes.
19 Q. -- and perhaps not been there in the morning.
20 A. There's a reference, I think.
21 Q. There is. It's 089-002-002. You might be referring to
22 the penultimate paragraph:
23 "Mrs Roberts stated that during the morning both
24 sets of grandparents were with Claire, with
25 Mr Roberts and herself arriving in the afternoon."

And you have taken that to indicate that the Roberts themselves or Claire's parents didn't actually arrive until the afternoon.

A. No, I've taken that to indicate that that, with other information, would suggest that there wasn't clarity about exactly what time they were there at. A later statement, I believe, says they were there from 9.30, but that is 2004.

Q. Yes.

A. And we know they were there to talk to Dr Sands, so we know they were there after 11 or 12.

Q. Well, the nursing note indicates that they were there actually earlier than that. Because prior to that, they had raised the concern about Claire's condition. I'm just trying to find that particular note to help you.

A. My understanding is when they raised their concern about Claire's condition, that is when Nurse Field went to get Dr Sands.

Q. And you --

A. And I'm not sure that in the nursing note it actually clarifies what time the concern was raised. I'm just saying that we're all dealing with recollections and that was a recollection at the time. I'm not saying it's correct; I'm just saying it was a recollection that came through in 2004. We know it wasn't correct; we

know they were there earlier than the afternoon.

Q. The Roberts themselves will deal with the accuracy or otherwise of this note. I'm not entirely sure it has been accepted by them as an accurate minute, but in any event they will deal with that. But the contemporaneous record, if you leave aside what has been summarised, if I can put it that way, out of the meeting in 2004, the nursing note is 090-040-140. The only reason I'm going to this is because the suggestion that they might not have been there pretty much first thing in the morning is something that I think Claire's parents have some difficulty with, but they will give their evidence on that.

If you see there "22/10 1996, 7 am" and then you see "8 am to 2 pm". There's a reference to "sleeping for periods" and so on. And then:

"Parents concerned as Claire is usually very active. Seen by Dr Sands. Status epilepticus, non-fitting [and so on]."

So their evidence is they were there first thing, round about 9.30. They saw her condition --

THE CHAIRMAN: It's okay. We don't need to go through it. That confirms that they were there in the morning because we know from the sequence of records after that if they were seen by Dr Sands and then steps were taken,

that those steps were being taken before lunchtime. So they must have been there in the morning.

A. Yes.

THE CHAIRMAN: Your point really, I think, is that this maybe illustrates two frailties. One is the frailty of memory and the second is frailty of note taking.

A. Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Thank you.

Then if we carry on with the information or the communications with the family and we move to the discussion that would lead to a brain-only autopsy. We can see that it was a brain-only autopsy, apart from any other thing, from the document 090-054-185:

"Hereby give consent to a limited post-mortem examination being carried out."

And then you see in manuscript:

"Brain only [underlined]."

And that's dated 23 October. So that's the formal document confirming that.

But at which point is that being discussed, so far as you're concerned? At which point would you have been discussing that?

A. I can't remember, but there's -- if we go through the notes, it will give us a better timeline. Certainly

during ... I don't know if it was discussed before I went, when I would have left after the second brainstems. My understanding at that stage -- there was the question of organ donation and what was happening. I don't know if we were discussing at that time with the parents and we -- that's Dr Webb and I because we were both there at the time -- around what we would do around post-mortems. I don't know when exactly that came during the day. It maybe came on a couple of occasions. My understanding is the consent was finalised at the end of the day.

Q. Well, the medical notes and records at 090-022-061 -- and the note, which is your note, signed at 18.25, and apart from the fact that you say:

"The diagnosis of brainstem death protocol is completed and that the ventilation should therefore be withdrawn."

You also say:

"Consent for limited PM given."

A. So it was certainly discussed by that time with them and they had -- and particularly with Mr Roberts as he consented to it at that time.

Q. There doesn't appear to have been a record, I'll stand corrected, of it being discussed at any earlier point.

A. No, and there's no record of any counselling during the

day in either the medical or nursing records as far as I can see.

Q. So at the time when you are discussing this with them, have you formed the view that this is not a coroner's case?

A. Yes. If it had been a coroner's case, the discussion -- if it was definitely a coroner's case, in other words if it was from unnatural causes, then this discussion would not have happened in this manner, because it would have been: we have no idea what's happening with Claire, we are very concerned, because we have no idea, we need to look into this and we need to discuss it with the coroner. I usually suggest that we discuss it with the coroner rather suggest it straightaway to a coroner's PM.

Q. We've got the second brainstem test being carried out some time after 6 o'clock in the evening. Are you likely to have discussed with Dr Webb or whomsoever you discussed it with and formed the view that this is not a coroner's case before then or after then?

A. If we have agreed the limited PM, then any discussions with the clinicians -- and every clinician has a responsibility around informing the coroner if they think there's an issue -- will have happened before 18.25 because we wouldn't have been able to go ahead

with consenting for a limited PM if anyone was raising any concerns around it being a coroner's case or any discussions had failed to determine that it should be a coroner's case.

Q. Yes. I'm not going to go into that in great detail because, as you know, there's a governance element to this and there has to be a cut-off point at some point. So the whole issue surrounding the coroner's issues, if I can put it that way, is going to be included in that aspect of the case, if I can put it that way. But I'm just trying to get the chronology here.

A. Yes.

Q. In your view, if I'm understanding you correctly, you would have formed or made the decision with your colleagues that this was not a coroner's case, certainly before this discussion with the parents.

A. Yes, but the fact that we had even asked them for a limited PM indicates that we wished further information.

Q. Yes, I'm going to come to that in a minute. In any event, that route of investigation has been ruled out, if I can put it that way --

A. Yes.

Q. -- at that stage because you don't think that that is an appropriate route.

A. Yes.
Q. So now you are down to: if we're not going to do that, do we need to do anything more at all? And I think you were just about to say that actually you've had the view that there was something more to be done from the learning point of view; is that correct?
A. From the learning point of view, yes, it's very important. We had working diagnoses. You have pointed out that we didn't have clear evidence around some of the encephalitis issues. We had our working diagnosis. A limited post-mortem of the brain would have confirmed that one way or the other. And that was quite important because -- I know you're going to talk about the governance at a later date, but there's two significant times for me in this when the coroner would have been considered. One is here, and one is when the post-mortem result was returned, because if it hadn't given any evidence of a viral encephalitis, our working diagnoses were all wrong and therefore we didn't know what was happening to Claire.

So at this point in time --

Q. Can I pause you there and ask you -- because you have used that pronoun again -- who is "we" at that stage?
A. Dr Webb and I would have been leading this. And I appreciate that in one of his statements Dr Webb said he

didn't be [sic] involved in this. I'm sorry, I strongly disagree. I would not be taking on the management of an acute neurology case when I had a consultant neurologist beside me in ICU without determining the way forward.

THE CHAIRMAN: But you have also mentioned a few moments ago that every clinician has a responsibility to advise the coroner if he or she believes there should be an inquest. Is that a way of saying he just can't opt out and say, "That's your decision"?

A. That's my understanding of commitment to the coroner. Be it the anaesthetist, the nurses or whatever, we all have responsibility.

MS ANYADIKE-DANES: Yes. So you've identified there were two periods of time in which it might be relevant to consider whether this is an appropriate matter to be referred to the coroner. One is at the very outset, at this stage.

A. Yes.

Q. The other is when you get your results back from the limited post-mortem and it turns out that your working diagnoses, your hypotheses about what had happened, cannot be substantiated from the evidence, and that would mean there wasn't the degree of clarity about what was the cause of her death and that would have been an opportunity to refer to the coroner. Do I understand

you correctly?
A. Yes.
Q. So if that's the case, let's now get to the limited post-mortem. Presumably, by the time you are speaking to Claire's parents after this second brainstem-death test has come back negative, you have formed the view -- with Dr Webb, I assume, from what you said -- that a limited post-mortem would be appropriate.
A. Yes.
Q. And --
THE CHAIRMAN: Sorry, is it more than you and Dr Webb? Did you mention --
A. Dr McKaigue would have been -- I don't know.
THE CHAIRMAN: Dr McKaigue and Dr Crean were around at different points, but Dr McKaigue more particularly in the early hours of the 23 October.
A. Yes. And he seems to have returned that evening.
THE CHAIRMAN: I know that you can't remember the discussions, but do you believe from your experience that he would have been likely to have been involved in any debate or discussion about whether Claire's case should be referred to the coroner?
A. If he'd been there at the time, yes. I don't know -- Dr McKaigue came back in by 18.45. I don't know where he was, say, at 18.00 or ...

THE CHAIRMAN: Okay, thank you.

A. I can't place him ...

MS ANYADIKE-DANES: I think the question more is: if he's around, given his expertise and his involvement with Claire at that stage, is his view the type of view that you would have wanted to include in your discussions?

A. Yes.

Q. I think that might help. There are two decisions to be made, are there not? At this stage, initially, are we referring this matter to the coroner? You all have your individual responsibilities, but I assume it's something that you discuss --

A. Yes.

Q. -- or would wish to discuss.

A. Yes.

Q. And the second decision is: if we're not going to do that, would there be merit and advantage in having some sort of hospital autopsy?

A. Yes.

Q. And then one can refine that as to what extent we will have that.

A. Yes.

Q. Would that be about right?

A. Yes.

Q. So if you were going to see who might usefully be

involved in the first discussion, you have Dr Webb, who has been involved in her care, yourself obviously, Dr McKaigue, who was there. Dr Taylor was there, also treating her. He was concerned that she had been polyuric and he was trying to address that. There's a fluid management issue he was trying to address. He was, at that stage, as you know, the consultant paediatric anaesthetist. If he was about -- and I'm not saying that he was, I'm simply trying to get the kind of specialism you would have wanted -- was his view one that you might have sought?

A. Yes, if he had been around at the time when we were discussing this, yes.

Q. That would be appropriate in your view?

A. It would because he was an intensive care consultant.

Q. So then, in some shape or form, the decision is made or at least you all conclude, I understand, that this is not an appropriate case for the coroner?

A. Yes.

Q. Is that a group thing? Do you get a consensus about that so far as you're aware?

A. Yes. In fact -- now, I can't remember in 1996.

Q. I understand that.

A. But in fact, if anyone says, "I think the coroner should be involved", there has to be a really good discussion,

and the coroner is accessible. So if anybody, certainly in recent practice, would ever bring that up, you would just phone the coroner, even out of hours, to say, "This is what's happened, are you content or do you want to do a full ...

Q. Yes, but in 1996 when perhaps the procedure for having a sort of medical assistant to help the coroner in those matters -- but in 1996, would you nonetheless have acted on a precautionary basis and if anybody had thought that was a coroner's case, referred it or sought further guidance?

A. I think we would, but remember I don't have clear recollections on place and time.

Q. I understand that. So then if that's to one side and we're dealing with the autopsy point, by this time, because it's recorded that consent was given, I assume from what you have said that there had been some discussion as to whether you should have a hospital autopsy at all and, if you should, what form it should take.

A. That's correct.

Q. And you say that's something that Dr Webb would have been involved in.

A. Yes.

Q. I think the chairman might have asked you. If

Dr McKaigue or any of the others whose views you might have sought in relation to the first query about an inquest were about, would they also have been likely to have been involved in this discussion?

A. Yes.

Q. Perhaps we had better put up Dr Webb's position. It's 138/1, page 52, the answer to question 34. Could we have alongside it the same witness statement but page 91, the answer to question 79?

It really starts off:

"Is this a coroner's case? No."

At (a):

"Identify at whose request and when the post-mortem was limited to the brain only."

Do you see that at (a)?

A. Yes.

Q. "I don't believe I was aware that Claire's post-mortem was limited to the brain only."

(b):

"Explain the reasons for the post-mortem being limited to the brain only and, in particular, state what you expected to learn from a post-mortem being limited to the brain only."

And he has said:

"I don't know why the post-mortem was limited to the

brain except perhaps that Claire's parents may have requested this. It may have been considered that her other organs were unlikely to have provided much other useful information."

So there we are there. And then if you see, at 79:

"At the time of Claire's death, state your view as to whether there ought to have been a full or limited post-mortem in relation to Claire and describe your involvement or input into the decision to carry out only a limited post-mortem. I cannot recall my view at the time of Claire's death, but I believe I would have expected her post-mortem to have been a full post-mortem, pending the parents' consent. I don't believe I was involved in the discussions about the extent of the post-mortem in relation to Claire."

And maybe if we go to the next page --

THE CHAIRMAN: Before you do, question 78 is on the same lines, isn't it?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: "I don't believe I was involved in the discussions about the extent of the post-mortem or whether it should be referred to the coroner."

And that's something you disagree with quite clearly?

A. He was one of the treating consultants, he was there

at the time of the brainstem, he was there when the discussions were ongoing, he was part of the counselling with the parents, so I'm just a little ... I know recollection on his part will also be difficult, but I'm a little confused as to why he perceives he had no input into it at all.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: So you have absolutely no explanation for why this might be his recollection or his evidence?

A. No.

THE CHAIRMAN: Sorry. If he had no input, then that would be irregular?

A. Yes. Especially when we're now on brain --

THE CHAIRMAN: Yes.

A. -- and wanting just to do brain and not the whole body, which I know is an issue around -- that has been criticised. So it really is important because his input as a neurologist has been essential.

MS ANYADIKE-DANES: Yes. So who would be in the position to know that the sorts of lessons you might want to learn about Claire's case actually could be entirely confined to an examination of the brain? Would you have much input into that?

A. I would have had input into that around knowing what investigations had been done previously to exclude

metabolic causes, knowing what the clinical pathway had been, and with some understanding of viral encephalitis and inappropriate ADH. So I would have been part of the picture.

Q. But previously in your evidence you have, on various points, indicated who you thought might be the lead consultant on one or other issue.

A. Yes.

Q. In terms of this issue, to confine any post-mortem examination to Claire's brain only, who would you have considered to be the lead clinician on that? I know you don't remember it, but doing the best that you can, who would you consider to be the lead clinician on that?

A. This is thinking, okay? This is looking back and thinking. I think the ultimate decision I would put to Dr Webb, which is maybe unfair because I'm putting it to him, but this was a child with an acute neurological condition. We had considered the need, and I believe he was there with me considering that need, for a post-mortem of some decision. So it was important that whatever information we got from the post-mortem was going to give us the most relevant answers.

Q. I know you can't remember it, but looking back at the documentation, if I can put it that way, what is it you thought you didn't know at that time that a limited

brain-only post-mortem might provide answers to?

A. I think the big answer was the viral encephalitis. Epilepsy won't show on post-mortem. Cerebral oedema was there on the CT scan and we knew from her condition that she had cerebral oedema and coned. So that wouldn't have given any additional information. When I look back in detail, there had been other tests done excluding metabolic causes way back from when she was a baby. Her blood sugar had remained -- there were various things that happened during her stay that made a metabolic cause unlikely.

So the most likely cause -- and the working diagnosis that we had and had had all the way through, and is documented all the way through, from my perspective, was a viral infection with a temperature and increased white cell count, with vomiting, and there's a debate around how many loose motions she had.

Then the development of encephalitis, query non-fitting seizures, and then of course the cerebral oedema and her ultimate death. So for me personally, looking back, what I wanted from the post-mortem was to confirm that there was a viral encephalitis. I think the other thing that may have been of help is in and around Claire's learning difficulties. Because I don't believe, looking at the records, that the parents had

been given a clear reason why she had learning difficulties, and sometimes a post-mortem of the brain may give further information. It may not, but it would have been an added reason in Claire's case to ask the parents if this would be possible.

Q. Correct me if I'm wrong, but one of the things that had never been explored is whether there was any possibility that Claire had got hold of some sort of toxin, which is actually what might be underlying some of her presentation. Because it is possible --

A. Yes.

Q. -- for that to produce some of her condition; is that not correct?

A. Yes. Urine was not sent for toxicology at the time of her admission, so if she had had it, it would have to be before the admission. The expert witnesses will give you more information on this. Her having accidentally taken a medication that would have caused these symptoms did not seem to be a reality.

Q. Sorry, can I pause you there? Is there any evidence on the paper of anybody actually having turned their mind to that possibility --

A. No, there's no evidence.

Q. -- and sought to exclude it?

A. No, there's no evidence on paper.

Q. I hadn't asked you before, but given nobody really knew what was going on, so presumably you take your widest brush, if I can put it that way, to it. Is that something that would have been appropriate even if it's just to rule it out?
A. At the time of her admission?
Q. Yes.
A. I thought I'd said it was. But I mightn't have. You're probably correct. But certainly yes, that was the one -- I think to be saying what else could have been done [OVERSPEAKING] --
Q. A full blood work up?
A. -- and her urine. But urine is more sensitive at times for toxicology.
Q. Were any bloods taken for examination as part of the post-mortem or examination on autopsy?
A. Those would all be done at post-mortem. I don't know what was done at the post-mortem. That would not be ... Once she died and we had agreed to go for a limited PM then Claire -- a clinical summary and the medical records would have gone to ...
Q. Yes. In case -- admittedly that sort of -- that kind of examination hadn't been carried out earlier. But it may be that there would still have been traces of something in her blood or urine that might have given some

indication of what was going on. But unless that was being specified, a brain-only autopsy wouldn't have required any of those samples to be taken?

A. No, but her clinical progress was not in keeping with her having ingested a toxin.

Q. Well, that might be a matter for others to --

A. The expert witnesses might help.

Q. And when you were answering just then as to what you hoped to learn, you couched it very much in: actually what you were trying to do was confirm a view that you had. But given that those were all hypothetical and differential diagnoses, there might be something else going on. So if you were really trying to learn what had happened to Claire, would it not have been more appropriate to say, "These are what we think happened", instead of just, "Can you confirm one or the other?", "Let's have a full post-mortem and see what that discloses. Let's have a look at what is in her liver and so on and see what that discloses". Why not do that?

A. Because I suppose we do not want to put a child who has died through anything more that will not give us additional information than necessary. In retrospect, a full post-mortem may have been of help, though I'm not sure we have any evidence that it would have given any

extra information.

Q. It's one of those things we don't know because it wasn't done.

A. No. But when you looked at the differential diagnosis of her encephalopathy, I'm not sure that a full post-mortem would have gleaned any further information.

Q. But isn't that the point, Dr Steen? That presupposes that that was the full range of differential diagnoses that were appropriate for her condition. It may not have been. There might be other things happening and it may be that you closed down, maybe prematurely, the opportunity to learn any more because those were the only routes being explored and they were going to be explored in that particular way.

A. But I'm not sure, even looking back, what the other illnesses were looking at [sic]. Even if you go through the huge list of differential diagnoses, et cetera, what would have been gleaned ... We had an amino acid chromatogram done when she was a child, a baby. We'd had a normal blood sugar right through. I'm not sure ... I'm not sure what information would have been achieved. I don't know what we discussed at the time and why we decided to just ask for this.

Q. Did the parents, in any way, indicate that they were particularly sensitive about further examination of

Claire and, therefore, restrict that to the minimum possible?

A. I have no recollection.

Q. If they had done that, is that something that you would expect to have been noted?

A. I'm not sure we documented very much in 1996 about what the parents felt and didn't feel. I think if we had strongly felt we needed a full post-mortem and the parent weren't willing, that would have opened a different direction.

MR QUINN: Mr Chairman, can I refer to witness statement 153/1, page 15? It's the first statement made by Mr Alan Roberts. There is also a supplemental statement made by him, which is 153/2. If one looks at the first reference I gave, WS253 --

THE CHAIRMAN: 153?

MR QUINN: 253, I apologise, 253/1. My pages are not paginated, but I think I have the right page. It's sub-paragraph 16(e). In fact, if you go up to (c) and (d), you will see what Mr Roberts' answer is in relation to the discussions that took place at around 5 pm, 1900 hours, on the 23rd. That's when the parents come back to the hospital after Claire was taken off the life support.

So one can see there exactly what the Roberts are

saying and that is emphasised then in the second witness statement made --

THE CHAIRMAN: Sorry, what you're highlighting is they're saying that Dr Steen was the only person who spoke to them --

MR QUINN: Absolutely.

THE CHAIRMAN: [OVERSPEAKING] but that doesn't mean that there wasn't a discussion between Dr Steen, Dr Webb, Dr McKaigue about what they agree or disagree --

MR QUINN: Of course [OVERSPEAKING].

THE CHAIRMAN: Then, at (e), the answer is that Mr Roberts is saying there were no discussions regarding a full or limited post-mortem and Dr Steen was advising that the hospital would carry out a brain-only autopsy.

MR QUINN: That's the point.

MS ANYADIKE-DANES: I think it's also at (d) actually because (d) is where they are being invited to discuss what options they were being offered.

A. Can I just [inaudible: no microphone] detail and I haven't looked at this page in great detail. They're saying that it's about 7 o'clock at night that I spoke to them about the inquest and the post-mortem, but in fact, from the notes, the consent for limited post-mortem had been given before that.

THE CHAIRMAN: I think half six, was it not?

A. Yes. It's just timing. It's ...

THE CHAIRMAN: In fact, it's 18.45, I think, which is about 7 o'clock.

MR QUINN: Basically around 7 o'clock.

THE CHAIRMAN: So 18.45 is close enough to 7 o'clock.

A. So we had discussed this actually before we terminated Claire's ventilation, before we stopped it. I don't remember, but there would have been -- for Mr Roberts to consent, I personally would have wished to give them the option of why we would have wanted a brain-only post-mortem -- and I wouldn't use the word autopsy -- a brain-only post-mortem or a full post-mortem or the coroner. We didn't have leaflets in those days as we do now, but I would have been going through those with them.

THE CHAIRMAN: Sorry, I can understand that if you're suggesting to parents that there should be a brain-only autopsy, that you would want to explain at least at some level to grief-stricken parents what the difference is between a brain-only autopsy and a full autopsy.

A. Yes.

THE CHAIRMAN: And that's one issue which might be easier to understand. Are you saying that it would also have been your expectation that you would have discussed with them the possibility of referring Claire's case to the

coroner?

A. I don't know which witness statement, but I thought in one of the documents -- can I put it that way? -- that the Roberts were saying I definitely said there didn't need to be a coroner's inquest.

MR QUINN: That's what they are saying, Mr Chairman.

THE CHAIRMAN: Yes. Okay.

A. They have said that I have definitely said that to them.

THE CHAIRMAN: They're saying that you were definitely saying that there didn't need to be an inquest.

A. Yes.

THE CHAIRMAN: Right. Okay.

A. But what I would say is -- in that situation, we'd have discussed why, especially if a parent was raising it as ... Well, why it wasn't needed.

THE CHAIRMAN: Okay. Sorry, Mr Quinn. Your second reference?

MR QUINN: The second reference was the second witness statement made by Mr Roberts, which is 253/1, page 1.

THE CHAIRMAN: I think you originally said page 3, actually.

MR QUINN: It's page 3. That's it. The last six lines:

"At 1900 hours, Dr Steen brought my wife and I into a small office in PICU, expressed her sympathy on our loss, and explained that the hospital would carry out a brain-only post-mortem to try and identify the virus

responsible for the brain swelling and Claire's death, and that there would be no need for an inquest."

That's their evidence, "No need for an inquest".

THE CHAIRMAN: Does that capture the gist of what you said?

A. I have no recollection. I --

THE CHAIRMAN: Sorry, does that capture the gist of what you might have said?

A. It captures the gist of what the parents have taken from it and, given the documentation is 16 years later ...

THE CHAIRMAN: Yes.

A. I think I would have been discussing that we referred to the coroner if we do not know the cause or if there's any concern that it's not -- I usually use the term "natural causes" -- and if that isn't the case, then we could sign a death certificate. But actually, because we're unsure, we think we know what happened with Claire but we're not sure, that this is why we would want to go to post-mortem. And then I think I would have said what the different types of post-mortem were and the options and the preferred options of the clinicians having discussed it. That's what I think I would have said.

MS ANYADIKE-DANES: If we leave that statement up there, Mr Chairman. If you see the last three lines of that paragraph saying "during our time". It goes on to say that the reason being given or the only reason for the

build-up of fluid leading to Claire's death -- I think that might actually have been what the parents were referring to when they said it was when they heard the reference to fluid and the amount of fluid that prompted them to think about their own daughter's death.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: I have asked you a number of questions about what you attribute the cause of Claire's death to be, and we have been through the issue to do with acute encephalopathy, and we've been through Mr McKaigue's note, and also the note that, at the time, it was thought that she had died from cerebral oedema due to neurological causes and that when the parents asked why her brain was swollen, it was explained it was probably caused by a virus. And then ultimately, I think you say you don't object to Professor Young's formulation, and that is at 090-011-067.

In fact, if we pull up --

A. That's at the inquest?

Q. Yes. If we pull up your witness statement 143/1, page 78, it says:

"I feel that Professor Young's formulation is one possible --

THE CHAIRMAN: Sorry, slow down. What part?

MS ANYADIKE-DANES: Sorry, I thought it was there.

A. It's at the top.

Q. It's at the top, I think:

"I feel Professor Young's formulation is one possible explanation of events. As a clinician, I would give more emphasis to status epilepticus and the previous history of epilepsy as per my draft certificate."

In fact, if we go back in that witness statement to page 70, you give a scenario. The scenario of events, which is just there under (e):

"Claire was suffering from viral gastritis/gastroenteritis, leading to encephalitis/encephalopathy, which precipitated status epilepticus leading to SIADH, low sodium, increasing cerebral oedema, which in turn further impacted on the SIADH and cerebral oedema."

And that's how you characterise that. Then just if we go back again to page 51, you say:

"My view was that Claire's condition was that she had most likely an encephalopathy secondary to viral encephalitis resulting in status epilepticus."

And so on. And there are a number of references in that witness statement where you concentrate, if I can put it that way, on the viral nature of her illness --

A. Yes.
Q. -- and the effects that that might have had. And that was your view?
A. Yes.
Q. Does it remain your view?
A. I've read the expert witnesses, I don't remember all their reports, but I do know that the majority feel that viral encephalitis was part of the complication, but that there was no EEG to confirm the seizures. It's also my view that because you've put it as fluid management -- because we didn't manage her fluid as we would manage it now, the fluid did contribute.
Q. Thank you. I asked you that, does it remain your view, but can we go back a little bit? This may be a matter better left to the governance, but now I've asked you that, maybe I'll just ask.
THE CHAIRMAN: If it's better left to governance, leave it to governance, because we have a limited amount of time today.
MS ANYADIKE-DANES: I understand. I will leave that over.
If I take you to the autopsy request form, 090-054-183, and maybe if we can pull up 184 alongside it. It's a bit difficult to read because it's in quite small writing. Did you complete this?
A. Yes.

Q. Can I ask where and how you will have gathered the information together to have completed this form?
A. This was a summary from the medical records and the nursing records that were in her notes, but because it's only a summary -- under "investigation" if you see "see chart" -- this, because it's only one page, would have gone across to the pathologist with her medical records, her file, because this is just a summary.
Q. Okay. So you would have sent this summary with her complete file, if I can put it that way, to the pathologists?
A. Yes, because it is only a summary. There's not enough space to actually give a detailed history.
Q. I understand that. And in addition to what you might have summarised from her file, would you also have spoken to the other doctors, principally perhaps Dr Webb, in order to get some contextual information --
A. Around?
Q. -- before you completed this form?
A. Well, this I think was all done that evening when we had been in ICU, talked to the parents, discontinued the ventilation and I completed the form, so it would be part of what we had been doing that evening.
Q. So you would therefore be informed by the discussions that you had had with Dr McKaigue and Dr Webb and

anybody else for that matter that you had managed to discuss it with, including the nurses. I think you had wanted to have some discussion with the nurses almost as soon as you arrived in PICU.

A. Yes.

Q. Can I ask why "consultant" is completed with you and -- in fact it's Dr Webb first and then you. Why is that?

A. This is a brain only post-mortem. Dr Webb was closely involved in the management of her acute neurological disease. We have reference -- and you are going to explore it further with witnesses about shared care -- but this to me further indicates that this was a combined management of this child at this stage.

Q. But you're completing the form, aren't you?

A. One of us had to do it.

Q. I appreciate that.

A. And it ended up being me.

Q. It would be you, wouldn't it, because you were her consultant?

A. But Dr Webb equally well could have given the information.

Q. But in terms of the responsibility for completing it, where did that lie?

A. Ultimately, it lay -- I remained the named consultant, so ultimately it lay with me.

Q. So why didn't you include simply yourself as a consultant, but provide for the information of the pathologists, if they couldn't see it from the notes, that Dr Webb had also been involved in her care?
A. Because it was a brain only post-mortem and Dr Webb was a neurologist. He had been part of the decision-making process. Usually when it's a brain only post-mortem, the information is in your pathology going to -- this is all governance now -- going to the neurologists for the neuropath meeting, et cetera. So the key information from this was important to me, but it was also very important to Dr Webb because he had been managing her from lunchtime on the Tuesday, working on what was his working diagnosis.
Q. Yes, but these are formal details and he wasn't her consultant.
A. He was one of the consultants looking after her.
THE CHAIRMAN: We're back on the same point.
MS ANYADIKE-DANES: Okay.
The date of admission. That's just an error, isn't it?
A. Yes.
Q. The clinical presentation. "Nine-and-a-half year-old girl with a --"; is that right?
A. "With a history of --"

Q. That sign means "with"?
A. Yes.
Q. "A history of mental handicap, admitted with increasing drowsiness and vomiting."
Why did you describe her in that way?
A. "Mental handicap" I know now, looking back through Claire's notes, is used several times. In the mid-90s, there was a movement away from the term "mental handicap", which was felt to be quite emotive and inappropriate -- as was "physical handicap" -- to the term "learning disability". That is the only reason. I assume that was written during the transition and it had been referenced elsewhere in her notes.
Q. The term "learning difficulty" is referenced in her notes as well, so why not use that?
A. I don't know. It was just whichever area of the note I was looking at at the time. In fact, I think I used the "learning difficulties".
Q. And that's why I'm simply asking why you didn't use it here.
A. I don't know why.
Q. In fact, I think if you had been looking through your notes, Dr Webb's note is -- not to be pulled up -- 090-022-053. That's a note he makes when he first sees Claire. He says:

"9 year-old girl with known learning difficulties." That's how he characterises her.

A. Yes, but mental handicap by definition, which has now changed to learning difficulties, encompassed, at that time, the whole gambit from a child with significant delay -- unable maybe even to feed -- to a child with poor progress within a school. It is an emotive term, it has obviously upset the parents, and I'm sorry about that. It was used in a context in the 90s where that was being changed over to learning disability. But by definition, it encompassed from really severe problems to less severe problems.

Q. Well, did you think it was relevant that the pathologists knew that?

A. Yes, because he was doing a brain post-mortem.

Q. Yes.

A. And he may find things and say, "Had this child any problems before this?" And she had had seizures. So it was quite important on a brain-only post-mortem because he may have found things and wondered what would happen. He had the notes, but I think it was important that he knew that.

Q. I understand. Since you say the term covers a full spectrum from really quite severe difficulty to relatively modest difficulty -- this child went to

school and communicated and played and so forth. You have seen the evidence from her parents, although you would not have seen her when she was herself in a way that you could assess that for yourself.

A. Yes.

Q. But since it did and that was one of things that you were wanting the pathologist to look at, to see if there was any cause that could be seen from the brain-only autopsy, would it not have been helpful to have given some indication of where she was on that spectrum?

A. I'm not sure it would make any difference to -- the neuropathologists perhaps could give better information. I'm not sure it would actually have added to what they would see under the microscope and be able to tell us about where she was on the spectrum.

Q. I understand. Then for the history of present illness -- I'm going to read it simply because it's quite difficult to get from there:

"Well until 72 hours before admission. Cousin had vomiting and diarrhoea. She had a few loose stools and then, 24 hours prior to admission, started to vomit. Speech became slurred, she became increasingly drowsy. Felt to have subclinical seizures. Treated with rectal diazepam, IV phenytoin, IV valproate, acyclovir and cefotaxime cover given. Serum sodium level dropped to

121 at 23.30 hours on the 22nd. Query inappropriate ADH secretion. Intubated and transferred ICU. CT scan, cerebral oedema."

MR FORTUNE: [Inaudible: no microphone] you have missed out:

"Fluids restricted, respiratory arrest [inaudible: no microphone] intubated and transferred ICU."

MS ANYADIKE-DANES: I beg your pardon. I had a few dots where I missed that out, yes:

"Intubated and transferred ICU. CT scan, cerebral oedema. Brainstem death criteria fulfilled at 6 in the morning and 18.15 hours. Ventilation discontinued, 18.45."

Can I now ask where you got the information regarding Claire's condition "until 72 hours before admission"?

A. That would have been just trying to summarise everything that is in the notes. And I do know there has been a lot of concerns about how the history was given and how it was interpreted and who had written "loose stools" and who hadn't, but that would have been from what I garnered from reading the notes.

Q. But where in the notes would you have got that from?

A. From an overall impression. This is a summary. So I don't think there's any argument that, over the weekend, she had been well up until the weekend.

Q. Yes.
A. That bit -- and I don't think there's any question the cousin had had a tummy bug, vomiting and diarrhoea. I think there are issues around the loose stools, Dr Webb having documented a different history from what the parents feel was correct.
Q. What about the, "24 hours prior to admission started to vomit"? Where would that have come from?
A. That came from -- the 24 hours could have been anywhere on the Monday. I didn't specify, it was just a few hours before admission. That is just --
Q. You said "prior to admission".
A. Yes.
THE CHAIRMAN: Since she was admitted on Monday evening, it reads as if she started to vomit 24 hours previously, on Sunday evening.
A. Yes, and I understand now, when you look at that, that could be your understanding of it. But we know that she started to vomit, I think, that day. I would have to go back through all the notes and work out where each bit of information came from -- and other witnesses might be doing that as well.
THE CHAIRMAN: But I think the concern is that there are some -- how fundamental they turn out to be, we'll see as the inquiry goes on because the medical notes and

records go over with this. But presumably, the purpose of drawing up this summary is to try to help the pathologist to understand what he or she is going to be looking at, give them an introductory picture and then they go and complete the picture themselves.

A. I'm not going to answer what pathologists do, but my understanding always was that they gave a really good search because they find things that nobody ever thinks about. So they do a really good search and see if it relates back to the history and the findings. It's up to pathology to answer that.

THE CHAIRMAN: Well, what's the point of you writing a summary?

A. Because then they can relate back and see, number 1, does what they find relate to what we think they had -- they had the chart and all the results as well. And number 2, have they found something that does not seem to have been covered in the history, something completely unexpected.

MS ANYADIKE-DANES: Is that what you anticipated that Doctors Herron and Mirakhur would be doing, that they would be carrying out their examination of the brain and whatever they saw, they would be looking to see the extent to which they can see that being reflected in anything in the medical notes and records? And vice

versa, do the medical notes and records guide them as to what they're seeing?

A. Yes, they would go through a process and examine the brain in detail, including sections and slides and they would look and all the rest of it. And then they would see if those findings tally with other information they have, be it laboratory reports, clinical history, anything else and see if it's in keeping or if there's any other areas of concern.

Q. But other information in the medical notes and records? That's the exercise you think they are embarking upon.

A. Well, that's -- why else would we send the medical records over to them?

Q. I'm going to ask you because Doctors Herron and Mirakhur have their own view of what use they make or it is expected they will make of the medical notes and records. That's why I'm asking you. So you have expressed a view as to what they do and the question I was going to ask you is: how do you know that that is the practice that they adopt?

A. As a result of a previous problem around post-mortems, et cetera, there has been quite extensive training on the focus on post-mortems and what happens to post-mortems, which is carried out on a regular basis, especially in RBHSC, in Children's.

Q. When would that have been?
A. I can't ... Mr O'Hara probably knows when the formal teaching started.
THE CHAIRMAN: This is human organs?
A. Yes.
THE CHAIRMAN: That report was -- my report was 2002. The inquiry was set up in 2001. And then before that, there was Alder Hey and Bristol. So Claire's death in October 1996 pre-dates the organs inquiry in Northern Ireland.
A. Yes, but counsel has asked me: how did I know pathologists do that? So what I'm saying is that there has been a process of formal training to clarify what I thought was the process, but going back, we would have been discussing post-mortems as part of our undergraduate -- we had, at that stage, extensive training on pathology in fourth year, so we would have an understanding of post-mortem processes, et cetera, right through our medical education.
MS ANYADIKE-DANES: So in 1996, you knew that's the practice that should have been being carried out when that brain-only post-mortem was performed?
A. My understanding was that that was the process that would be followed and that's why the medical notes were required, if possible, to go with the patient.

Q. As opposed to simply examining the brain, taking whatever stains they wished to do and seeing to what extent what they see there assists in the question that you have asked, whether one can confirm the presence of viral infection --

A. Yes.

Q. -- which is of a limited autopsy in itself a limited exercise?

A. Yes.

Q. But you thought that, as I understand it, the practice would be that something broader would be happening, that they might be doing that, but they would be doing that in the context of looking at Claire's medical notes and records that would be accompanying her?

A. Yes, and in fact they could call back at any time, because the brain post-mortem takes quite a while. They could call those records back at any time if necessary if there was something they needed to check.

Q. If you had listened or heard the opening from counsel for the Roberts family, you'll know that they have their concerns about the accuracy of that summary, and I know that you've said that it's only a summary.

The first is that their view is that Claire was well when she went to school on 21 October -- and if she hadn't been well, they wouldn't have sent her -- and

returned home from school with a note that she was unwell. So that's the picture in relation to Claire. That Claire's cousin had a tummy upset, but not vomiting and diarrhoea, and that point wasn't communicated, so they're at a loss about that. Claire herself did not have diarrhoea, she had one loose motion on the Friday, that was it, and she did not have any seizures --

A. Sorry, was that 72 hours before her admission, was it, that she had a loose motion?

Q. One loose motion, yes. And she didn't have any seizures on 20 October, which relates to the point that she was felt to have subclinical seizures.

Where did you glean the information that she was felt to have subclinical seizures?

A. The GP has queried seizure at the time of admission. Dr Webb and Dr Sands have suggested non-fitting status, which is subclinical, you can't see it, you just have this altered awareness and various other features. Then there are the questions that she actually may have had seizures, according to the attacks chart, but they would have been seen, so they become clinical rather than something that isn't very obvious. There was a jerk or something like that.

Dr Webb, I know, feels that some of the teeth grinding and various other things he observed was

sub-clinical seizures. It's another word for non-status, non-fitting status.

Q. Even though the way to confirm that, as the experts for the inquiry have said -- and for that matter some of the current textbooks have said -- was not actually taken? So there is no confirmation of that.

A. No, and you note "felt to have".

Q. Yes.

A. But there's certainly also -- and I don't think the experts are querying that is the episodes that she had on the attacks at 3 and --

Q. It's the status epilepticus is the issue that I was drawing your attention to. Then when you list out the medication, why don't you mention midazolam?

A. Because it was a summary. I have no particular reason for not mentioning the midazolam. I don't think there's any particular reason why I did or didn't mention anything in that. It was a summary and the medical records and all the drugs and all were going over with her.

Q. So it's a partial summary?

A. Yes, because there's only a limited amount you can put in.

Q. Well, you probably could have fitted in midazolam in there.

A. Yes.
Q. In retrospect, do you think it would have been better or more appropriate to have included that?
A. I'm not sure the midazolam would have made -- I mean there's so much more I could have included. Do we want to include when her sodium went high rather than low?
Q. You were listing out her medications, if I may say, and midazolam was quite a significant and powerful medication given to her.
A. Yes.
Q. And all I'm asking you is: do you not think, in retrospect, it would have been more appropriate to have included that?
A. In fairness, it would have been good to include it, though I'm not sure how much it adds to the overall picture for a pathologist when the chart was available to them.
Q. Well, you knew that she had been given midazolam, didn't you, because you were looking at her notes and records?
A. Yes and I think I have even written in my own records that the midazolam is no longer running.
Q. Yes, so if you were looking at that, then you would have noted the amount of midazolam that was prescribed.
A. Yes.
Q. Did it not occur to you that that might be rather a lot

of midazolam?
A. I would not have used midazolam in any practice at that time. I didn't notice -- when she went to ICU, her drug kardex would have been rewritten and I did not recognise the stat dose of 120, and neither, in fact, did anyone even at the inquest notice that. And as for the midazolam infusion, I would not have been aware of what was an appropriate infusion of midazolam.
Q. I understand. What about the phenytoin?
A. The phenytoin, I did not go back and check the calculation. I had the serum levels of the phenytoin.
Q. But you looked at the notes?
A. Yes, but I didn't look at them in that much detail to calculate -- those drugs were being prescribed by Dr Webb. I knew what the serum level was, which may have impacted on her level of consciousness or drowsiness, and I did not check Dr Stevenson's calculation.
Q. But when you looked at the calculation for phenytoin, did it not leap out to you that there must be something wrong there?
A. I'm not sure. That calculation was not even noticed at the inquest by the experts.
Q. I'm not asking about that. I'm asking you about you because you now are looking at the notes and records,

everything is very much fresher than when you were going to the inquest and, in any event, the inquest was prompted by certain other considerations, and nobody was really concerning themselves with medication at that point.

A. Yes.

Q. Whether or not they should have is another matter. But the emphasis then was on fluid management, low sodium, and all that sort of thing. At this stage, when you're trying to look at her notes and records, you have also been trying to understand for yourself what on earth has happened. You're now in the process of trying to summarise matters so that you can complete an autopsy request form.

A. Yes.

Q. You have accessible to you people to discuss things with. When you're looking through that and trying to understand that, do you not see that some fairly elemental errors were made in the calculation of the drugs?

A. I don't believe I saw it at the time.

Q. Should you not have picked those up?

A. I should have, yes.

Q. And if you had picked them up at that time, what do you think, as part of a -- for Dr Stevenson and whomsoever

else had been involved in it -- education or learning process, should have been done by you, the consultant paediatrician?

MR FORTUNE: That's more governance.

THE CHAIRMAN: We're on the autopsy request form. Let's get through the autopsy request form.

MS ANYADIKE-DANES: I understand, Mr Chairman.

THE CHAIRMAN: That's steering way off.

MS ANYADIKE-DANES: I understand.

THE CHAIRMAN: The one big issue on this form, doctor, is under "past medical history". You said that Claire had had seizures from six months to four years.

A. Yes.

THE CHAIRMAN: You may have heard, if you didn't know already, that Mr and Mrs Roberts are extremely distressed and concerned about how that reference could possibly have come to be made in that document. Because she hadn't had seizures until she was four. In fact, for quite a few years before that.

A. She had been off her valproate for some time, but she had been continued on valproate until -- I don't know when. Her Ulster Hospital notes ...

MR FORTUNE: Sir, in fairness to Dr Steen, if you actually look at the GP's referral, which is 090-011-013, if you look at the line against "history and examination", it

says:

"Fit free for three years."

It depends how you interpret that.

THE CHAIRMAN: That would take Claire up to six, so that can't be the source of this information that she had seizures until she was four. Because if Dr Steen had relied on that, then she would have had fits until six.

MR FORTUNE: Well, I accept that, sir. But whether four is right or wrong, the implication there is that Claire had had fits for certainly more than four years, maybe as many as six.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Well, is that the source of your information?

A. I don't know. I would have to go back through all the records and see who had recorded what and where I got the age of four from.

Q. This is part of actually what you thought was important in terms of what you might learn through the brain-only autopsy.

A. Yes.

Q. So these sorts of details, as to what her history was in relation to seizures and so forth and her medication, that's just the sort of thing that you would be looking particularly carefully to identify, as it doesn't

immediately appear from her medical notes and records? This is her past history.

A. And it is past history. And the significance of it, I think, is that she had had seizures, she then was well and didn't have any and was off all treatment, and that was the important bit. So there was ... There was a heightened possibility of her having further seizures because she had had them previously.

Q. I understand the logic of it. I'm simply trying to find out where you got the information from.

A. I would have to go back through it all and work it out, and it'd be very hard to work it out, but I can do so.

Q. I think there is a reference in the medical notes and records at 090-022-053, I think.

MR QUINN: 090-022-050, where ten lines down it says:

"Seizures, six months to one year."

"HPC" is in the column.

A. "But at age four, she had times 1 seizure. Seizures 6 months to one year controlled by valproate. Age 4 times 1 seizure."

Now, does that ... I don't know. Is that where I got it from?

THE CHAIRMAN: Thank you.

A. And you had another reference, counsel.

MS ANYADIKE-DANES: I did take you to another reference, the

top there, the third line from the top:

"Six month old, seizures and one year ... for this."

A. "Investigated for this."

Q. Yes, "investigated for this".

A. "NAD." In other words, they didn't find a cause for the investigation.

Q. Yes.

A. So I may have taken it from the presenting complaint, I don't know.

MS WOODS: Mr Chairman, I wonder if we could have the document up that we were previously looking at?

THE CHAIRMAN: The autopsy request form?

MS WOODS: Exactly, sir.

THE CHAIRMAN: It's 090-054-183, please. Can you give us the second page of it too, page 184?

MS WOODS: It's just a small point but I wonder if we could -- I'm struggling to read it.

THE CHAIRMAN: Which page are you on?

MS WOODS: The questions that were being asked about Dr Steen's basis for writing that Claire had seizures from six months until four years. It's a small point, but I just want to draw perhaps the distinction between having seizures from six months until four years and then the note that's written by Dr O'Hare, which is seizures from six months until one year and then

a suggestion of a gap, and then one further seizure at four years old.

A. And the neurologist, I'm sure, can answer for you how we manage epilepsy at childhood and the need to have the children at least two years seizure-free before we would consider weaning treatment. This is Dr Gaston's management of this child, I believe, not ours -- mine.

MS ANYADIKE-DANES: But in any event because I know it is a matter of concern, so perhaps for completeness, there are two letters -- one of the things that Dr Sands wants to do is he wants to discuss with Dr Gaston Claire's previous medical history. The upshot of that is he receives two letters, both of them 1996, one of them 30 May 1996, which starts at 090-013-018, and then the other is dated 2 August 1996, and that one starts at 090-013-016. If we go back to the first one, which is 30 May.

She is being described there and some of her difficulties. All of these traits are part of attentional difficulties:

"Very difficult to rate her behaviour ... therapeutic options ... other medication ..."

A. I'm sorry, if you go off the first paragraph:

"Claire: nine years, five months, known to have moderate learning difficulties and history of seizures

from six months to four years of age."

Q. Yes. And then that she's:

"... off Epilim for the past year and seizure-free."

THE CHAIRMAN: Is there a general issue here, doctor, that when something finds its way into medical records, it tends to be repeated from then on, or it can be, as if it is accurate?

A. Dr O'Hare didn't have this.

THE CHAIRMAN: That's right.

A. So Dr O'Hare took the history, if you like, from the parents without this information.

THE CHAIRMAN: Yes.

A. This then, to us, is information of what actually has been happening when seen at clinics or in hospitals and what's been recorded at the time. There's always a risk that it will be carried on through, but when you are taking your first history, you usually try to take a fresh history and then look back at what documentation there is. Recollection is such a problem, but you look back at whatever documentation there is to help you decide if there is any other relevance or has something been misconstrued. And perhaps Dr Gaston misconstrued it as well. But Dr O'Hare's history would have been taken without this information.

MS ANYADIKE-DANES: Just so that we're clear, when it came

in, to the extent that it was any different to any of the recorded history previously, should that history have been updated to reflect the communications with Dr Gaston?

A. I'm not sure when this came in, but there should have been some comment to say, "Notes from Ulster suggest ..." In fairness to Dr Gaston, I see he had just met Claire and he was just getting to know her so another consultant must have been looking after her.

Q. The point simply is, if this is updating information, should that not be reflected in the notes?

A. Yes.

Q. Thank you. And then if we go back to the document, to have the two side by side, 090-054-183, 090-054-184.

A. Sorry, when I looked through that -- and it's another red herring I am sure -- but anyway ... They had considered, at one stage, putting her on Ritalin. It predisposes to seizures. It's one of the things we have to watch out for when we're prescribing it, but I'm not sure if she was on it when she came in on this admission. She had no history of it.

Q. If you look at the nurse's notes, it's clear she wasn't on it. So then you see under "investigations", "see the chart", what does that mean?

A. That means the medical records. We do refer to them as

charts, but I can understand that the inquiry means the charts or obs charts and stuff like that. But by that we mean the entire medical record including the nursing notes, the medical notes, what investigations and results are available, any letters that have been written, drug kardexes, obs charts, the whole --

Q. Everything?

A. Everything that would have been available at the time because results would have come back later.

Q. Yes. In your next section, "clinical diagnoses", you put:

"Cerebral oedema, secondary to status epilepticus, query underlying encephalitis."

Where did you get that from?

A. That, I think, was our discussion, that the encephalitis had triggered the seizures and the encephalitis had all been part of it and what we needed was to be -- from this post-mortem, one of the things we were looking for was sign of the encephalitis. So I put a query, I don't know why I put a query, because that's what we would like to know: is there encephalitis underlying? There wasn't an EEG to confirm the presence of status epilepticus.

THE CHAIRMAN: Your evidence about 30 minutes ago was that the brain-only post-mortem would answer the question of

whether it was viral encephalitis.

A. Yes.

THE CHAIRMAN: And you have your question mark there at the bottom of page 183.

A. And it doesn't -- post-mortem won't show you having fits. It might show you a cause of the fits if there's scarring or anything.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: And this clinical diagnosis is something that arose out of your discussions with Dr Webb, so this is a consensus point, is it, so far as you are aware?

A. As far as I'm aware, yes.

Q. Dr Webb's evidence is slightly different from that. He thought that Claire had died from cerebral oedema, which I just took you to earlier, due to SIADH following viral meningitis. That's his classification.

A. However, he did treat her for status epilepticus, non-fitting or otherwise.

Q. Well, then maybe I'll ask you. Where it says "clinical diagnosis", what are you intending that to refer to, what you think is the problem that gave rise to her death or what she was being treated for?

A. What we think was the problem. It's our clinical -- it's our working diagnosis. It's ... And part of what I would have hoped the pathologists would do would be to

say yes or no, "Yes, that confirms it or, no, we actually think it doesn't confirm it, and this might be the answer, or we can't help you with your answer".

Q. Yes. Then just so that we know, how does that clinical diagnosis link to the list of clinical problems in order of importance?

A. Well, that was us trying to set up the vicious cycle or -- I mean, I've written it, so I'll say that's me trying to understand the vicious cycle that had been set up. The brain was swollen, there were seizures going on, there was inappropriate ADH secretion, and it was felt that the viral encephalitis, which has another question mark beside it, was one of the triggers. As we get to the governance, you'll know there has been great debate about what order you put all these in and where you put hyponatraemia in as well.

Q. Yes. Why I'm asking you about the relationship between those two is, what's thought to be the difference, just for example why would you not put "inappropriate ADH secretion" under the clinical diagnosis?

A. Because it was an complicating factor of the underlying disease, it was a complication rather than a ... It was a consequence, I think, is how some of the experts have put it, rather than a primary problem. But so was the cerebral oedema.

Q. Exactly. But you said "as some of the experts have put it". If we leave them to one side for the moment and, doing the best that you can, why would you have put it there and not in the clinical --

A. No particular order. I think we've always struggled with the vicious circle that was set up and where the different elements of that are included. We did not include fluid management in that, we didn't consider it in that, I didn't consider it in -- it's written down and it wasn't considered at that time.

MR FORTUNE: Sir, Dr Steen has been going for well over an hour. Dr Steen has gone through the whole day. I do not know whether my learned friend is very close to finishing.

MS ANYADIKE-DANES: I am. Subject to anybody else, I am.

A. We'll go for it.

MS ANYADIKE-DANES: I'm grateful.

THE CHAIRMAN: Let's ask what has to be asked and keep it as tight as we can. Then I will break for a few moments so other people can consider whether there are any wrap-up questions or any particular point we want to come back to you on, and then we'll finish. Okay?

A. My preference is to stop, but this has to be sorted. We need to get moving on and I'm content with us moving on.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you very much indeed. I do only have a very few questions for you; you had embarked upon answering some of them. It's that list of clinical problems in order of importance.

THE CHAIRMAN: If it's a vicious circle, you could put them in any order because it's going to the circle, isn't it?

A. Yes.

MS ANYADIKE-DANES: Exactly. I think the only thing there is, once you have your inappropriate ADH secretion, if I can put it that way, there seems to be -- the bit of the circle that isn't in there are the things that relate to fluids.

A. Yes.

Q. Because that SIADH can lead you into that loop, if you like, and you might have seen that that loop was involved because of the low sodium and the amount of fluids?

A. But the low sodium is mentioned in the clinical summary.

Q. I understand that. That's why I'm asking you because there's already been some identification in the notes, not just by Dr Stewart, but also Dr Webb has mentioned that. So I'm just wondering why you didn't include in that loop so people can see the true interactive nature, if I can put it that way, of the various things that led to such a complex list of problems for Claire.

A. Inappropriate ADH would be known to cause low sodium and the low sodium is already mentioned in the present illness. The implications of using fifth normal as her maintenance fluids at maintenance levels I don't believe was recognised, and it's not there because fluid management was not recognised at that time.

Q. So if that's something that anybody had recognised, then am I to understand that they had failed to draw that sufficiently to your attention so that you could include it in that?

A. Yes. And it takes us right back to where we were an hour or so -- I don't know whether it was before or after the last break. But if there had been felt to be mismanagement of the fluids which had contributed to Claire's death, then we shouldn't be issuing a death certificate.

Q. I understand that point. The only point just to get across is if anybody thought that the low sodium fluid overload and so forth of the persons that you were discussing things with, that that was a relevant factor, then if you haven't recorded it there and I understand -- am I understanding you that somehow that wasn't made sufficiently clear to you, that you could have included that in that list of clinical problems?

A. Yes.

Q. So then if we deal with the death certificate, (a) is:
"Cerebral oedema due to ..."
And you have some options here.
A. Yes.
Q. And you choose to identify only one, which is the status epilepticus. Is there a reason why you didn't include in that the viral encephalitis, for example, which has been a feature, as you've recognised, or the SIADH?
A. The SIADH is a consequence, so I didn't include that. Why I didn't include the viral encephalitis, I don't know. But if you actually look at what we issue as the death certificate, it comes in a book and there's a stub down one side where you put down the basic details, and then there is a copy somewhere of what you write down. That goes down to the registrar.
And then on the back -- I think it's at the back -- there's a wee box you tick if further information is going to be available at a different time. My practice would normally have been that when you were issuing a death certificate -- I know we're talking about the autopsy request form at the moment. But when you were issuing a death certificate, if you felt further information would be available at a different time, such as when you got your post-mortem result back, you tick

that wee box at the back.

Q. Yes. But if we're sticking with this at the moment, why didn't you include something that has been a feature in the way that you have discussed her condition, the viral encephalitis?

A. Because it wasn't confirmed.

THE CHAIRMAN: So if I understand it correctly, the particular reason that you want a brain-only autopsy on Claire is to confirm whether there was viral encephalitis? And, if there was, then if that had turned out to be the result of the autopsy, that would have been added to the death certificate?

A. Yes, because we ticked the wee box.

THE CHAIRMAN: But at this stage when you're saying what the death certificate is showing, you're uncertain about viral encephalitis, so you don't put it on?

A. Yes.

MS ANYADIKE-DANES: Should you equally have been uncertain about status epilepticus?

A. Yes.

Q. Nothing has actually confirmed status epilepticus.

A. No, there have been observed attacks and there have been clinical impressions of her seizures.

Q. Yes, but if you were following on from what you just told the chairman, in fact the only thing you're certain

about is that there was cerebral oedema?

A. Yes.

Q. And the rest is to actually try and establish what caused that cerebral oedema. Would that not be appropriate?

A. Yes.

Q. So it might have been better only to have filled in "(a) cerebral oedema" and then what follows "due to" is actually what you're seeking guidance from the brain-only post-mortem to tell you?

A. Yes, but we have to ... if you're going to issue ... Is this governance? About --

Q. No, I'm simply asking about --

A. No, what we put on a death certificate and what we don't put on a death certificate, um ... there's certain wording that you're encouraged not to use. So viral encephalitis, is it an antecedent cause? I thought it was. We were doing a post-mortem to find out. I didn't list it there, but I believe I left open the opportunity to come back after the post-mortem result to confirm whether it was there or not.

Q. I understand that point. The only point that I'm trying to put to you is that you were no more certain about the presence of status epilepticus than you were about the query over the encephalitis because you didn't know.

You could have known -- not you personally, but it could have been known. If an EEG had been done, then you'd know that for certain, but one hadn't been done. In the absence of that, you weren't certain about status epilepticus?

A. But the clinical impression was that that was what she was suffering from, so I have relied on Dr Webb.

Q. I understand that --

A. -- to help me with that area.

Q. And you might say that the assistance you had with the viral encephalitis was, as you put it earlier, the high white blood cell count?

A. Yes.

Q. So you did have --

A. And the --

Q. [OVERSPEAKING] a little supportive evidence for both?

A. Yes.

Q. And the only question is: why not either leave off both or put both on?

A. Or add in "inappropriate ADH".

Q. Yes.

A. I don't know now.

Q. Okay. If we go down to the death certificate, there's a question there:

"Will you or a colleague be attending the review

session at 1.45 on the day of the autopsy?"

And you circle that "no". Is there a reason for that?

A. I wouldn't have been available to attend. I wouldn't have been available to attend, which is number 1, I would have had a clinic commitment. And number 2 is this was a brain-only post-mortem and we'd no reason to think there was going to be a lot of blood from a clot or anything like that. The actual information obtained -- and I can only assume Dr Webb felt the same -- was what was going to be found when the brain had been fixed and slides were taken. I don't think anyone expected to see anything other than a swollen brain from cerebral oedema. But I would have had clinical commitments at that time, I would not have been available.

Q. I understand. I just want to ask you one further question. And that relates to -- you very helpfully said, because you can't remember, that if Dr McKaigue was there at the time when you were trying to find out what had happened, principally to speak to Claire's parents, or Dr Taylor had been there, they're the sort of people who you would have involved in a discussion as to whether or not we should notify the coroner, whether or not it would be helpful to have a hospital autopsy,

and in that regard whether it should be brain only. They were part of the people that you might have had that discussion with?

A. Yes.

Q. Just for completeness' sake, do you think you might also have extended that discussion to cover what sort of information you should be providing for the purpose of the brain-only autopsy?

A. I don't know. I really can't recollect. I can't recollect who was there and when they were there. We can only work it out from the time.

Q. No, but had they been there, would you have been seeking their view to help you to complete this?

A. Probably, yes.

Q. In the way that you would of Dr Webb?

A. Yes, because we would have been there as a team discussing a patient, so everybody's contribution would have hopefully been heard and noted.

Q. I understand.

Mr Chairman, I don't have any further questions, but you indicated you might rise for a few minutes.

THE CHAIRMAN: Yes, there are probably some points. We're nearly finished in this segment of your evidence, doctor. If you wait for a few moments, I will come back, we will sort out any further questioning, and then

and sort out what's going to happen on Thursday and Friday.

(5.10 pm)

(A short break)

(5.23 pm)

MS ANYADIKE-DANES: I have only two points to raise; they both arise out of the transcript. The first comes from page 113 [draft].

THE CHAIRMAN: Is this today?

MS ANYADIKE-DANES: Yes. It really starts at line 3. If I read it to assist, it's my question --

THE CHAIRMAN: Sorry, doctor, this is the one document we can't put up in front of you. Ms Anyadike-Danes will read it.

MS ANYADIKE-DANES: It's my question to you at line 3:

"You've already acknowledged that those things were differential diagnoses, that's viral infection, encephalopathy, encephalitis. Nobody has actually confirmed the diagnosis of encephalopathy or encephalitis?"

And you answer no.

Then I start to say:

"That's a differential --

And then there's a bit of overspeaking -- I apologise -- and you say:

"They are working diagnoses, they were based on clinical signs as well as laboratory investigations."

What do you mean by "working diagnoses"?

A. What we were working on to manage her condition. It is what we were using to try and work our way through what was happening to her. We always have working or differential diagnoses that we have to start with, and we have to start working with, and then the passage of time or other investigations will give us maybe a definitive diagnosis. So working is what we were using at that time to direct her treatment at that time while we were waiting for further information.

Q. It may be terminology. Is there any difference, and, if so, what is it, between a presumptive diagnosis and a working diagnosis?

A. I'm not sure in the clinical, going through the day, that's that much of a difference.

Q. Are they different though?

A. I don't know. Working diagnosis is what I'm assuming I would use at any one time to determine the treatment while waiting for further information. It's not the definitive, it's not the end. Presumptive is in the same way. You're thinking that that is the diagnosis and you are focusing your treatment on that unless investigations, et cetera, or the path of the natural

illness takes a different direction. So I'm not sure there's a lot of difference.

Q. That's my point. If there is any difference at all, does one indicate a more concluded or more refined view than the other?

A. No. I think one maybe is a more pragmatic view of what can we get on and do while we work out what the definitive diagnosis is.

Q. So there's no particular progression from one to the other?

A. I'm not sure, and, again, it would depend on the scenario we put it in. I'm not sure there is a significant difference, no.

Q. Maybe I can help you in this way. When you're using the terminology, is there any significant progression from one to the other?

A. No, because with both of them I am saying that we don't have a definitive diagnosis.

THE CHAIRMAN: Does it mean: it looks like this, but we're not sure that it's this, and we'll care for the child and give tests and give medication, and that will confirm the diagnosis or, alternatively, it will steer us off into a different direction?

A. Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Then there's one other passage, if I can take you to it. It's at page 176 [draft] and it starts towards the end of line 10. This is just for everybody else's reference. I will read it to you. If you don't grasp the full thing, if you ask me, I will repeat it:

"I think the other thing that may have been of help is --

This is all to do with the limited post-mortem, brain-only.

A. Okay.

Q. "I think the other thing that may have been of help is in and around Claire's learning difficulties. Because I don't believe, looking at the records, that the parents had been given a clear reason why she had learning difficulties, and sometimes a post-mortem of the brain may give further information. It may not, but it would have been an added reason in Claire to ask the parents if this would be possible."

Are you okay with that?

A. Yes.

Q. Is that something that you believe you would have discussed with the parents, the benefits of a post-mortem in that respect?

A. I would have expected it to be part of the discussion.

Q. The parents are pretty clear that no such thing was

discussed with them.

A. I would think it very unlikely when we were discussing it, that we wouldn't have brought in the issue around -- because it was about learning and about how we could take things forward. It would have been part of the discussion.

Q. So can we do it this way since you actually can't remember it yourself, that that's something that you would have considered appropriate to raise with them?

A. Yes.

Q. And if you didn't raise it with them, well, it's something that maybe you think you should have because it would have given them a further understanding of what they might learn, together with yourselves, from a limited post-mortem?

A. Yes.

MR QUINN: Mr Chairman, just for complete clarity on that point, we've taken instructions on that issue, and the parents say that that was absolutely never raised because it's such a fundamental issue in relation to Claire that both or one of them will have certainly remembered that.

THE CHAIRMAN: Mr and Mrs Roberts believe that if that had been mentioned to them at all, they would remember it?

MR QUINN: Absolutely.

THE CHAIRMAN: And they have no recollection?
MR QUINN: And if you require them to make a further statement about that --
THE CHAIRMAN: No. Sorry, I'll come back to the further statements point in a minute, but I understand your point. Mr and Mrs Roberts had cared for Claire all her life. She had a degree of difficulty, which is described in various terms, some of which they find a bit difficult and hurtful. But their belief is that if Dr Steen had said anything to them about an added advantage of a brain-only post-mortem shedding some light on why Claire had this difficulty, they would have remembered that.
MR QUINN: It's not their belief, it's their clear recollection.
THE CHAIRMAN: Okay. Thank you very much.
MS ANYADIKE-DANES: Those are my questions, Mr Chairman.
THE CHAIRMAN: Thank you very much for that, Dr Steen. Thank you very much for coming for all three days this week. I'm very grateful to you. We will see you again at the governance stage. Thank you.
(The witness withdrew)
Could I say, Mr Quinn, just for the benefit of your clients, we've been sitting longer days, particularly yesterday and today, and I want them to understand that

within reason I will arrange to recall any witness if important points crop up which haven't been dealt with. I don't want them to feel that we're rushing or anybody else to feel that we're rushing. I know that Mr and Mrs Roberts will be particularly anxious that we cover the important points thoroughly.

That leads me to on tomorrow. The timetable tomorrow is, as it stands: Dr Bartholome in the morning, Dr O'Hare by video link in the afternoon. I think Mr Reid is going to take both of those witnesses tomorrow; is that right?

MS ANYADIKE-DANES: That's correct.

THE CHAIRMAN: So far as Friday is concerned, I said earlier on today that Dr Volprecht was now unavailable from Germany. I think that in those circumstances there's a question about whether we might just try to deal with Dr Sands on Friday. Would that be a preference?

MR GREEN: That would be a preference. He has, as you know, sir, spent quite some time now on the starting blocks, as it were. He would dearly like to get started first thing on Friday if you're amenable to that, sir, and get through as much of his evidence on that day as possible.

THE CHAIRMAN: I am amenable to that because it fits in with the evidence we've heard this week and, by tomorrow, we'll have also heard from Dr O'Hare. I have to make my

peace with Dr Hughes, who was going to come up from Dublin on Friday. She also, coming up from Dublin, wants to be dealt with and to get away. And, particularly coming from Dublin, it's not quite as convenient for her to come backwards and forwards. I'm sorry that Dr Sands has been kept waiting. We will do everything we can to get through his evidence, or at least as much of it as we possibly can, on Friday.

MR GREEN: Thank you very much.

THE CHAIRMAN: Okay. So there will be a bit of juggling of the timetable on the week after next, the week of the 29th, but that's how we stand for tomorrow. So tomorrow morning, we start with Dr Bartholome and then Dr O'Hare by video link in the afternoon. Thank you very much.

(5.35 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X