Monday, 17th December 2012

(10.00 am)

(Delay in proceedings)

(10.10 am)

THE CHAIRMAN: Doctor, yes, please. Thank you. Have a seat.

DR HEATHER STEEN (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Steen.

Dr Steen, before I take you through to some of the issues, more or less in their chronological order, there was a point that arose last week when Claire's parents were giving their evidence that I would like to ask you about.

Dr Walby gave -- you and, I believe, Dr Webb and possibly Dr Sands also saw a copy of the original hospital notes to allow to you draft your statement for the coroner; isn't that right? Or at least you had access to them.

A. Yes.

Q. Were you here when Mr and Mrs Roberts gave their evidence?

A. No. I am sorry. I wasn't able to attend.

Q. That's all right. I think we can pick it up in the transcript for 13th December, and if we start with

page 127.

MR FORTUNE: You want to go back to page 121, which is the issue of bias in the request for the autopsy.

MS ANYADIKE-DANES: Yes, certainly. So then if you look at line -- oh, sorry. I was going to go to line 20. In any event at line 16 is where Mr Roberts identifies what he refers to as another critical area of concern and he says:

"And that was a bias attached to that request form [that is the autopsy request form] to the pathologist, which pointed the pathologist in a certain way."

Were you here to hear Dr Herron's evidence?

A. Some of it, yes.

Q. So you may have appreciated from that that his evidence was that he is actually quite busy or at least the department is quite busy and they rely quite heavily on the information on the autopsy request form. If they had an opportunity to, of course, they would like to look at the medical notes and records, but that wasn't always possible, and certainly if they got an autopsy request form which had detail on it which all seemed to connect and make a certain sense to them, then possibly that -- I wouldn't say disinclined, but it meant they felt it less necessary to check up the details in the medical notes and records. Dr Mirakhur's evidence was

she didn't think she would have to check details and she would accept what was in the autopsy request form. So that's the starting point for the issue that Mr Roberts is making in relation to bias. His point is that all that information, with its errors and with its slant, is actually pointing the pathologist towards a viral encephalitis or a viral element of some description.

A. I heard Dr Scott-Jupp gave evidence on this and I know -- I haven't heard the pathologist experts, but my understanding when I filled in that autopsy request form, and indeed up until I heard part of Dr Herron's evidence, was that that was a brief summary. The reason for the records going over was that those records would be looked at and that information would be used to assess them. I had thought at the beginning of Dr Herron's evidence he had suggested the summary allowed them to timetable the -- which post-mortems were carried out when on the day. I was very surprised to hear that they didn't go back through the records. I believe Dr Mirakhur suggested that the final report not be issued prior to the neurosciences multidisciplinary meeting when there was that clinical input to allow the whole thing to be summed up, but I certainly did not introduce any bias that I was aware of into the autopsy report. As far as I was concerned,

I was giving information with medical records for reference to a pathologist, who would examine the brain, describe what they had seen and then see if it fitted in with the clinical scenario and, if it didn't, raise those issues with the clinicians.

Q. Yes. We will actually come back to the detail of that in a little while. I wasn't taking you there. I was actually setting the scene for the context of Mr Roberts' concern?

A. Yes.

Q. So he starts with that concern that there is a bias. Then you see he goes on to say -- in fact, the chairman raises it with him:

"Then the next point you wanted to make from the medical records was this entry about 'encephalitis/encephalopathy' and I think unless you have anything more to add, we have gone through that."

And then he asks if there are any more specific issues.

I think if I can now go to page 127, because that is a specific issue, if I can put it that way, and if we start with line 20, he says:

"I think it's pretty obvious, if a doctor looks at a medical note and she's about to face criticism, that she will want to go through the medical notes,

scrutinise the medical notes and perhaps see what their content it."

Perhaps we can bring up 128 as well:

"I feel that if Dr Steen was reading through the medical notes, she would realise that there had to be -- well, if she looks at her definition, she is confident that she has brain infection within the post mortem report, but the medical notes do not find encephalitis. I feel by that Dr Steen need to close the circle within the medical notes."

Then the chairman is putting it quite clearly:

"Question: If I understand rightly, in effect what you're querying is whether when Dr Steen saw the notes and the issues had been raised on the back of the documentary. She then saw that there wasn't a reference to encephalitis, so she got Dr Sands to write it in. Bluntly, is that what you're saying?"

"Answer: That's my belief."

Then if we continue on, you can see the chairman's comment there:

"I'm trying to expose exactly what is being suggested."

And Mr Roberts talks about:

"... they conspired to fabricate notes in order to try to see off the queries which you raised some years

later."

Mr Roberts says:

"Exactly, yes. I think Dr Steen, looking at the notes, would realise that there had to be a trigger for the status epilepticus -- or as she had put down 'non-fitting status' -- there had to be a reason for that and that is why I believe the 'encephalitis' was added into the medical note in and around the ward time."

Then if we just see where we go further on 129, if we bring that up. There we are:

"It is one thing for me to decide that there's been errors and omissions. You'll understand that it's a much greater jump for me to say that notes were fabricated after the event. In order just to be fair to everybody, isn't it right that from the time Claire came in, there was a bit of an issue and a bit of a question about encephalitis because it's in and then it's stroked out? So from the start encephalitis had occurred to the admitting doctor and then to Dr O'Hare."

He agrees with that. I'm not sure that the point gets any further developed than he has already expressed it there, which is that in order make things fit, if I can use that expression, then there is an addition to the medical notes and records that's certainly not

contemporaneous with whenever that discussion that Dr Sands said he had with Dr Webb, but is much later after the UTV programme and it's a product of some sort of communication between you and he. I think that's the essence of it. Can you comment on that?

A. When I knew I would be involved in this inquiry, I understood there would be a review of all the clinical notes and all the issues and our decisions would be questioned and we would have experts to inform us. I was quite shocked to find that honesty and integrity was going to be questioned in this way and I think other witnesses have too. I was brought up to tell the truth and, if you don't tell the truth, you were in more trouble than if you didn't. That's a value I brought to my children. That's a value I brought to my work. I have never been involved in a cover-up. I have not asked anyone to alter the notes. I would not involve anyone in this.

I understand there's concerns. A child has died, which is tragic. A child has died because of medical mismanagement, which is tragic. To compound the whole issue, the medical mismanagement wasn't noted for eight years and the parents had to come back to find it, and I understand that that is just very difficult for the parents, but I never asked anyone to cover-up the notes.

I'm unsure why it is felt adding those two words in would have made any difference. My understanding is that's the note Dr Sands made before Dr Webb came, but Dr Webb's notes talk about encephalopathy. He started acyclovir in the afternoon. So encephalopathy and encephalitis were there in Dr Webb's notes. So why would asking someone to go back eight years later to add those two words in make a difference?

Q. Well, can I ask you this question, which I think in a way you've touched on some of it: can you understand how, in Claire's parents' -- and indeed her family's -- position, there might be a loss of trust and confidence between them and the clinicians?

A. I can understand, and I understand their grief and their difficultly coming to terms with everything, and I can understand that they are troubled by the way processes have taken place. I can only say that myself and anyone else who I have been aware of involved in this case have tried be open and honest all the way through. We have tried to be sensitive. We have tried to give info. Sometimes the information we have given may not have been correct, but we felt at the time it was correct. I have left the door open for the parent to come back any time if they had questions, and I am not aware that anyone tried to cover anything up.

We tried to give information we had at the time in a way that the parents could understand and leave the door open for them to come back if they had other questions.

Q. Can you understand how that perhaps feeling of the loss of trust and confidence is exacerbated maybe or allowed to develop by, when they do have the opportunity to talk to Claire's clinicians, both in 1996 and in 1997, what they hear now does not entirely accord with what they were told then? Can you understand that situation?

A. I can --

Q. And for that matter -- sorry -- just to finish that off -- and for that matter what they were told in 2004, so it is not just now.

A. Our documentation of what they were told in '96 and '97 is poor and I think it was Mr Roberts who talked about the mists coming down. So I understand that there's a difference in the information coming forward. That doesn't mean that the information being given at the time was not the information that the clinicians thought was correct at the time and being given to the parents in a correct way.

I apologise if they feel they have been misinformed. From my perspective, I have no recollection, but I have no reason to think that I misinformed them deliberately.

It is not how I practise medicine. It is not how I practise my own life and my own family life. I have tried to provide information to this family from what I have been given and if I've misinformed them, I am sorry.

I understand now when they look back it looks as if someone has done something wrong, trying cover it up, but at the time I am quite sure that neither myself nor anyone else tried to cover anything up. This is a tragedy. I hope I am a reflective practitioner. We have all been taught to be reflective. I think the chairman suggested that we are naturally defensive if something arises that's an error. You know, you have a natural defence mechanism. That's quite right, but we have been trained that you actually say "oh" -- rather than being, "Let's not pretend it happened", it is "oh, right, could this be a possibility, do we need to look at it again? What can we learn from it?" That's how I have practised medicine.

So if I found a problem and I knew it was a problem, whether I was criticised or not, my approach always has been: Okay, can we look into this in more detail, what is to be done, what do we need do for the future?

Q. Well, if you leave aside the fact that anybody intentionally tried to mislead, if we leave that aside,

and I think in your evidence during the clinical phase of this you did acknowledge that there were some things that could have been done better.

A. Yes.

Q. I think you expressly stated the blood test should have been carried out earlier.

A. Definitely.

Q. I think you have also said that maybe they -- or if you haven't said it, I think it has been implied from what you said -- there could have been better communication, coordination of communication. The records could have been better kept so that people understood what had happened before them and there was a more accurate account in order to base views and communicate to the families and forth -- the family and so on.

As you look at that time now, can you develop that, because you have just mentioned the fact that you are taught to be reflective. It is one of the things you try and do and --

A. Uh-huh.

Q. -- in fact, in 2004, you were clinical lead. Would you be leading people on how to hopefully approach a situation exactly like this?

A. Yes.

Q. But in any event, the reflective manner is something you

would want to encourage, I presume. So if you do that and you apply that now, can you help with the areas where you think, frankly, there was a falling short?

A. I think you've mentioned communication and I'll deal with that first.

Q. Yes.

A. Because communication is on various levels, I think, when you look back. There is communication between nurses and doctors, between doctors and doctors, between doctors and nurses. So there's the professional communication, which was not as good as it should be.

Q. Well, if I pause you there, as you are looking back, what do you mean by that?

A. I mean that there's no -- on the Tuesday morning, on the post-take ward round.

Q. Yes.

A. I have no recollection of where I was. We know I was contactable. Why I wasn't on the ward I don't know, but I think it should have been clearly documented when I was with patients because I did see one or two patients on the ward, what happened with them. So I think there's the issue of documentation of which doctors see patients when and then what plans are made for them. I think there was no clear documentation of communication between myself and the registrar and the

registrar and myself. We believe --
Q. There isn't any, is there?
A. No, we believe conversations take place, but nothing is documented. Therefore when you go back, you cannot say what happened because nothing is documented. So we need better documentation. There needs to be clear communication. I have would have liked to have very clearly been able to say that Dr Sands had phoned me at a certain time, that this is what I had said and this is what was in place, that I had phoned the ward. So There's the issue around that sort of documentation and that communication. I would have liked clear evidence that I kept the juniors up-to-date and the juniors kept me up to date. I am not sure how clear those lines of communication were. I would have liked to have seen a clear plan between Dr Webb and myself at teatime and, indeed, I think I have previously said it was with deep regret that I didn't return at teatime and I would have liked to have seen clearer documentation in the notes from both nursing and medical staff of what exactly had been said to which parent, and then what the parent had actually understood by that.
Q. These things you would have liked to have seen, I take it you are dealing with them from the perspective of what is reasonable to have expected in 1996.

A. I can't remember.
Q. I understand.

A. I can't put myself back to 1996, but they are reasonable standards of care.
Q. Yes, and before you go on to talk about other elements where there might have been deficiencies or where things may have been done better, if we just stick with those that you have explained now, firstly, whose responsibility it was to make sure those things were done, and if they weren't done -- and it wouldn't take you very much reflection on looking at the notes to see that things weren't quite up to the standard perhaps that you would like -- what happens then? Whose responsibility is it to appreciate that from the notes and do something about it, if only for the learning of the junior doctors involved?
A. Well, ultimately it was my responsibility as the consultant in charge of Claire's care, and it would have been also part of Dr Webb's reflection as the neurologist who was involved in supporting the neurology side of Claire's care.
Q. And when do you think that should have happened, that reflection?

A. I think it should have happened contemporaneously. I think there should been a degree of reflection there and then. Again when we were feeding back to the parents -- and again I believe Dr McKaigue remembers the case being presented at a mortality meeting. I can't remember, but again that was a time when there could have been reflection and that reflection should have resulted in discussion with junior doctors and nursing staff about how to improve things.
Q. Well, would you agree there's absolutely no evidence of that actually happening?
A. No, there is no evidence.
Q. Which is possibly its own recording issue.
A. Yes.
Q. If there isn't any evidence, and maybe because it didn't happen, at least not in the way that you are suggesting would have been appropriate, what is the reason for that?
A. Sorry?
Q. What could be the reason for that, for why it just wouldn't have happened?
A. Why what wouldn't have happened?
Q. The kind of reflection you are talking about, which should have happened, which would have led to lessons being learned for the junior staff and translating

itself presumably into some better action or something.
A. I am not sure why it wouldn't have happened because the process was there. We have no evidence the process was followed in so much as there is no documentation there.
Q. Yes.
A. But I don't know -- I mean, I don't know what was discussed at the mortality meeting, whether there was discussion about improved note taking, about communication issues. I don't know. So I don't know if the process failed or not, but I do know there's no documentation to support the process did, you know, happen.
THE CHAIRMAN: Doctor, I have to make it clear that the process did fail.
A. Yes.
THE CHAIRMAN: Okay. I think you said a moment ago:
"[You] don't know if the process failed or not, but I do know there is no documentation to support the process."
Without going nearly as far as Mr and Mrs Roberts did last week, the process did fail in 1996/1997.
A. Around improving communication between staff?
THE CHAIRMAN: Yes, because there is no evidence whatever that after Claire's death any of the doctors or nurses sat down and thought, "How did this go wrong?", "How

could this all have been going wrong in front of us and none of us spotted it?" Mr and Mrs Roberts went home on Tuesday night sometime after 9 o'clock, expecting to come back and see Claire the next day and got the most awful shock they will ever have by being called in at 3 or 4 in the morning. It did go wrong.

I don't want to go over all the ground you have gone over before. I know you want to respond in the strongest terms to the suggestion made last week that there was a fabrication at some point perhaps in 2004 and 2005. I have got your response to that. In fact, you say:

"I am sorry. However much I can understand Mr and Mrs Roberts' concerns, that simply did not happen."

Isn't that --

A. That's correct.

THE CHAIRMAN: Well, I have got that, so let's move on.

MS ANYADIKE-DANES: Thank you.

So then in terms of anything else that you would recognise now as being a deficiency or lack of appropriate care, if we put to one side the record-keeping, although you would include in the record-keeping, would you not, the way that the medication was recorded?

A. Well, we were dealing with communication.

Q. Ah, communication. Sorry. Yes.

A. The first thing we were dealing with was the communication between professionals --

Q. Yes.

A. -- but also communication with the parents.

Q. Let's go to that then.

A. Okay. Communication with the parents is two ways, the information given and the information understood.

Q. Yes.

A. I have no doubt that people throughout the years have given information, but perhaps not in an appropriate way for the parents to understand, and they certainly didn't understand what was happening that Tuesday night, because they wouldn't have gone home.

Q. Yes.

THE CHAIRMAN: That then led into the other problem, which is: did the doctors understand what was happening on Tuesday night? Because when Dr Webb went home, he thought Claire was going to recover. I accept that because I know from Dr Webb coming backwards and forwards a number of times on Tuesday afternoon that he was committing himself to Claire's care.

A. Uh-huh.

THE CHAIRMAN: Right. So I don't think for a second that Dr Webb would have gone home on Tuesday at some time

around 5 or 6 if he had thought she was in real danger. I also suspect that Dr Sands would not have left if he had thought that and I also suspect that if you had been informed that there was a girl who was very, very seriously ill, that you would have returned. So I believe you have would have returned --

A. Uh-huh.

THE CHAIRMAN: -- if you had received that message.

A. Yes.

THE CHAIRMAN: But one of the points which Mr Roberts made, which I have to say does appeal to me, is whether when Dr Sands gave evidence about Claire being the sickest child in the ward, whether that is not something of a retrospective interpretation of how sick Claire was and whether how sick she was was missed, even by about 5 or 6 on the Tuesday evening.

Do you see how that can fit into the picture? Because if she was as sick as Dr Sands has described, then the three people who were involved in her care -- namely yourself, Dr Sands and Dr Webb -- all left.

A. Yes.

THE CHAIRMAN: You weren't beyond being contacted, but would you really all have left if there was a view that she was very seriously ill?

A. I think -- I have no recollection. So it's a matter of

looking back and I agree with you, when you look back through her records on that Tuesday afternoon, she comes across, looking back, as a very, very sick child, even at 5 o'clock, and she certainly was sick enough that I phoned back. So whatever information I had about her, it made -- it was enough to make me phone at the end of my clinic rather than just go home without making any contact with the ward.

THE CHAIRMAN: Let me just pick you up on that. I understood -- please correct me if this is wrong -- that your phone call at about 5 o'clock on the Tuesday afternoon -- it is either you ringing from Cupar Street or the ward rings you at Cupar Street -- and this is a way of confirming, in either direction, that you don't need to come back or whether you do need come back. Isn't that right?

A. But it would not be done every time.

THE CHAIRMAN: Right.

A. It's done when I'm -- there's someone ill or there's something that has been worrying me that I think isn't tidied up.

THE CHAIRMAN: But if you got the impression in that phone call that Claire was not well, but not so unwell that you needed to return --

A. Yes.

THE CHAIRMAN: -- that is a sign that the seriousness of her condition was missed.
A. Yes, it could be taken as that.
THE CHAIRMAN: And if the seriousness of her condition was missed between the doctors and nurses, it must follow that the parents weren't told how seriously ill she was.
A. Yes, and I think the parents' actions show they were not fully informed of how sick she was. The parents didn't -- there is no way they would have gone home.
THE CHAIRMAN: Exactly. In fact, Mrs Roberts said last week they wouldn't even have gone for lunch if they understood she was so ill that she was so seriously unwell that another doctor was going to be brought in.
A. Yes.
THE CHAIRMAN: They would have stayed to see that. Given what we know about how constantly the Roberts family were at Claire's bedside, that makes sense, doesn't it?
A. Yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Dr Steen, the issue is you are trying, so far as I can tell, to make some concessions as to what you think was poor or inadequate or sub-standard care --
A. Uh-huh.
Q. -- that she received. That's what I understand you are

doing. So you had started off talking about the record-keeping. Then you went to the record-keeping in relation to the parents. I think you have conceded that the record-keeping is very poor in relation to that.
A. Yes.
Q. But when you link that with how serious Claire was, her illness and that therefore that was not properly communicated and recorded as having been communicated to the parents, the point -- and I am sure you have taken it -- that the chairman was making is that all presupposes that everybody has understood she was that ill, as you seem to be able to glean from her medical notes and records.

If they had not appreciated that she was as ill as that, then that is an issue all on its own, and that's precisely the sort of thing that presumably you would want to have discussed at a mortality meeting or something of that sort because there would definitely be learning that should come out of that have if a consultant paediatric neurologist has not appreciated that, if your junior paediatric team have not appreciated that and, therefore, clearly the nurses didn't appreciate that. That's a big point and it needs to be addressed.
A. It is.

Q. What I am putting to you is it is not just a matter of recording -- I am sure Dr Sands said something of the sort, that if he had been invited to attend that meeting, he would have remembered it because he had been involved in that child's care. There is not a single piece of paper that emanates from the kind of review you are suggesting should have happened to identify: these are the learning points, this is what we need do, we need take the junior doctors over this point -- or whatever is your conclusion as a result of that -- because this has been missed. So it is not just a matter of recording in and of itself. Nobody actually remembers having a meeting where it became clear to all that their care of Claire had been deficient and may have been partially responsible for her death.

I presume that if you'd given something of that sort, you would remember that. I don't know how many children have died in your care. I presume Dr Sands, when he gave his evidence, he would remember that, but nobody remembers that kind of exchange.
A. Well, I have no recollection -- I appreciate what you're saying -- of what happened at the time.
Q. I appreciate that.
A. I would think specifically at the mortality meeting that is the conversation that should have been held, and we

should have been in a position to minute it, and then we would have been clearer about whether the conversation was there or not and if the learning was identified or not.
Q. Well, if you are presenting it as Claire's consultant paediatrician, would it not fall to you to be drawing together these threads of learning that you will be wanting to make sure that the junior members have embraced?
A. I think there's two strands to that. Firstly, normally when we're presenting at the mortality meeting, we are presenting facts initially because if you try to draw the stands together yourself, you are missing the learning that might be achieved.
Q. Yes.
A. I can't remember this case, but I am just saying any other cases I have done --
Q. Yes.
A. -- my process it would be normally present the facts first --
Q. Yes.
A. -- because otherwise you bias the history.
Q. Yes.
A. So present the facts. Then have a discussion and determine if there's learning. If you present the case

purely as what you perceive are the learning things out of it, you may miss other things. So I think the presentation of the case, a bit like this inquiry, has to be factual first, a discussion and then learning.

Q. You are not being prescriptive as to how you present it.

A. Yes.

Q. I am saying: you have clearly identified learned friends learning; whether anybody else brought any other points, you have some clear points that you would want junior doctors and, for that matter, anybody else to take out of it.

A. Yes.

Q. What I am putting to is given that you were the consultant paediatrician, did it not fall to you to make sure those were taken forward?

A. Yes.

Q. Thank you: then I asked you about the medication, the recording of the medication. The deficiencies, would you accept, fall into two areas of difficulty: one, that there seems to be some dispute over the way the dosages were communicated and that she seems, therefore, to have received an overdose: an overdose of phenytoin, because there was of a simple arithmetical miscalculation; and an overdose -- a considerable one -- of midazolam, because there seems to have been miscommunication or

mishearing over what the appropriate dose was.

Then there are other deficiencies as to when things are signed off, whether they are given at that particular time, whether that's properly recorded. Those fall in the area of -- let's call them the medication issues. Is that not something that troubles you?

A. Yes, and medication issues still occur and they trouble us a lot.

Q. Yes.

A. And there's a lot of work that has been done on it. The two drugs you have mentioned are not drugs I would have used or prescribed. I do, however, think when I was going through the notes that there was an opportunity for me to identify them. They weren't identified and they weren't identified for the coroner and I think part of the reason they weren't identified is that the kardex wasn't put alongside the notes, the sign off.

So the 120 of midazolam was on a kardex whereas the 12 was in the notes.

Q. I understand that. But you don't need that in relation to phenytoin. The phenytoin calculation is right there and it is an arithmetical error.

A. I didn't check that.

THE CHAIRMAN: You told me when you gave evidence before

that you were not very familiar with these drugs. They are typically administered by a neurologist, rather than a paediatrician.

A. Certainly in 1996.

THE CHAIRMAN: That's what you would have liked to discuss with Dr Webb?

A. Yes.

THE CHAIRMAN: I mean, it's an unfortunately simple point: no such discussion ever took place.

A. No. The drug errors were not noticed.

THE CHAIRMAN: Neither in 1996/7, when you were both in the hospital, or in 2004/5, by which time he had left the hospital.

A. Yes.

MS ANYADIKE-DANES: I am grateful to you that you are sort of trying to identify some of these points that you recognise now, but if we go to the point that the Chairman has just raised: the two of you had to sign off on a brainstem test form.

A. Yes.

Q. And one of those had to do with the presence of, loosely speaking, the presence of any sedating drugs because that would be relevant to the presentation.

A. Yes.

Q. If you were going to do that, did that not mean you had

to look at the drugs to see actually what was prescribed and when it was prescribed because that is likely to have had some kind of impact on her current state?

A. We -- I have no doubt we considered her anticonvulsants when we were signing that form off. There was a serum phenytoin level of 19.2 at least two hours before the brainstem results, midazolam had been discontinued, therefore, were those drug dosages at that point in time sufficient to have her unresponsive, not able to breathe? So I think my approach -- and it is only working back and trying to reconstruct.

Q. I understand.

A. My approach was: were there drug levels in her blood at 6.00 am sufficient to cause her condition? And because I had the phenytoin level, I did not go back -- and I am not sure if Dr Webb went back -- to look at what had been given because we have a serum phenytoin level.

Q. Yes. I am not getting into the substance of that point. I am asking about the process because this is governance now.

A. Yes.

Q. Would not the process mean that you really ought to have looked at what was in her system because actually you only had one level of anticonvulsant medication result,

which is phenytoin --
A. Yes.
Q. -- which is at the higher end of the therapeutic range?
A. Yes.
Q. And, as you will know, one or two, I think, of the experts for the inquiry have been concerned that you would proceed with the phenytoin level at that end of the range, but be that as it may --
A. Uh-huh.
Q. -- in order to form a view, you have to look at the drugs, because you only know one result.
A. But midazolam would be out of the system; you couldn't measure serum midazolam.
Q. How do you know whether it was out of the system?
A. Because it has a very short half-life.
Q. You knew that sufficiently about midazolam in 1996?
A. Yes. That's why it was by infusion --
Q. And you discussed that?

A. I can't say we discussed it or not, because I have no recollection.
Q. Does that mean you went back to look -- to see when the midazolam was prescribed to know the midazolam would be out of her system?
A. I can't recollect what I did or didn't do. I can only

reconstruct from the notes. I have noted the midazolam was discontinued. And I would not undertake brainstem tests without being very sure about each area.
There were two real areas when one looks back at Claire's. One was around the drugs and one was around the sodium level. Her blood gasses fell within the range that we required and I wouldn't have approached that form without discussing those with Dr Webb and the two of us being happy to move forward.
Q. Yes. Okay. If you are looking -- and this is the final point on it -- from a governance point of view, it means in a very important area which I have just identified to you has, for some reason, not led to you looking at the actual dosage, checking when it actually -- what level was last given and therefore being able to satisfy yourself on that basis that everything is in order to proceed. I am not talking about the substance of it --
A. No.
Q. -- just the process because that means, although that would have been the process, the two of you have missed those errors.
A. We missed the drug errors, yes.
Q. You missed them then. You missed them when you did the review in 2004.
A. Yes.

Q. Is that therefore not a point that somehow something which could have been quite significant in terms of the effect it had on her presentation, when the doctors were trying to work out what are the implications of her presentation for her condition and her differential diagnoses, something that was potentially significant about that, there was an error about it or there are errors about it, because she shouldn't have received that level of medication?
A. I am sorry. You have lost me with that question.
Q. The point I am trying to get to is: because you missed that sort of thing, which is very important, and the junior doctor involved is not helped to see the potential significance of what is seemingly just an arithmetical or a transcription error --
A. Because we missed the drug transcribing, there was no feedback to the junior doctors about drug errors.
Q. Exactly.
A. That was an important learning point that was missed.
Q. That was an important learning point?
A. Yes.
THE CHAIRMAN: There was one other point that emerged since you gave evidence because Dr Herron gave evidence after you in this inquiry. Dr Herron says that on its own the over-administration drugs should have lead to a referral

to the coroner. It wasn't a point that he picked up, and I am assuming it wasn't a point that you or Dr Webb picked up, but Dr Herron has said, on its own, the fact that Claire got too much midazolam and too much phenytoin should have lead to her death being referred to the coroner because nobody could be satisfied in those circumstances the cause of her death was known and that there was a natural death.
A. Well, that's right, because there was a medical mismanagement on the way through to that event --
THE CHAIRMAN: Yes.
A. -- and that is another indication for referral to coroner.
MS ANYADIKE-DANES: That is another deficiency. In fact, one that went unnoticed despite reviews for some considerable time.
A. Yes.
Q. And then even leaving aside the learning that you take from 1996/1997 about that, should there not have been some learning about the fact you can have, to all intents and purposes, a case note review to explain to the parents what happened and that that's still missed?
A. Yes, and I think there is an issue about just how critically we can manage to go through these notes within our governance arrangements to identify all the

problems, and I am not sure that there still isn't problems when we have cases about being able to do the detailed review that this inquiry has done because there were reviews carried out. There were reviews carried out by experts and yet things have been missed. I don't know how we put a process in place where all the details are picked up.

THE CHAIRMAN: Let me explore that with you, because that's important going forward.

A. It is.

THE CHAIRMAN: It is important beyond Claire's case. It is impossible you can have an inquiry like this, which goes on for too long, but it shouldn't take an inquiry like this to pick up significant issues like drug overdoses. Right? So when you say you are not -- you are still not sure about how you can go forward, even within your updated governance arrangements, what is your concern?

A. The most detailed in-house review we probably do is root cause analysis where a serious or adverse incident has been done and you actually have people who are able to go through the notes in detail. I think to be able to go through some of the charts and go through everything in detail is very, very difficult. The drug errors should be picked up now because we finally have pharmacists on the wards who review all the drug

medications, which have been carried out and ensure that the drug medications, if there's been an error, are identified through. We have a much better review of ongoing concerns during patient care. We have much better adverse incident reporting, but when you look at how this case is gone through in detail and the little bits that have been picked up, I don't know how we would pick those up. I mean, if they were missed at the coroner's ...

THE CHAIRMAN: : Yes.

A. We can put in as tight --

THE CHAIRMAN: Can we agree it shouldn't emerge because Mr Roberts is sitting on his computer late one night looking at the records and then he finds this point that everybody has missed?

A. No, it shouldn't.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: I am taking it a little bit out of turn, but since we are dealing with this particular area, maybe you can help it with this: I have understood the point you made to the chairman that not every review of every child's case notes can take the form this inquiry has taken, but I think you have just conceded you don't need that to identify some of the points you have just been conceding.

A. Yes.

Q. But if one looks at the letter that Mr Roberts wrote dated 8th December 2004, and if we pull that up, 089-003-006. Let's have the next page too, 007, alongside it.

This is Mr Roberts. He is looking at things, trying to puzzle out what had happened to his daughter, does not have obviously the benefit you do in terms of trying identify these things. He doesn't know exactly what it is, but he gets himself to paragraph 4, which relates to the anticonvulsants and he is raising questions about the number of anticonvulsants and antibiotic drugs through Tuesday:

"Did this mixture of medication compound and worsen Claire's symptoms given that her sodium levels were falling?"

He doesn't know:

"Should the medication have been stopped?"

And so on. Then at paragraph 5 he says:

"What impact would the combination of both strong medication used along with an incorrect fluid type have on Claire?"

Maybe he is not there able to exactly say: I think she got twice at much phenytoin and three times, or whatever it is, as much midazolam, but he is pointing

you to, he is directing you to the anticonvulsant: tell me what you think the implications of that are. How could that not have required you, in 2004, to go back and think, "Let's look very carefully at exactly what was prescribed and what was administered and when that happened?

MR QUINN: Before that comes in, could I remind the inquiry that, at this time, Mr Roberts didn't have Claire's notes, Mr Chairman.

A. I am aware they didn't have Claire's notes. They could have had them at any time they wished them.

MS ANYADIKE-DANES: Is that not pointing you to --

THE CHAIRMAN: I think the point of the intervention was, if this was an issue, it was not really a complaint Mr and Mrs Roberts had not been given a copy of the notes at that point. The intervention was: if Mr and Mrs Roberts are picking up this issue as a concern to which they are seeking an answer, how can it not be picked up when they receive a reply or for the purposes of giving them a reply?

A. I am not sure -- I can't remember how this is responded to. I can no longer hold facts in my mind.

THE CHAIRMAN: Okay.

A. But did this mixture of medication compound and worsen Claire's symptoms, given that her sodium levels were

falling? To me, now, today, I read that as a combination of: did the medication affect the serum sodium level directly?

MS ANYADIKE-DANES: Sorry, Dr Steen, that's not the question I am putting to you. He doesn't have the benefit of her medical notes and records. So he doesn't actually know there was an overdose; he just wants to know what is the effect. And what he knows is quite a bit in terms of different amounts of anticonvulsant were administered to his daughter. What I am asking you is: when he raises queries like that, does it at the very least not require you and whomsoever are going through the case notes to actually look at what was prescribed, what was administered and when that happened?

A. Yes, and presumably I went back through the notes and did not do the calculation round the phenytoin, did not know the midazolam one, but had serum phenytoin levels to reassure me that the phenytoin levels in her blood, although initially high at 9.00pm, was down to the therapeutic levels at 4 am.

Q. I appreciate at 4 am, but he is actually asking during the course of her treatment. So is what you are driven to say that even though something like that has been identified -- not in the precise terms as I am putting to you now, but an area has been identified -- even with

that, still the clinicians going through her medical notes and records are not able to see at the very least that the phenytoin resulted from an arithmetical miscalculation?

A. We obviously didn't. I mean, we didn't, and nobody recognised it up until this inquiry. We didn't check Dr Stevenson's sums.

Q. So then that will have some bearing on presumably the learning that surrounds case note reviews. They obviously have to be a little more thorough.

A. Yes, and around drug errors now we at least have pharmacists on the ward for the last couple of years, who would be identifying those in detail and be feeding back on those. That's just one step to try to reduce dug errors.

THE CHAIRMAN: The issue before was that there were not pharmacists who were working in the Children's Hospital --

A. That's right.

THE CHAIRMAN: -- they were working in the main hospital, if that's not the wrong term. How many do you now have in Children's?

A. Don't quote me, but we have at least one fully on for the oncology unit and that works purely for oncology. We have two junior pharmacists, one on Allen Ward and

one on Barbour Ward and Paul Ward. They are there certainly most mornings, although they may be called back to main pharmacy in the afternoon. Their job is to go through each drug kardex, each discharge slip, identify any problems, make suggestions about drugs we could use in a slightly different way to help overcome problems. Then there is a senior pharmacist who has an overview of PICU.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you.

Well, that seems to have addressed the recording and so forth issues around the discussions or the communications and the medication. Are there other areas that you think were deficient now when you apply your retrospective or reflective hat?

A. So we have covered the fact the documentation was inadequate?

Q. Yes.

A. It did not help with communication.

Q. Yes.

A. And there were significant problems with communication between professionals and between parents.

Q. Yes.

A. And when we reviewed the notes, important issues were missed --

Q. Yes.

A. -- despite reviewing them several times, which could have learning points.

Q. Yes. Anything else?

A. You are going to have to help direct me. I am sorry. I am very, very tired. I am very tired.

Q. Oh, well, I am sorry. I wonder is there any issue around the cover?

MR FORTUNE: Can I help? If you direct Dr Steen's attention to the discussions with parents and in particular the issue of the post-mortem and the autopsy, you may find that fruitful.

MS ANYADIKE-DANES: Does that help direct you?

A. I am never quite sure if Mr Fortune helps.

MR FORTUNE: Dr Steen, I am your counsel!

MS ANYADIKE-DANES: We will move on.

A. Okay. I think one of the areas we need -- we are discussing about is communication with the parents and correct information because the parents were dependent on me as her clinical lead --

Q. Yes.

A. -- with Dr Webb beside me to provide the correct information for them to make their judgments at a time when they were very, very emotionally upset.

Q. Yes.

A. They couldn't think. They were dependent on the information myself, Dr Webb and other professionals gave them to make judgments around the end of life of their daughter and around what needed to be done at the end of life, and I was her consultant. Dr Webb was with me, but it was important that we gave information to them in a way that would help them with that.
Q. Well, if we come then to the post-mortem element of it.
A. Uh-huh.
Q. If you had formed the view this was a coroner's case, which you know many of the clinicians who have given evidence thought it was, and that's what should have happened, but leaving that aside, that's not something that you're really going to take the consent of Claire's parents about. If it is a coroner's case, you have a statutory obligation and that's the end of that.
A. Yes.
Q. So let's go to the limited post-mortem, which is something that can be done. I wonder if that's where you are going, that they were dependent on you to provide them with information about that.
A. Yes.
Q. Is it not correct, though, that you -- well, you can help me. I didn't get the impression from your evidence -- and certainly from their evidence -- that

you were saying, "Well, on the one hand, you could have a full post-mortem or you could have a limited one. These are the pros and cons of both. You know, if I were you, I would think we could perfectly achieve our objective by having a limited one". That's not how I thought the evidence went. I thought the evidence was that a limited post-mortem would suffice and you were seeking their consent for that.
A. I think I said -- and I am not sure whether I said it, but I thought I said that we would have -- that my practice --
Q. Uh-huh.
A. -- when I am discussing it with parents is to discuss all the options and then suggest which one would be the best option forward. I realise that I have no recollection of this, but any other cases that I do remember, it was very much, "This is our problem. We think we know this is your daughter's cause of death and we either have enough information to go ahead and sign a death certificate or we can sign a death certificate and we'd like additional information or for other reasons we want a hospital post-mortem or we need a coroner's post-mortem". So there are several: there's death certificate; death certificate, limited post-mortem; full hospital post-mortem; or coroner's

post-mortem. I would normally discuss all those issues with the parents.
I realise the parents do not recollect all this being discussed. I genuinely believe that myself -- and Dr Webb was with me -- that Claire's illness was related to her brain, that it was a neurological illness and that any additional information would be gleaned from a brain-only post-mortem. I fully accept that on reflection it should have been a coroner's post-mortem, and that way there may be further information -- I don't know if there would have been further information, but there may have been further information for the parents.
THE CHAIRMAN: I think I have to say to you, doctor, my primary concern in this issue is not whether it was a full or brain-only autopsy; my primary concern is that it should been referred to the coroner.
A. Yes, and on reflection it should have been for several reasons.
THE CHAIRMAN: And I think one of them is that she had arrived in hospital on Monday evening. She is effectively dead in the early hours of Wednesday morning, subject to this testing that follows. That is not the expected outcome of Claire's treatment, and my concern is that in order to decide to not refer Claire's case to the coroner, you would have to have a degree

confidence about what the cause of death was, and I don't understand, from what happened, how that degree of confidence was held.
A. I think Dr Webb had a strong degree of confidence in the epilepsy triggering the SIADH. There was a viral illness. I am not sure, but looking back in my mind, I think, was: did the viral illness also cause the encephalitis? But that's only reconstruction.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: We don't need to express that further, because the chairman, I think, has expressed his view.
THE CHAIRMAN: I should say for the record that that view is subject to submissions from everyone, but I think there's a fairly strong direction in the evidence of the various experts and I think various people within the hospital accept that it should have been a coroner's post-mortem for a variety of reasons.
A. Yes.
THE CHAIRMAN: But the one which seems to me to have been most likely to be evident, even in the early hours of 23rd October 1996, was whether anyone was able to say with confidence that Claire died from natural causes --
A. Yes.
Q. -- without an issue arising from the management of her care.

A. Yes.
MS ANYADIKE-DANES: When you -- sorry.
MR FORTUNE: [Inaudible: no microphone] Dr Steen accepts, on reflection, it should been a coroner's case and you have just heard her say that.
A. There were several points you have raised.
MS ANYADIKE-DANES: When you are doing your review of the medical notes and records in 2004 for the purpose of reaching a view for Dr McBride and also going into the meeting with Claire's parents, do you consider again -- you have everything before you then, including the autopsy report and a little bit of the benefit of hindsight. Do you consider then that she should have been reported to the coroner or is that something you have realised now, having heard the inquiry?
A. No. It was very obvious in 2004. We missed the drug errors, but Professor Young picked up the fluid mismanagement. He talks about three slices of a pie and which proportion is attributable to which, but it was very obvious the minute he did his fluid review that there were concerns.
Q. We will come to that in a minute. I am actually interested in your own thought process. So before you have had the benefit of Professor Young's view, you are asked to look through the medical notes and records and

you are doing that.
A. Yes.
Q. When you do that, do you have a view then, "This is something that probably should have gone to the coroner"?
A. Yes, because, by 2004, thinking around fluid management has significantly changed and the case was being reviewed with a different knowledge base.
Q. Yes.
A. And with that knowledge base, it became quite obvious that there were concerns around the medical management. Not all the concerns were recognised.
Q. Yes.
THE CHAIRMAN: Apart from the guidelines on hyponatraemia, which had been published in 2002, was there any other significant area of learning or was it the Northern Ireland guidelines?
A. The whole management of encephalopathy had significantly changed. So a child who came in with neurological symptoms, the fluid would have been restricted straight away. There would have been -- no matter the sodium being 132, the sodium would have been much more closely monitored. The fluids would have been managed differently. A CT scan would have been done. An EEG, if it was during the working day, would have been done.

Transfer to PICU would have happened.
THE CHAIRMAN: So these -- sorry. Just to get it clear, these are not hyponatraemia-related developments; these are sort of parallel developments in encephalopathy are they? They might end up at the same point, but --
A. Yes, because the hyponatraemia was part of the problem, but there was the rest of the problem. You still needed to manage all her symptoms and try to investigate it more fully and work things out in a better way.
When we were reviewing the notes -- I believe when we reviewed the notes in 2004, we were trying to remember what was happening in 1996, because that's what you review to, not what you know at the time, but I think when I had time to sit down and go through the notes, that I did recognise, yes, it wasn't just the fluids. There were issues around the fluids, but there were other issues as well.
MS ANYADIKE-DANES: Yes. Can you help me with this, though, because even before you get to 2004, your other time to review matters is when you get the autopsy report back.
A. Yes.
Q. I mean, you had given the parents a view of things as you saw them when -- just before you got the CT scan back and then when you did. So you have talked the parents through and given them the information as you

believed it was at that time.
A. Yes.
Q. But that's partial because you have told them you really want a brain autopsy done so you can get information on what you think is the viral cause.
A. Yes.
Q. That's the trigger for all this.
A. Yes.
Q. That is what thought and that's what the parents have remembered from your discussion with them, that very high in the explanation was some sort of viral condition; would that be fair?
A. Triggering all the events?
Q. Yes, but a viral condition.
A. Yes.
Q. When you get the autopsy report, you have another opportunity to revisit things. In fact, you have ticked the box at the back, which means that you could have revised the death certificate, could you not, in the light of that information?
A. Yes.
Q. So then when you get the autopsy report back, it becomes quite clear that whatever they found as any kind of viral presence was very, very low grade. In fact, if you had discussed it with them -- and you might well

have, I don't know -- but they presumably would have told you what they told the chairman, which is it certainly was nowhere near a level that would have contributed to her death and, in fact, Dr Herron was of the view that, you know, it was marginal whether it really was there. It was all very subtle, if I can put it that way. So that's the information you get back. Does that not cause you to pause and think, "Well, if it's that subtle, maybe that wasn't the trigger, so maybe something else was going on"?

A. Dr Webb and I wouldn't have met with the parents until we had discussed the post-mortem results and I don't know what was discussed. I do know the CSF, which albeit post-mortem -- and which has a funny protein level -- showed an increase in white cell count, and I believe Dr Webb and I perhaps over-interpreted the changes that were noted on the post-mortem report, but certainly when we went to talk to the parents, we seem both to have felt that the issue was a viral illness starting seizures, some encephalitis and inappropriate ADH complicating the whole issue, causing low sodium, adding to the cerebral oedema, which any of the two other conditions could have caused, and the vicious circle that is set up.

Q. I presume that's going to be another in your catalogue

of criticisms of note taking, because if you had a meeting like that that satisfied both of you that your original view was correct and had, if you like, been confirmed to a degree by the post-mortem report, none of that is recorded anywhere.

A. No, it is not and the information of the meeting with the parents is not recorded anywhere, just the two letters that went out as a result of them.

Q. So then if we then move away from the issue of the referral to the coroner and how the limited post-mortem occurs and the feedback from that to the parents and all those issues, which I presume, as you have -- as I have been putting them to you and you have been coming back to me, you are conceding some deficiencies in those areas.

A. Yes.

Q. Is there anything else that you think you could have reflected on, could have done differently, could have been the subject of review, but didn't appear to happen?

A. You need ...

Q. Let me help you in the way I was going to. We are coming close to a break, I know, but perhaps you can assist with this.

A. Yes.

Q. I think, to a person, the junior doctors -- certainly

those who were on the night shift -- talked about the heavy burden that was on them.

A. Uh-huh.

Q. I think it was Dr Bartholome who talked about the 115 beds or so she was covering. She was the most senior doctor. She was also very, very conscious she had to keep a close eye on the junior doctors and what they are doing, can't just expect them to be getting things correct all the time. So you are overseeing them, looking at the patients, making perhaps quite serious decisions about children in that way, and that was a burden, and I think the inquiry's experts, certainly Dr MacFaul, thought it was intolerable that she was required operate like that in terms of the implications for patient safety.

A. Yes.

Q. And Dr O'Hare wasn't in a very much better position. Just from Claire's point of view things, things weren't so acute for Claire then as they were on the evening of the Tuesday.

A. Yes.

Q. That's something that Dr Bartholome thinks has been raised. We haven't seen, again, the evidence of anybody thinking about what the implications of that might be for the safety of sick children. Is that something that

you think should have been given greater attention?

A. I think it was being given attention and I think it's been given attention from when I was even a registrar, because I covered 125 beds. Although the surgical side looked after their surgical side, the staffing levels in the Children's Hospital for junior doctors were extremely stretched, and I believe there were discussions with Commissioners around how to address it. In 1999, when we got our new PICU unit, new guidance had come out from standards in care around PICU and we finally got -- I think it was two additional doctors to allow us to set up a separate rota for PICU from the others. I also remember I think it was 1999 that Ian Carson and I met with Commissioners for the first time to talk about the European working time directive, and the fact that if our juniors were doing 96 hours a week, then to try to get them to even 48 hours, we needed double the junior doctors. And I have worked those wards. I know how stressed it would be, and I still to this day don't know why nobody phoned the consultants. When you got really pushed -- so if I had been the reg, which I had been a few years before, on the ward, and I couldn't really get do things, I would have phoned the cardiologist or neurologist. To this day, I am still phoned -- I have gone in one night and

spent six hours in casualty simply because casualty, which I am not responsible for any more, couldn't cope but the reg asked would I come in and help. So the staffing levels were very difficult.

THE CHAIRMAN: Let me check I understand this: this issue of staffing levels was going on for years before Claire?

A. Yes.

THE CHAIRMAN: Was it a funding issue or was it because there weren't junior doctors who were available to be employed if the funds were there?

A. Recruitment was much better in 1996 because we didn't have some of the EEC restriction around us and a lot of Indian doctors wished to come over for two or three years' experience to gain higher qualifications. So you -- it was possible to recruit overseas doctors for a limited period of time. So that meant --

THE CHAIRMAN: So it was a funding issue then?

A. There were funding issues. The junior --

THE CHAIRMAN: Doctors were available from wherever, but there weren't funds to engage them; is that right?

A. Yes, and I think when we finally got the money for PICU, we actually brought in what is called clinical fellows. They were not training posts. The number of posts for training reflects the needs of the consultants, not the needs of the service, if you follow me. So if you know

you are going to have ten vacancies, you make sure 10 juniors are coming out skilled. So your training posts are geared towards the consultant requirement in the future and therefore other posts need to be brought in. They are called staff grades or specialty doctors or clinical fellows, which are non-training, but are people with two to three years' paediatric experience.

THE CHAIRMAN: To what extent did the restrictions imposed by the working time regulations help to the argument to the Commissioners that the numbers have to be increased?

A. Well, I think there were two things. Firstly, they knew they had to double the number of doctors. You know, the level of staffing was incomplete, but they also then -- there was a lot of work -- this was not sitting out on its own for junior doctors. So we had the whole issues around appropriate staffing for specialties and sub-specialties. The surgeons were bidding for additional doctors to help the surgical end. The surgeons were throughout really 2004, 2012, all the way through, they have been taking a much more direct consultant hand-on care to their patients with them being managed much more by them. So the whole picture of the children being admitted, the type of child being admitted, because we have so few beds, and how they are being managed is different now from 1996. The staffing

levels are slightly better. They are still very stretched, but they better.

THE CHAIRMAN: Are there three registrars on at night instead of one?

A. There is a -- there is an experienced doctor in PICU. Regs are gone. There is two years -- you qualify and you do two years foundation. Then you have run-through training, which is 7 years. So you would like people in PICU to at least be year 3 to 4 of the run-through training. It doesn't always work that way. So you have a stand-alone PICU rota, but with the consultants in an awful lot because the experience is not high. You have A&E with a consultant or experienced doctor on until midnight-ish. They will stay if it is busy. Then you have the reg who should be at least three years into their run-through training, if not four years into their run-through training on for the medical wards, and the surgical wards are much more self-reliant and you are much less likely to be involved with them than in 1996.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Just one final point that, because I am very conscious of the time and your need for a break, and that is the changes that you have talked about, they are all several years after the event.

A. Uh-huh.

Q. But it would seem that in Claire's case, possibly the thinness of cover, if I can put it that way, during the night was an issue for her care. It may well have been -- I have no idea -- that Dr Bartholome was so tied up she didn't have an opportunity to contact anybody she wanted to do that. If she was caught up doing whatever it was she was doing, if that's the case, then the cover for children like Claire was too thin; would you accept that?

A. Yes.

Q. Yes. So then if you've done your review -- I don't mean your case note review -- your review of her case and you have made your presentation, is not one of the issues that must have been in your mind: this could be dangerous?

A. Yes, the staffing levels in children were dangerous. They were very difficult and that's why consultants are very willing to come in if there is any question. I have still no idea why neither consultant -- be it via nurse or SHO -- were not consulted.

Q. I understand that, but the point I am going to next is: if that's recognised they were dangerous and, in fact, in Claire's case that might have been relevant that, thinness of cover, is that not something that you want to be pushing up the line to your clinical lead at that

time and even maybe the medical director and ensuring that that's recorded somewhere: "this is a potentially dangerous situation"?

A. And I believe there is something with Dr Mulholland in 1996 which identified problems with medical staffing.

Q. So you think that was done?

A. Yes, I do think.

Q. And was it identified as a particular problem, not just the general thinness of cover, but a particular problem in this case?

A. I can't tell you because I have no recollection and there is no documentation.

Q. If you were going to make that point arising out of Claire's case, is that something that you would record somewhere as opposed to have a discussion over coffee with your medical director or clinical lead?

A. I don't -- no, I have no -- there is no documentation that I have recorded anyway.

Q. I appreciate that. I am asking you what the practice was or what the form was. If you wanted to raise an issue like that of concern arising out of a patient of yours who died, how would you do that?

A. It would be done through the mortality meeting and through the directorate meeting.

Q. And does that mean, because we know that sometimes these

meetings are not minuted for various reasons --

A. Uh-huh.

Q. -- but something like that, is that the sort of thing that you would expect to find recorded in writing somewhere?

A. Yes, and junior doctors -- the directorate meeting ... I believe, at that stage, part of the agenda for the directorate meeting included junior doctor issues and the junior doctors had a representative which came to that meeting and lots of issues around staffing, etc, would have been raised in the directorate meeting.

MS ANYADIKE-DANES: Mr Chairman, I am conscious of the time.

MR FORTUNE: Sir, can I deal with three matters to assist both with you and my learned friend?

THE CHAIRMAN: I am about to let Dr Steen go for the day but if you can address them briefly, that's fine.

MR FORTUNE: Dr Steen is going to address them.

First, we have the chronology which is to be found in Dr Rooney's witness statement at 177/1. It's page 34 and onwards. The question you posed to me on Thursday, sir, was: do I have specific instructions as to the authorship of that chronology? The answer is yes. Dr Steen was and is the author of that document.

THE CHAIRMAN: Thank you.

MR FORTUNE: Secondly, sir, a matter that has been in the

background and it may well be that Dr Steen can assist you. You will recall that Dr Steen was contracted to work ten sessions: eight in the community and two on call.

THE CHAIRMAN: Yes.

MR FORTUNE: Whether that has an impact on clinical care within the hospital as opposed to within the community, if you want that addressed now, it's clearly something that Dr Steen can discuss and give evidence.

MS ANYADIKE-DANES: Sorry to interrupt. I was going to raise that matter later. That's a matter that is perhaps is not subject to a one or two-sentence answer. So I was going to raise that later, bearing in mind how long Dr Steen has been giving evidence, but I have that point.

MR FORTUNE: We are talking about concessions and I am trying to clear the wood.

THE CHAIRMAN: Let's get the quick point out of the way, because it will impact on how much more needs to be developed tomorrow.

MR FORTUNE: Finally this --

THE CHAIRMAN: If what you are saying is about getting the concessions out of the way and Miss Danes is saying she wants to ask more than one or two more questions on this, let's see what the concession is, because that

will affect the follow-up questions tomorrow.

MR FORTUNE: Okay. Dr Steen?

A. That's a document -- I think I developed that.

THE CHAIRMAN: Thank you very much.

A. I was asked to do what was called a patient journey, so I think that's a patient journey or the chronology.

MR FORTUNE: [Inaudible: no microphone] working in the community.

A. Working in the community. Two posts went in 1995: one in south and east Belfast and one in north and west Belfast. Both posts were eight sessions in the community and two in the hospital. They were put in -- new funding with good reason because it was recognised that children with complex chronic disease, when admitted to hospital, were being seen by different doctors for short periods of time and there was no continuity of care. So the main thrust was to give a link from community paediatrics, which deals with the whole gambit of educational medicine, vaccinations, public health, child protection, but also chronic illness and chronic disability. The idea was to give better continuity of care. So Dr Nan Hill went into south and east and I went into north and west in 1995. We had two sessions for acute services, including on call. I moved from my post in April -- I think it was

April 1997. By that time, it been recognised that two sessions could not allow you to do acute on call, that the risks associated -- the fact you were chasing your tail. You were in at 8 o'clock in the morning trying to see patients before you went to the community. You couldn't give continuity of care. You were too dependent on juniors and others following it. That was recognised, so when I moved in 1997, I -- there was a deal done so that the person who replaced me in the community had six sessions in the community and four in the hospital. The other posts, south and east post, was also redefined to give three sessions in the hospital. Other posts going in -- these were all Eastern Board posts -- to the Ulster Hospital gave even more sessions to the community. The college now recognise if you are going to be a community paediatrician and do acute on call, there should be a 50:50 split. So it was very difficult.

THE CHAIRMAN: The college is the Royal College of Paediatricians?

A. And Child Heath.

THE CHAIRMAN: Yes.

A. Their advice now is it's a 50:50 split because it is recognised if you are actually going to give continuity of care to inpatients, you actually need to programme

time to be in the hospital.

THE CHAIRMAN: So the advantage of giving a continuity of care for chronically ill children outside the hospital is clear, but the enthusiasm in 1996 to do this had to be rebalanced --

A. Yes.

THE CHAIRMAN: -- because it adversely affected the continuity of care of the children in the hospital?

A. Of the acutely ill, yes.

THE CHAIRMAN: Thank you.

A. I think Allen Ward's team were particularly affected in that the only consultant who was there for any significant time of the week was Dr Redmond and even on a Friday she was in Downpatrick. Dr Reed was between the nursery and there and the hospital and I think he had only maybe one or two sessions in the hospital -- in Children's. Most of his sessions were in RJMS Nursery. Dr Hill and I were basically in the community. So that Allen Ward team, it was difficult.

THE CHAIRMAN: Thank you very much. There is a third point, Mr Fortune.

MR FORTUNE: I will lead this, if I may.

Sir, you have heard a lot of evidence about the involvement of Dr Webb and his three visits to see Claire during the afternoon. In so far as Dr Steen

herself is concerned, she has already told you -- and she will repeat it, no doubt, that she remained Claire's consultant throughout and, as far as she is concerned, Dr Steen, what does that mean?

A. Well, that means I was responsible for every element of her care and therefore when there's failures in her care, I have to accept responsibility for it. I was guided by Dr Webb for her neurological status, but I was her consultant.

MR FORTUNE: That's the third point and the concession.

THE CHAIRMAN: Thank you very much.

Thank you, doctor. I think, if this is a convenient point, we will leave your evidence for tomorrow morning.

A. Uh-huh.

THE CHAIRMAN: Thank you very much indeed.

A. Thank you.

MR FORTUNE: Can I seek your leave, at an appropriate time, to ask Dr Steen how she is? I do not wish to discuss the evidence, but I do wish to enquire about her state of health.

THE CHAIRMAN: Yes. Thank you very much.

Doctor, thank you for coming this morning.

A. Thank you.

(The witness withdrew)

THE CHAIRMAN: We will take a ten-minute break and we will

then hear from Dr McBride.

(11.30am)

(A short break)

(11.40am)

(Delay in proceedings)

(11.50 am)

THE CHAIRMAN: Okay. Miss Danes?

MS ANYADIKE-DANES: Could I call Dr McBride, please?

DR MICHAEL McBride (called)

Questions from MISS ANYADIKE-DANES

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think it is still just good morning, Dr McBride.

A. Good morning.

Q. Dr McBride, do you have your CV there?

A. I do indeed, yes.

Q. Thank you. Before I come to that, you have made two statements for the inquiry. The series number is 269. The first is dated 14 September 2012. Then you made a second statement dated 9 November 2012, which essentially was to provide substantial documents that you felt might be of assistance to the inquiry; is that correct?

A. Well, it was to answer two specific questions in my first witness statement, it was to provide any e-mails

relevant to this case. So I asked that the Trust carry out an e-mail trawl of any relevant e-mails during that period and that was the product of that trawl.

Q. But your substantive statement is the first one where you deal with the issues?

A. That's absolutely correct, yes.

Q. And subject to anything you say now in your evidence, do you adopt those statements as your evidence?

A. I do adopt those statements, yes.

Q. Thank you very much indeed.

Your CV is to be found at 311-041-001. We can see that from September 2006 until the present day you were and are the chief medical officer for Northern Ireland.

A. That's correct.

Q. There are some very helpful indications in your CV as to essentially the development of matters since that period of time, some of them your own initiatives. I am not going to ask you about those because what we are really dealing with are the matters that concern Claire's case and therefore it's really, so far as your involvement is concerned, when you were the medical director?

A. Okay. Thank you for that clarification.

Q. It's not because those things aren't relevant, they are, but just not to this phase of the investigation, if I can put it that way.

So from that point of view, the page I would like to start on in your CV is 311-041-004. So I'd like to concentrate there. That really says that in 2002 up until September 2006 you were medical director. Can you remember when in 2002 you became medical director?

A. I don't remember precisely. I believe it may well have been in the summer of 2002. Sorry. Maybe I could expand on that a little bit.

Q. Yes.

A. I think it was perhaps in August of 2002.

Q. August? Because I just noticed that the job description for the post -- which we don't need pull up, but it is to be found at 269/1 at page 24 -- and at page 26, which is the concluding page, it gives that as January 2002 and the job specification, which comes immediately after that on page 27, that also has January 2002. Is there anything there that can confirm exactly when you were in post? That you have, I mean.

A. Unfortunately no. Given that you have highlighted the dates on the job descriptions, that would suggest that my -- I mean, again there may well have been -- the job description may be drawn up in advance of my applying for the post. So that may have been the case. I am not clear. I cannot recall the actual date of my interviewing for the post and being successfully

appointed to the post. My recollection is that it was in the July or August of 2002, but I stand to be corrected on that.

Q. Thank you. We might be able to find that in a different way. Under the "key achievements", which we find on that page, 004, I would like to ask you some questions about some of them. If we take the first one, the introduction of integrated governance strategy, can you say exactly when you introduced it and what it would have involved in 2004, say?

A. I think I have covered this in my first witness statement. That's 269/1, I believe, on page 19. If that could be called up or if that would be helpful to the inquiry to look at the information contained within that.

Q. Uh-huh.

A. Essentially, as you are aware, clinical governance and the statutory duty of quality was introduced to Northern Ireland in 2003 and that was following the consultation document "Best practice, best care", which was a public consultation around the introduce of a specific approach ton ensuring the quality of health and social care services with a view to setting explicit standards within organisations, to be accountable for the

implementation of those standards and a mechanism for ensuring compliance of those standards, and particularly with the establishment of the Regulation of Quality Improvement Authority with independent inspection of the quality of health and social care services.

I think on -- if I -- yes. Just prior to -- sorry. Maybe if we could go to the previous page, page 18 of the statement -- I apologise -- and maybe if we had 18 and 19 together. Would that be possible?

Q. Uh-huh.

A. Thank you. Yes. So that basically sets out the evolution of clinical governance and indeed the duty of quality in Northern Ireland from about halfway down page 18 there you can see. Yes, that's highlighted.

Q. Uh-huh.

A. That was similar to the arrangements that were developing in the rest of the United Kingdom. The seminal document I, suppose, that was published was a paper by Sir Liam Donaldson and Gabriel Scally, who described the concept, as it were, of clinical governance, basically making the point that the quality of care that is provided in health and social care organisations has the same corporate priority and should have the same corporate priority as any other aspects that was within the organisational span and control of

hospitals. So this was the start of a journey of implementation.

The department at that time established a clinical governance support team. They appointed a lead governance risk lead to support organisations on that journey to implementing clinical and social care governance. There was of a baseline assessment which all health care organisations, all trusts, were required to carry out in 2002 with a view to going live with clinical governance arrangements, I believe, from early in 2003.

Q. Yes.

A. Sorry?

Q. Sorry. I appreciate some of that and you have been very helpful in the way you have set it out in your witness statement and, to some extent, we have been assisted by the inquiry's experts who have addressed --

A. Oh, sorry. Okay. Apologies.

Q. No, no, no. They have addressed the period prior to that so that we can see the lead into the period you are talking about, so it is helpful.

A. Okay.

Q. What I particularly wanted to know is, under your key achievement, you specifically referred to:

"Introducing an integrated governance strategy."

And I wondered if you had a date for that. I might have missed it in your document, but I wondered if you had a date for when you introduced it.

A. I believe it is in the document. If you look at the second page, page 19, it is 2009, is it not, "integrated governance strategy" -- sorry -- 2006 -- "and associated structures and reporting arrangements". I subsequently in my witness statement, 269/2, page 28, there is an e-mail dated 6 October of 2005. Again, this I suppose highlights the approach that we were taking within the Trust at that time looking at what was evolving in the rest of the United Kingdom in terms of bringing together the various strands of governance. All of those responsibilities that an organisation has in terms of corporate governance, information governance, research governance, clinical and social care governance, and financial governance and control, and bringing those together in an integrated governance strategy aligned to accountability and performance arrangements within the organisation and clear lines of accountability -- with, you know, delegated accountability within the organisation through divisional directors and divisional managers up to the executive team and then accountability to the Trust board. So it was basically local accountability and

responsibility, overarching oversight at a corporate level and then board level accountability --

Q. Yes.

A. -- to the chair and to non-executive directors.

Q. Would I be right in saying, given you have got it there in 2006, that was one of the things you had done towards the end of your tenure?

A. Yes. I think the other thing I would wish to highlight -- probably maybe on the next page, I think, page 20 -- I mean, it's just an example of how we were seeking to ensure -- yes. There we are. Sort of halfway down the paragraph there, a report in March 2006. We were also -- I mean, one of the difficult niece relation to ensuring and assuring assurances within an organisation around the safety and quality of care is the difficulty in developing metrics, measures that can assure ourselves on an ongoing basis as executive directors of an organisation around the quality and safety of care. What we are very good at in the Health Service -- and we were very good at that point in time -- was having a series of process measures, process measures around how long people would wait for certain procedures, how long they would wait for surgery. What we did not have at that time was a systematic evidence-based process by which we could

assure ourselves on an on going basis of whether or not our services were safe, performing to a high level of quality, and moving from that, a situation where when something goes wrong, then you investigate to a situation in a real-time ongoing measures of the quality of care. So what we developed -- sorry.

THE CHAIRMAN: It is one thing to reduce the waiting lists and get people treated more quickly, but the next step is to make sure they are being treated well and the step after that is, if they have not been treated well, to sort out why they were not treated well and trying to ensure this doesn't happen again in a system operated by human beings.

A. Yes. The only qualification I would make, chair, is that I would not suggest that is necessarily a hierarchy of prioritisation. Certainly how long people wait for a particular procedure can and often is a very good marker of quality. Obviously if someone is waiting in pain and distress for a procedure that's required, that's poor quality care.

So process measures, if indeed we are measuring how long people wait for surgery, if that's excessive, then that's a marker of poor quality care. Indeed, I was not, unfortunately, able to find a copy of this report

and I still haven't been able to find a copy of the March 2006 report, but, as I say, I have found a copy, last weekend, of one of the clinical indicator reports which went, on a quarterly basis, to the Trust board. So if that would be of assistance to the inquiry, I am very happy to share that.

MS ANYADIKE-DANES: Yes.

A. Basically these are measures across all areas in the hospital from intensive care, cardiac surgery, Children's Hospital, around measures of quality of care. We agreed these. These were evidence-based. We had benchmarks, which I have alluded to here, with CHKS, which is a comparative health intelligence company, and we used statistical process control charts, which is just a statistical analysis of all mortality across the trust to ensure that when it was benchmarked against similar sized organisations across UK, that our patient mortality was within control limits; in other words, it wasn't excessive. If it was becoming -- if it was going above sort of the two standard deviations, obviously that was an early warning that there's an area of service we needed to look at and we would investigate and seek to establish whether that was -- I mean, I don't want to get terribly technical here -- whether it was common cause variation. In other words, you will

see, in any process, variations over time, or whether or whether that was specific cause variation, which showed we had a problem.

Q. I don't mean to interrupt. You went on to deal with a larger question than I necessarily wanted to deal with.

A. I apologise.

Q. No, no. Although those are larger issue we do consider. You are also dealing, now that I have established it with you, at a slightly later period in time than I was first wanting to establish. I am interested in knowing where we stand from 2002 up to 2004. 2004 is your first contact, if I can put it that way, with Claire's family and what happened in relation to her treatment and its aftermath.

A. Okay.

Q. But if I just ask you out of these -- if you bear in mind that's my priority just at the moment. I am looking to see which of these achievements had been introduced in relation to that time frame. So if I ask you, for example, still on that page 004, you led the introduction of root cause analysis, RCA, to investigate serious adverse incidents, SAIs. The introduction of root cause analysis, had that happened at a period between 2002 and 2004?

A. We introduced that from memory, and again, as I have reflected in my statement, towards the end of 2003 is my recollection.

Q. Thank you.

A. It is difficult to be more precise about it than that.

Q. Then if I ask you. The review of -- I am going over the page, 005. There was a review of clinical audit and introduction of standard and guidelines. If we deal with clinical audit, is that something that had been undertaken between 2002 and 2004?

A. Again, I find difficult to answer precisely on that in terms of timescales or dates. Apologies for that. I think I suspect that it certainly was in the period between 2002 and 2006. I am sorry I can't be more specific than that.

Q. That's fine.

THE CHAIRMAN: These would inevitably have been evolving during this time with drafts and pilots and so on.

A. Yes. I have no doubt that there would be. I mean, what we established or what I established was -- again, apologies for the passage of term -- I am struggling to recall the term -- I think it was a clinical effectiveness and guidelines unit. Obviously, I was leading on this, but I was leading on it on behalf of the Trust. What we were seeking to do it was,

I suppose, develop audit from where its origins were, which was -- and I exaggerate to make the point, so I hope you'll allow me some licence do so -- where audit was seen as something which doctors and nurses do in terms of ensuring that they are assessing their care against extant standards and those would be standards often that come from Royal Colleges around appropriate treatment. What we were attempting to do was actually take clinical audit with guidance which had been issued from a range of bodies, including the department, and ensuring that we systematically used that information to assure ourselves as an organisation that we were doing the things that needed to be done and we were doing those in the right ways. So we had a much more -- a view to having a targeted programme of clinical audit. So at the -- I have mentioned earlier in my witness statement of 269/1, we had mid-year and end-of-year accountability reviews with all of the directorates, and again that would have been in the period, certainly at least from my memory, from 2002 through to 2006.

MS ANYADIKE-DANES: Uh-huh.

A. The clinical information, clinical indicator reports we referred to would have been used within those accountability reviews chaired by the Chief Executive so that the Chief Executive was assured around the quality

of services and a range of other organisational corporate objectives within the business plan and indeed, during those accountability reviews, each of those divisions -- whether that was women and children's or whether it was medicine -- would have also been required to produce a record of their audit ability at this time and indeed were required to link their audit activity to their divisional risk register in terms of the risks to either non-achievement of particular priorities or indeed risks in relation to some of the services that they were providing.

So it was basically using, taking -- I suppose if I could summarise -- taking audit from the realms of the medical profession and saying, "Yes, it is the realms of the medical profession in terms of ensuring ourselves, as doctors, about the quality of the care that we are providing", and basically ensuring that we were utilising this as an organisational tool to provide assurance within the organisation.

Q. You have just explained something I was going to ask you.

In relation to all your initiatives or the key achievements that you introduced, I presume that if you are introducing an initiative like that, you are putting in place a system to audit, monitor, evaluate those

initiatives and then report back as to how they need to be, in any way, altered or improved in response to the information you are getting. So I understand that you had a clinical audit process, but did you audit your initiatives, if I can put it that way, and if you did, is there the evidence of that in reports or minutes or something of that sort?

A. Obviously I think one of the difficulties -- and I apologise for this in terms of preparation of my statements -- was the difficulty in getting information and particularly records --

Q. Uh-huh.

A. -- which would remind me of sort of the development of some of these areas. So I would have no doubt that if indeed those minutes are available or those notes of meetings that it would demonstrate the evolution of those processes. As I say, I have found some records which may be of interest in relation to one particular division around their accountability review --

Q. Yes.

A. -- and their audit, which I am very happy to make available to the inquiry.

Q. I think that would be helpful, Dr McBride. This is not just a trail of how you developed a particular initiative, with which I think you have helped, and

there would be drafts and revisions and so on and so forth. What I was asking you -- and I think you have now just answered it -- was that you would put in place systems to audit, monitor, evaluate the actual process of implementation of those initiatives?

A. Well, absolutely. Again, that was the culture of the organisation. The culture of the organisation was, as indeed consistent with the department's policy, was there are clear standards. Those standards need to be implemented. There's accountability to the Chief Executive and members of the board of that organisation, myself included, are included for the implementation of those.

Q. Thank you.

If I can now take you to your job description, which is to be found at 269/1, page 24 it starts, and if we could perhaps pull up page 25 alongside that. The first -- it is quite small, but I think we can all read it.

The first is your accountability. You were accountable to the Chief Executive and, in fact, later on in your witness statement you talk about the meetings you would have with the Chief Executive and sometimes the chairman of the board.

A. Yes.

Q. And we will come to specific areas where I would like to ask whether that subject constituted a report to either of those, but anyway that's your reporting line. It seems from the job description you really were either coming in to introduce change or you were coming in to manage it and further it, if I can put it that way; would that be fair?

A. I think it was both.

Q. Yes.

A. I think again, as I have explained -- I have attempted to outline the development of clinical governance across the UK, in Northern Ireland and the Royal. I think my predecessor had certainly been at the forefront of developing clinical and social care governance in the Trust. Certainly, I think we were recognised as an organisation at that time as being at the forefront of that. I think that we were committed to continuing to do that because it was the right thing to do. We were very conscious of our duties and our responsibilities and our accountability for the services that we provided.

Q. Yes. Leaving aside the first two things, which are to assist in the formulation of policies and strategies and so forth, and providing effective leadership in all areas relating to clinical governance, I wonder if you

can help me on the second page under item 9. You were required to work with the director of nursing -- and that would have been Miss Duffin at that time.

A. No, that would have been Miss Deidre O'Brian.

Q. Sorry. I beg your pardon -- and the clinical director to ensure all aspects of clinical governance are embraced by management and membership of the clinical directorates. What sort of level of contact was required to achieve that between you and the director of nursing and the clinical directors?

A. Sure. Obviously with the passage of time I can't recall the exact names of various meetings or indeed the frequency of those. Certainly --

Q. Let me help in this way. For example: would you have had monthly meetings?

A. We would have regular meetings. If I could develop that? Certainly as an executive team, we would meet at 8.30 on a Monday morning, informal meeting, is my recollection. That wasn't a minuted meeting, it was a -- We would have discussed the week ahead and the week that was and any emergent issues. We would have --

Q. Sorry. Pausing there. You said "any emerging issues". What are the sorts of things you would expect them to be bringing to you or you would be wanting to discuss with

them?

A. Well, it was an opportunity basically not to have any formal discussion about any matters but basically to have an opportunity in a room to say, "Actually, I need talk to you about something. Can we arrange a time?". That was the format. It was not a formal briefing. It was basically a meeting of the Medical Director, Chief Executive, director of nursing, director of HR, the divisional directors, as they were, and the directorate managers and it lasted probably no more than 30 minutes. So it was a very short meeting. As I recall, that was on a Monday morning, but again I may be remiss in that.

Q. But out of that, you might develop meetings to discuss in more detail somethings that had arisen?

A. Yes, and that was the purpose of it.

Q. So it was a scheduling meeting in some respects.

A. No. It could be used for that and sometimes was. There were regular meetings of the executive team. Again, my apologies. I can't recall how frequent those meetings were, but those would be the executive directors within the organisation and also attended by the divisional directors. I should add that the clinical directors, as is mentioned here, those organisational arrangements, evolved and clinical directors remained, but over and above that, there was a tier of divisional directors.

I can't recall exactly when that divisional structure was put in place. The divisional directors and clinical directors remained accountable to the Chief Executive and the clinical directors were professionally accountable through to the divisional director and there was a line of professional accountability through to me. There was also then regular meetings obviously of the Trust board and again the frequency of those --

Q. I will come to that slightly later on.

A. Okay.

Q. Under that paragraph, you have a meeting with the associate medical director or at least you assist -- with the associate medical director, you are ensuring a proper system of clinical audit for assessing and reviewing the quality of services provided.

Is that the same sort of contact that you were just helping us with in relation to the associate medical director?

A. Yes. I mean, it would have been. Again, obviously with the passage of time, I am sorry. I can't provide any more detail of that.

Q. No, no. I am just --

A. That would be the nature of that work and also to ensure that guidelines were implemented effectively across the Trust --

Q. Yes.

A. -- clinical guidelines.

Q. One of the things you also do with the associate medical director -- was that Mr Walby at the time?

A. No. That specific -- sorry. The reference -- is this the reference at 12 or the reference 14?

Q. Well, I am actually going deal with the reference at 12 at the moment.

A. Okay. The reference at 12 was Mr Walby, yes.

Q. What I want to ask you then is: with him, you are providing claims investigation and management service for claims of a clinical nature and so forth and to assist the coroner. What was your role in assisting coroner?

A. I had very little contact with the coroner. I mean, the nature of my responsibilities were such -- as you can see from the job description, they were quite wide-ranging and obviously the hospital was a large and complex organisation. So there was a system of delegated, I suppose, accountability within the organisation. Mr Walby was accountable to the Chief Executive in relation to his responsibilities. There was a line of professional accountability to myself in that he was my associate Medical Director.

Q. Sorry. What I am actually --

A. But I would not have been involved, you know, directly or on a day-to-day basis in relation to matters pertaining to the coroner.
Q. Did you have any responsibility at all is what I am trying to get at because the way it is framed suggests you might because you are doing something in connection with Mr Walby. I am just trying to find out what your particular role was.
A. Again, just to go back on that, I am not saying I didn't have responsibilities in that area. That's not the point I was making. I am basically saying the associate medical director had lead responsibility in that. He is accountable to the Chief Executive for the execution of those responsibilities. There was a line of professional accountability to myself. I certainly would have had an oversight of those arrangements. I think that is the point I am making --
Q. I understand.

A. -- although there was no line management accountability.
Q. But you would be expecting him to keep you in the loop, if I can put it that way?
A. Absolutely.
Q. Yes.
A. And he did.

Q. Thank you. I was not suggesting he didn't. It is just your expectations.
Then if we look at 19, one of your roles is:
"Liaising with key doctors outside the Royal, including the CMO."
Did you have regular meetings with the CMO or were these just as matters arose that you wanted to bring to her attention?
A. Again my recollection is that there were regular scheduled meetings with the chief medical officer. Indeed it was her -- Dr Campbell at that time -- given her other wider responsibilities at a regional and indeed national level, at occasions those meetings would be chaired by a deputy, but certainly those were regular meetings. Again, I can't recall the frequency of those.
Q. Then if we pull up an organisational structure that we had to sort of guide us for 1995/1996, it is 303-043-510. If we can just enlarge that a bit. You can see the basic structure of it and where the medical director sat, who was then Ian Carson. You see the director of finance, director of nursing and medical director and so forth. You can see corporate affairs is over that side and you can see the chief executive, Mr McKee, and the chairman.
Were there material difference between that

structure and when you came on board in 2002?
A. Again, I don't have the organisational structure in front of me for comparison.
Q. I understand.
A. And I have not seen this before. So --
Q. I don't want to put you in a difficult position. I am content that you can reflect on that at some other stage and maybe we can get some assistance as to what was the structure for 2004.
A. I mean, if the answer -- if the question is around accountability lines --
Q. Yes.
A. -- accountability lines, and I am not certain whether this is seeking to represent accountability lines and reporting lines, but certainly the -- and I think it demonstrates, as I mentioned earlier, the accountability of executive directors to the Chief Executive of the Trust and indeed executive directors and the Chief Executive's accountability to the Chairman and the board, which was comprised of the non-executive directors and the executive directors. So that overall structure is correct. It would be the same in those accountabilities.
In terms of the structure below that, in the blue boxes, that changes and evolves over time and certainly

was not the structure and certainly wasn't the structure at the time I left the organisation and the names, clearly, were different.
Q. Of course. Can I ask you this, though: you had liaison with corporate affairs/corporate communication when you were medical director at the Trust.
A. That's correct, yes.
Q. And what sorts of issues did you liaise on?
A. It would have been a range of issues, particularly, for instance, if -- I think the corporate affairs -- from memory, again, this is -- had a wide range of responsibilities. It wasn't just in relation to media and the media side of things. It was also in relation to matters which involved engagement with the public, whether that was in relation to a consultation on a proposed reconfiguration of service, which obviously I would contribute to and be involved in. So developing, for instance, a plan for the provision of perhaps surgery or a different model of providing surgery and engaging with the local community in that discussion. It might also -- their responsibilities would extend into, you know, engaging with the media in relation to, for instance, outbreaks of infections that might occur --
Q. Yes.

A. -- significant events that may have occurred. And clearly, as the medical director -- and clearly this was an established pattern -- sorry -- an established practice -- that often when matters of that nature arise and are a cause for public concern, then the medical director, you know, has a key role in explaining both what has happened, why it has happened and providing appropriate reassurance and reassurance on the action that has been taken.

Q. Thank you. I wonder if I could bring you back to item 20 in your job description? That's 269/1 at page 26. There we are. Thank you. You can see:

"Taking responsibility for some aspects of the public image of the Royal hospitals, dealing with media and the local community particularly where clinical matters are to the fore."

If we just leave aside the local community for the moment. If you can help us with what are the aspects of the public image of the Royal hospitals in relation to the media that would bring you to be involved -- obviously they are going to be clinical -- and how early would you expect to be brought into something that's going to hit the media in relation to clinical issues?

A. I am not certain I would interpret that as you have. I think "public image" is much wider and much broader

a term, I would suggest, than "interaction with the media". I mean, the media is but one aspect of it.

Q. Yes, but that's the aspect I want your help on.

A. Well, as I was explaining, later, my responsibilities were in relation to some of the wider aspects. I would often be brought into matters if indeed there was a matter, I suppose, pertaining to a clinical issue that had arisen, and I would be asked to perhaps engage with the media in relation to explaining, as I said earlier, what had actually happened or what we understood had happened, why we understood that had happened and actually what it was, as an organisation, that we were going to do to put that right. So that was certainly a frequent requirement.

For instance, if I think back, just as you asked, one of those was around endoscopy. As you know, there was a significant problem identified in relation to the decontamination of endoscopes. That obviously caused It is one of those systems issues which had arisen, very complicated origins of the problems, and I won't go into the detail, but clearly we had a large number, thousands of patients who were concerned and anxious about the risk -- or any risk -- of blood-borne viral infections. We set up a helpline. We brought people back for clinics and, indeed, during

that period clearly there was a lot of engagement with the media both in terms of seeking to explain what happened, why it happened, and ensuring that we were communicating what we were doing to put that right. So that would be the nature of the sorts of incidents.

Q. Perhaps if I take -- when you said, probably rightly, that I had taken a rather narrow view of the public image ... Well, let's take something that might, depending on when you actually came into your post, but it would have happened either at that time or just before it, which is the introduction of the hyponatraemia guidelines. They were issued in March 2002 by the CMO. Do you recall when you came into post what role you played in ensuring that those guidelines were complied with, implemented, the appropriate education was provided and that you had some way of auditing the extent to which they were being complied with? Would you have been instrumental in any of that?

A. I can't recall the details from that time, but again from memory -- and again I stand to be corrected on this -- my under -- my recollection, as I said earlier, was that I took up post in the July or August of 2002. Again, I acknowledge the date of the job description which you drew to my attention. What I do recall is that communication from the department some time in

2003, I believe, seeking assurances.

Q. Yes.

A. It might have been earlier, it might have been 2002, I can't recall, but some time in that period between 2002 and 2003 after the publication of the guidance --

Q. Yes.

A. -- and their dissemination, seeking assurances from the trust around their full implementation.

Q. Yes.

A. As I recall, that correspondence obviously would have gone to the Chief Executive and indeed I probably would have been tasked with seeking those assurances from the various areas of the hospital that were relevant.

Q. Well, would you have been tasked with the role of putting in place some sort of system whereby you could audit their compliance with them or monitor their compliance, evaluate how well the education around them was working, where they were cited, and so on and so forth, all with a view to ensure that you could -- not you personally -- but the Trust could, when required by the CMO, give some confirmation that what she had wanted to happen in relation to those guidelines, was, in fact, happening? Would that have fallen to you to put those systems in place?

A. It certainly would have fallen to me on behalf of the --

probably on behalf of the Chief Executive to ensure we got those assurances from the hospitals where those guidelines were relevant. I personally would have not at that time -- again, I can't recall the detail of this, but I would not, at that time, have walked into individual units to ensure that the wallcharts, et cetera, were being prominently displayed. I would have sought an assurance from the relevant clinical director or divisional director that the guidelines had been implemented at that time.

Q. It is the system I am asking you about.

A. Sorry?

Q. It is the system I am asking you about. I don't suggest you had the time or it was appropriate that you wandered around to see where the posters were stuck. Was it part of your role to set in place --

THE CHAIRMAN: I think that's what Dr McBride was saying.

It was your job to get the assurances from each relevant director or unit, which you could relay to the Chief Executive, so that the department could be reassured that the guidelines were being followed.

A. I think that's the point I was trying to make. It is not to diminish the fact that it is important that someone is walking around and ensuring -- the inference being that that isn't important. That is important. It

is important that someone is walking around and actually checking add ascertaining that the guidance is in place and it is displayed prominently and people are following it.

My responsibilities, given the delegated system of accountability, which I described earlier when we were going through my job description, and indeed the development of integrated governance, it would have been in that delegated system a responsibility to seek those assurances and provide those assurances to the Chief Executive then and basically to the Trust for onward communication to the department.

Q. I understand that. What I was wanting you to help me with was whether, apart from routinely asking the appropriate people to whom ultimately devolved the responsibility, whether these things were now in place, were people complying with them, what was the incidence of people not complying, what were you doing about it? And apart from asking them in that way, was there some more formalised system -- when you were talking about the introduction of your clinical audit and so forth, did you have a more formalised system for being able to actually keep track of what was going on and what the rate of complaints was?

A. I can't recall back that far in terms of the exact details of that, but certainly, if indeed I was seeking assurance on behalf of the Chief Executive to provide that assurance to the department, in that delegated system of accountability, there would be a requirement and obligation on those from whom that assurance was being sought to ensure those arrangements were in place. Again I can't recall the exact timeline, but I know that there were audits of implementation of those guidelines. I can't recall -- and again I would be incorrect were I to expand on that any further because I can't recall any detail. There were certainly external audits of compliance.

Q. You're quite right, the RQIA audited that.

A. Yes, at that time, as I recall.

Q. The first time they did that was in 2008. That was their summary validation report. Then they had another report in 2010. What I was trying to see was whether, internally, you set up a system, but I think you have taken us as far as you can from your recollection.

So if we go back to the media issue. As you know, in 2004 UTV aired the programme or documentary "When Hospitals Kill". When did you first know UTV was going to air a programme like that and how did you know that?

A. I believe I first became aware, from memory, the day

before the programme was due to broadcast. So I think -- from recollection, I believe the -- just reading from the details here, the programme broadcast on the 22nd. I believe I was made aware of the fact that the programme was going broadcast on the 21st, which was the day before. I was brought up to speed that there had been an exchange of correspondence at that time, I think, between the Trust and UTV in relation to the planned broadcast.

Q. Yes. I might have framed the question badly. I don't mean: when did you know that's when the programme was going to go out. When did you know there was going to be a programme like that?

A. As I say, as I answered earlier, the day before the programme was broadcast.

Q. Well, you said that Mr Walby would keep you in the loop and he did keep you in the loop of the very first fax that we have found in the papers provided to us or the first document, as I can see it, that relates to the UTV programme. It is 141-034-001 and it's a fax which is from the corporate communications, Christine Stewart, to Mr Walby. You can see it is dated 26th May. What's happening there is they are concerned about a television journalists who is apparently making a bit of a pain of himself in relation to and it says, "This Lucy Crawford

case", which certainly gives the impression it is not something new. They are aware of what the Lucy Crawford case is and that's what they are being pressed for information about. But he didn't bring that to your attention, that they were making a documentary?

A. I have no recollection of that being brought to my attention. I mean, I stand to be corrected on that, but my recollection is the first time I became aware of the documentary was the evening before it was broadcast.

Q. Then there's a bit more. It goes on on 24 September and that's at 141-032-001. This is also from corporate communications for Mr Walby's information. She has been getting enquiries from the press about Lucy Crawford. UTV may be doing a programme and she wants the coroner's final verdict. This doesn't jog your memory at all?

A. No. I mean -- I honestly don't recall being made aware of that. I may be mistake in my recollection, but I honestly have no recollection of that.

Q. Well, then in October matters get to a stage on 7th October when Brangam Bagnall provide a letter. It is 141-028-001, and Brangam Bagnall at that stage were the lawyers acting for the Trust and they are concerned about the way the programme might be going to portray the Royal Group of Hospitals:

"On the basis of the information which is contained

within the e-mail, I refer particularly to the following statement:

"'I have to point out that in the forthcoming programme, we will be relying on documentary evidence including statements made under oath which clearly proves that the Royal did mislead the coroner'.

"My clients trenchantly denies that."

The solicitor is seeking a retraction, otherwise they will consider their options. That's quite a serious stage to be reached because what's being suggested was the Royal was involved in a cover-up. That was not brought to your attention either?

A. I have honestly no recollection of that being brought to my attention at that time.

Q. Then the response to that, 12th October 2004, reference 141-029-001: they don't accept their journalist has acted in any unreasonable fashion. This is back from the UTV solicitors:

"The matter under investigation in the proposed Insight programme is of the highest public interest. Prior to transmission, an offer is again given to the Royal to put forward any possible explanation for the failure to tell the coroner in April 2000 that Lucy Crawford had died from dilutional hyponatraemia. Any explanation would inform the programme makers."

Going back to that part in your job description which clearly refers to your interaction -- just give me one moment. It is item 20:

"Taking responsibility for some aspects of the public image of the Royal Hospitals, dealing with the media and local community, particularly where community matters are to the fore."

That would seem to tick that box, the exchange between the solicitors; would you not agree?

A. Certainly there are clinical issues there, yes.

Q. Well, not only that --

A. And significant clinical issues at that.

Q. Sorry?

A. Significant clinical issues at that time.

Q. Yes, a very serious allegation is being made against the royal that it misled the coroner. The solicitors, on behalf of UTV, are referring to that as the highest public interest and that's what they propose to include in that documentary, but you don't recall knowing about that?

A. No. Again, as I have stated earlier, I have absolutely no recollection of that communication or that series of communications or engagement with the Trust. Again my recollection, as I stated earlier, was that it was immediately prior to the broadcasting of the programme.

Q. Well, if that's the case, would you not have wanted to have known about something like that earlier?

A. Again, I suspect that -- I mean, certainly it is a matter I suppose with -- I mean, looking at the series and trail of communication, I think certainly it is a matter which I would have wished to have been aware of, yes.

Q. And if you had been aware of it, what would you have been seeking to do?

A. I think it's very difficult at this point to look back to that time and determine what I may have done. I think certainly I would have wanted to know certainly the details of the particular case or cases that were concerned.

Q. Yes.

A. I would certainly want to know what the nature of the concerns were. I suppose my primary consideration on this would be that the nature of the impact that such a documentary would have in relation to wider public concern, you know, getting back to my --

Q. Exactly?

A. -- the role as in my job description, and particularly as it related to public confidence in the service that was provided. Certainly that would be me --

THE CHAIRMAN: Would you, as the medical director, not be

called up to front the Royal's response?
A. I think it is very likely that would be the case.
Q. From the documentary, when it was transmitted, it showed one of the doctors in the Royal being doorstepped in the car park.
A. It did.
Q. It is strange this news never reached you prior to the day before it was broadcast because I am presuming that that doorstepping of the doctor in the car pack did not take place the day before it was broadcast; it is likely it was done before then.
A. I accept that and accept the points you are making. I certainly do not recall being advised or informed of this prior to ...
THE CHAIRMAN: Then when you did find out on the day before the programme that the programme was about to go out, do you recall being told any of this background that there had been these exchanges going on for the last couple of months and, "We have a doctor who has been doorstepped in the car park because apparently requests for interviews were not responded to"?
A. I don't recall that level of detail in the discussion. I do recall a discussion and I was certainly briefed on the day before the broadcast of the broad details of the broadcast and the nature of the allegations that would

be made. I believe at that time I did inform the department of that from memory. The programme was being broadcast at that stage and certainly there was, I suppose, little opportunity for me to intervene to do anything at that point. Again, that is my recollection of the sequence of events and the timings.
MS ANYADIKE-DANES: That's the point, isn't it, Dr McBride, why you would have wanted to know beforehand, because you have just explained that if you had known beforehand, you would have made some investigations. You would have tried to find out what the background is, what the nature of those cases are and why an allegation like that is going to form part of programme.
I can pull you up another document. I wonder if it would help. It slightly predates when you said you were first alerted to it. It is 023-045-105. I don't know why that's not coming up: shall we try that again. 023-045-105. No? Okay.
Well, I will have to tell you what it is. It's an e-mail dated 20th September 2004. It's from Christine Stewart, who you have already seen her fax in relation to corporate communications. It is going to Colm Shannon at the department; okay?
A. Uh-huh.
Q. What it says is --

THE CHAIRMAN: He is in the press office?
MS ANYADIKE-DANES: Yes, he is in the press office. Thank you, Mr Chairman. So it is one press officer to another, essentially. 20 September 2004. What it says is:
"I have just spoken with Dr Bob Taylor, consultant anaesthetist in PICU, who was involved in the management of Adam Strain and gave evidence at the inquest."
Okay?:
"Following a detailed examination of the issues surrounding patient AS [Adam Strain], there were no new learning points and therefore no need to disseminate any information."
I am sorry that you are having to hear it from me and we don't have it up to look at.
THE CHAIRMAN: We will see if we can get a hard copy for up.
MS ANYADIKE-DANES: Here we are. (Handed). Just because nobody else has it, for the benefit of everybody else, while you are doing that, I will just read the third and final paragraph:
"Our hospital has an established structure for the teaching of the management of fluids to doctors in training. However, should those doctors continue in the treatment of children when they leave the Royal, it is their responsibility to stay up-to-date in current

management techniques. I hope this is helpful."
So that's the e-mail going?
A. Yes.
Q. What seems to have happened is, although we don't know, is that the department obviously wanted some information in relation to the Adam Strain case. Christine Stewart at the Royal is providing that information, having spoken to Bob Taylor.
What I wanted to ask you is: had you known that the programme was going out and was going deal with three children, all of whom ultimately died at the Royal, and one suggestion in this case is that there was -- this case being Adam -- that there was a cover-up in terms of -- rather that the coroner had been misled, would you not have wanted to put in place some means of finding out exactly what happened and would you not have wanted to know who was going to be the source of that information as opposed to leaving it to a press officer to go and find out for herself what happened?
A. Certainly, I mean, as medical director, I would have wished to have been aware of this.
Q. Yes.
A. Certainly. I was not involved in any of those discussions. I certainly don't appear to be copied into this e-mail.

Q. No, no.
A. I wasn't aware of that. I have no doubt that others within the organisation obviously may have been aware and were engaged and seeking to engage clearly with the producers. Certainly that -- to my recollection and to the best of my recollection, that was not drawn to my attention.
Q. I understand, but would you not have expected there to have been some sort of discussion about, "Well, if this programme is going to go out about these three children, let's find out exactly what happened so we can prepare ourselves. We know where we might be vulnerable and where we should be making concessions or where we consider we acted appropriately"? Some structure for fact finding, at the very least, should have been established, would you not think?
A. Certainly I think -- I wouldn't quite put it in those terms, in terms of establishing whether we were vulnerable and where we give concessions. I think the primary priority here is in relation to -- certainly from my perspective, would be the wider public concern that there would be in relation to the safety of services within the Children's Hospital. The fact that there were, you know, children currently in the Children's Hospital receiving fluids, children about to

come into hospital for surgery, that would have been my primary consideration.
Q. So if I take you on that point, so what you would presumably want to know is what happened? Why were lessons, if that is the case, not learned, and how have we improved from that period, because you have cases that span 1995, 2000 and 2001 in those three with Adam, Lucy and Raychel. So why I'm asking you about this is what has happened is that the press officer has gone to ask the very person in the Adam Strain case who actually did not, until sometime this year, accept the coroner's verdict. So if you were looking for an independent view as to exactly what happened and how it came to be that there may not have been the appropriate lessons learned, that may not have been the most reliable source to go to.
A. I am not sure what to comment on as a question.
Q. The question is: should you -- not necessarily you; if it is not brought to your attention, you can't be involved in it -- but should there not have been some way of the Trust establishing for itself what happened at the very least?
A. I think certainly that would be a reasonable course of action I would suggest, yes.
THE CHAIRMAN: Perhaps a more fundamental point: how would

Christine Stewart knows to go to Dr Bob Taylor?
A. I can't answer that. I don't know.

THE CHAIRMAN: If she did that, she must have been getting a clear direction from somebody who -- either she has looked into who treated Adam and found Dr Taylor's referred to, or she's been given some steer from inside the Royal, which is entirely legitimate for her to be given that steer, which leads her to Dr Taylor, but it doesn't lead her to others who took a different view about whether anything should be learned. Those other people are within the Royal.
A. I think that would be a logical conclusion. I think it would be unfair to, as you say, Christine Stewart in her capacity as a press officer -- one would surmise she was acting on a source of advice she had received in terms of where to seek that information.
THE CHAIRMAN: Yes.
A. Absolutely, and indeed in terms of the information that was being conveyed, clearly Christine Stewart was not in a position to comment on the accuracy or otherwise of that.
MS ANYADIKE-DANES: But that's why somebody needs to establish how we are going to go about finding the information. The other point that it raises -- this is

the information she receives, that there was a detailed examination of the issues surrounding that patient and there were no new learning points and therefore no need to disseminate any information.
Following on from the point that the chairman put to you, that actually wasn't the view of Dr Murnaghan. Dr Murnaghan thought there were things to be done. Not only did he think that, but what he intended to do was to establish a seminar afterwards where you would bring together the likes of Dr Taylor, Dr Hicks and so forth, and they would have a seminar and they would extract actually the learning points to disseminate. For various reasons, that didn't actually happen, but that was his intention. So the information that Christine Stewart is being given to pass on to the department may be seriously flawed, but what I'm seeking from you is the system or the structure that the Trust would have put in place to ensure that it identified the appropriate information and passed that on to the department.
A. I honestly can't answer that. As I said, I wasn't, to the best my recollection, involved in those discussions at that time. My earliest recollection of being aware that the programme was being broadcast was, I believe, on the day before the broadcast. I have no recollection

of being briefed or consulted prior to that date, but, I mean, I stand to be corrected on that, but I honestly have no recollection.

Q. If that's the case, is that not some sort of failing in the Trust that they didn't alert you, the very person who might have assisted in ensuring that the information was appropriately gathered and passed on, that you weren't alerted until it was really too late to have much say in?

A. Certainly in retrospect I would have wished to have been involved earlier, yes.

Q. I think you are right about the -- certainly Mr Walby seems to have spoken to you on the 20th and you see that from 141-026-001.

A. Sorry. I can't see anything.

Q. It is going to come up. I hope so?

A. Okay.

Q. This is endorsed on the bottom of an earlier e-mail, which is from Jo McGinley, but you can see down at the bottom in Dr Walby's hand:

"20th October. Spoke to McBride."

Is that what you were referring to, the time you were first alerted to the programme?

A. Yes.

Q. Can you remember what he told you?

A. Yes. As -- again, I can't recall the exact details of the meeting, but my recollection is that the meeting took place in my office. I believe that Peter Walby was present. I believe that there may have been someone from the press office. I am not certain whether or not there were representatives from the Trust solicitors at that time, but I certainly was briefed in relation to -- I don't know if it was on that date or, as I say, the immediate run-up to the programme, but I was certainly briefed in relation to the three cases.

Q. You are quite right. We will come to briefing. There was an e-mail. I think it is to be found at 269/2 at page 65. Yes. If you come to the one from Jo McGinley, dated 20 October, and you are Ccd in it. So is Peter Crean, Bob Taylor, Donncha Hanrahan and Heather Steen. It tells you:

"The programme is due to go out tomorrow night at 9.00 pm".

And so on. Then you CC that on to Mr Walby the next day. What can you recall of what Mr Walby told you or what you were told during that briefing session?

A. As I believe -- again, as I recall that, I was

advised -- I provided a short summary of the cases that -- of the names of the children that were likely to be mentioned in the programme and I was advised, I believe, in relation to the engagement that there had been with UTV in relation to the broadcast and I was made aware, as I recall, of the nature of the allegations that were being made.

Q. So you knew what the issues were?

A. In so far as the information was relayed to me at that time. I mean, it would be, I think, unfair to say that I had a broad grasp of the detail, but certainly I was made aware the programme was being broadcast, it was in relation to a number of deaths that had occurred and previous inquests and I was made aware that there were allegations going to be made in relation to the Trust misleading the coroner.

Q. Thank you.

A. From memory.

MS ANYADIKE-DANES: Mr Chairman, I am about to go on to a slightly different ...

THE CHAIRMAN: Let me just ask you before we leave that point: although the documentary was broadcast in 2004, doctor, it featured significantly Adam's death in 1995, Lucy's death in 2000 and Raychel's in 2001 and there was particular focus on the fact that it was only after

Raychel's inquest that more facts had emerged about Lucy's death a year earlier, and that led to Lucy's death being referred to the coroner out of sequence, if you remember that. I am just wondering because that did involve -- Adam was only treated in the Royal and he died there, but Lucy and Raychel came into the Royal, one from the Erne and one from Altnagelvin, and both eventually died in the Royal. By the time they each reached the Royal, their position was beyond saving.

Do you remember being aware of any of the issues, in particular, about Lucy in 2001, 2002?

A. I have to say I don't. Again I think the first occasion that I became aware of some of the details, and again I was at that meeting. I had an update in relation to the UTV documentary. I don't recall any of the details -- being previously aware of the details up until that point. That's my recollection.

THE CHAIRMAN: Okay. Thank you. We are going to break for lunch. Do you mind if we cut it to 45 minutes; is that a problem? Is that okay? So we will come back at 1.45. Thank you.

(1.00 pm)

(The short adjournment)

(1.45 pm)

MS ANYADIKE-DANES: Good afternoon.

A. Good afternoon.
Q. I had been asking you about that e-mail and what you might have wanted or would have perhaps even expected to see in place if the Royal was going to prepare itself for understanding the issues that were likely to be aired in that programme.
You did then know from the e-mail I put to you right towards the end that it was actually going to go out on the 21st and what time it was going to go out.
A. Yes.
Q. Did you watch it then?
A. Again I just refer back to my witness statement. I believe I did watch it that evening. Again, certainly to the best of my recollection yes.
Q. I presume you would have wanted to.
A. Certainly given that I was aware it was going out and given the nature of the concerns that were being raised in the documentary, absolutely. So that's why I'm certain -- almost certain I watched it that evening. I would be surprised if I didn't.
Q. I understand that. When you watched it or ultimately realised what was in it, if I can put it that way, what was your immediate reaction to what ought to be happening as a result of it?
A. I suppose it's very difficult, given the time that has

elapsed, to remember what exactly was going through my head at that time. I suppose there were a couple of issues which I believe immediately occurred to me. One was the one I mentioned earlier in relation -- firstly, I did watch the documentary. I remember certainly the impact of particularly the interview with one of the mothers of the children that had died, which I think was particularly poignant and obviously -- so that registered with me. I was certainly concerned in relation to the nature of the allegations that were being read in the documentary and, as I mentioned earlier in evidence, I was concerned what the potential impact of those allegations might be by way of public confidence in the services that we were providing and, indeed, the integrity of those that were providing those services.
Q. Yes.
A. I must say at the time I recall being somewhat incredulous around the scale of the allegations that were being made. I certainly do remember being -- that I was very concerned. I think that's ...
Q. Yes. What steps did you want to take as a result of it? I presume you thought that something ought to be done. At the very least, finding out better what had happened and perhaps addressing that issue of public trust and

confidence.
A. I honestly, thinking back now, don't recall the exact detail of the discussions that occurred at that time. There were certainly discussions I recall at the -- there was certainly a briefing to the Trust board in relation to the documentary. In relation -- in its aftermath. I don't know how soon that meeting was following the broadcasting of the documentary and the Chief Executive at that time briefed the board around the documentary and the nature of the allegations that had been raised.
Q. Well, did you at least want to get hold of the records in relation to those three children at the very least and see exactly what they disclosed as to what had happened and what lessons should have been learned that may not have been learned?
A. I don't believe I did that at that time. I can't recall doing that. I don't remember exactly the timescales. I am sure you have the details, perhaps, there, but I do recall certainly being aware that very shortly after the broadcasting of the programme we were aware of ongoing police investigations following the allegations that had been made. I recall I was aware that a number of members of the medical staff in the Children's Hospital had been interviewed by the police, as I recall, and

I remember that shortly thereafter -- again I don't remember the timescales -- that there was an announcement of this public inquiry, but again I don't recall that period of time, whether that was -- and I am sure you probably have those details.
Q. What I am trying to say is why isn't it a natural thing do to say, "Let's get hold of the medical notes and records. There is an allegation, not put too fine a point on it, that all these children died of a condition called hyponatraemia, which seems to have passed by unrecognised in our hospital. Either it was something that happened in our hospital or that process had already started before they came to the hospital and they died there, but there is some learning that seems not to have carried forward"?
THE CHAIRMAN: Sorry. By the time of the documentary, this was a matter of awareness because the hyponatraemia guidelines been published. So it can't be that you didn't know that -- it can't be -- you must have been aware of hyponatraemia. Whatever you recall specifically about the guidelines coming out, you would inevitably have been aware, I take it, they were out.
A. Yes.
THE CHAIRMAN: And hyponatraemia had emerged, as an issue, much prominently than it had done before.

A. That's absolutely true, Mr Chairman. My understanding at that time was clearly following the guidelines coming out in 2002 and around the assurances the department had sought and we had provided was that clearly there was an issue around the use of hypotonic saline in children in particular and that at a particular point in time -- and obviously these are matters for the inquiry to properly consider -- there was a lesser degree of awareness, shall we say, in relation to the risks associated with that.

MS ANYADIKE-DANES: Dr McBride, that's not the point I am asking you about.

A. Yes.

Q. Yes, that had happened and, as a result of what happened if relation to Raychel and Lucy, the CMO set up a working group and ultimately guidelines were published in March 2002. That's not the point I am asking about. The point I am asking about is your process, lessons learned: at some point you would have thought you are going to have to deal with the question of how this could have happened in succession, three cases, and we don't appear to have appreciated it was happening, and properly disseminated information to alert others in the community, whether it's just at our hospital, in other hospitals, that there is a risk in relation to these

matters. So it's the lessons learned point and dissemination that I'm really asking you about.

A. Sure.

Q. Because that was one of the things in the -- in the programme, and that's why I'm asking you: did it not occur to you that -- not necessarily for to you do it personally, but to call up the files so that you can see what actually happened in the aftermath of those children's cases?

A. I suppose maybe if I am understanding you correctly -- we are maybe talking about two separate elements in relation to this in terms of learning. One was: what was the immediate learning in relation to clinical practice and how was that captured, identified, disseminated in or around the time of those deaths back in 1995/1996.

Q. Uh-huh.

A. I suppose the latter point is also around: what were the systems -- maybe that's the point that you are making --

Q. Yes.

A. -- that were in place at that time --

Q. Yes.

A. -- which should have, could have, identified what those issues are and disseminated that information within the organisation and more widely.

Q. Yes.

A. If it's the latter point, obviously the systems were, as I explained earlier in taking you through the governance arrangements within the organisations, were very different now. I think there was a sense that whilst the development of clinical governance and the development of integrated governance was very much a journey right across the United Kingdom, that we had much more robust arrangements at present, i.e. at the time of the broadcast of the documentary in 2004 than were in place back in 1996. That's not to say there weren't arrangements in place. It would be fair to say they were less systematic in 1996.

Q. Precisely. All I am asking is whether you wanted to get the papers up so you could see what failings there were, if any. I am going to come to when the department actually asked to you get the papers.

A. Sure. If I could expand on that: I think the point is -- and perhaps I have not communicated it terribly clearly -- I think the point ... As I understood it, as the chairman intervened, the learning in relation to the risks associated with the use of hypotonic saline had already been identified. That learning already been disseminated to the Health Service in Northern Ireland and indeed disseminated in the Health Service in

Northern Ireland ahead of other parts of the United Kingdom in that it had been identified here first. I think I suppose my response to your question was: there was a sense that that was a problem which had been identified. Guidance had been issued, that guidance had been implemented. The vulnerability in the system had been addressed.

Q. Okay.

A. The question in relation to an analysis or understanding of the governance arrangements at a time in 1996 when those governance arrangements no longer existed was not something which I suspect was viewed as -- would have been a fruitful exercise in that those arrangements were now much more robust. I think again there is also the point that -- I don't know the timescales -- events very rapidly overtook us in terms of, as I mentioned earlier, we were aware of active police investigations at that time following the allegation of the documentary and shortly thereafter the Minister announced the public inquiry.

Q. Let's pull this up. This is the letter from Clive Gowdy, the permanent secretary, to the chair of the Trust, 127-002-001. Here we are. It is dated 28 October, just within a week of the programme going out. You can see what it says:

"The UTV Insight programme of last Thursday evening made a number of allegations associated with the tragic death of Lucy Crawford. The department is currently considering how it should respond to these allegations. Without prejudice to the outcome of these deliberations, there is a need to ensure that all relevant records and documents are secured so that, if necessary, they can be made available for independent examination."

Then it goes on to say:

"... the department now requires you, as chair of the Royal Group of Hospitals Trust to take whatever steps are necessary to secure and keep safe all documentation which is within the custody or control of the Trust ... pertaining to the death of Lucy Crawford, Raychel Ferguson or Adam Strain."

Then it goes on, in quite some detail, to enumerate what those documents may be. Then over the page, if we pull that up, 002:

"I would further require that you confirm to me in writing that your organisation has taken the necessary action and secured all relevant information by Friday, 5 November."

Then it says who it is being copied to. Why I was asking you the question before and then have drawn your attention to that is I have taken your answer to be

that, in terms of the lessons learned and how these things happened and so forth, maybe the time has passed and you don't feel -- I think you used the word "fruitful". Here is a department that certainly feels there is something that warrants investigation. In fact, they've talked about independent, if necessary, investigation. So the department thinks there is something that needs to be investigated. It happens to be in the Children's Hospital where all the three children who are the subject of the documentary actually died. Now that you see that, can you not see that maybe the Royal itself should have been securing the documents and instituting its own investigation?

A. With respect, I don't think that's what the letter was -- unless I am misinterpreting. Again it was a letter to the Chair Undoubtedly that letter would have been discussed between the chair and Chief Executive. I can't recall being party to that conversation or indeed whether my views were sought. They may have been; I just can't recall. My interpretation of the letter is that the department is signalling that it's actively considering what further steps need to be required in relation to the allegations that have been raised. It is basically directing that the Trust take necessary action to secure all relevant

information. That would be my interpretation of that.

Q. Oh, yes. That's exactly correct. All I am asking you is: given that the department thought there was still some investigation that needed to be carried out in relation to these three deaths and what their implications are, given that they happened in the Royal, did the Royal not think that at the very least it should be calling up these documents in relation to these three children and carrying out its own investigation?

A. Well, again, I don't believe that the letter suggests that. If anything, it suggests that what is required of the organisation is to secure the records and indeed that the department is giving active consideration to an independent review. Again, I can't recall the exact discussions or indeed any discussion that has happened at that time. I certainly wasn't party to anyone between the department and the Trust in relation to or indeed other organisations in relation to the plans for the public inquiry. I don't know at that stage what discussions, formal or informal, there had been in relation to the consideration of a public inquiry. I just don't know.

Q. I understand that.

THE CHAIRMAN: Let's move on. We have a lot of ground to cover have this afternoon.

MS ANYADIKE-DANES: There is just one last point I have been asked and that is: did you provide the confirmation in writing that was sought? I beg your pardon. Do you know if the confirmation was provided?

A. Certainly when a letter of that nature comes from the department, I would certainly anticipate a letter of confirmation was provided. I certainly don't recall that.

Q. Would you expect to see a letter like this?

A. I may well have seen -- sorry. This letter or the response?

Q. Well, both. Would you expect to see a letter like this?

A. I mean, the letter was addressed to the chair of the Trust.

Q. Yes.

A. In such circumstances, it would not necessarily have been copied to me as medical director. I mean, I have no doubt that I was probably aware of this. I can't specifically recall. I don't certainly specifically recall being copied into the letter or indeed the response. I may have been, but I wouldn't -- I wouldn't expect necessarily.

Q. Okay.

A. I mean, just to expand upon that, because it is an important point, I mean, obviously the department was

directing the letter to the chair of the board of the organisation, who would liaise with the Chief Executive. So this was clearly done on accountability lines into the organisation. You know, I and the other executive directors in the organisation are accountable to the Chief Executive. So that was the direct mechanism for the communication to be formally made into the organisation.

Q. At any point, did it occur to anyone in the Trust that there might actually be other cases?

A. It certainly didn't occur to -- well. Sorry. I don't know how to answer that.

THE CHAIRMAN: I am not sure if it is helpful. Let's be more precise. I am not sure if it is helpful to ask Dr McBride if at any time it occurred to anybody in the Trust, which employs thousands of people.

MS ANYADIKE-DANES: Those people in the trust who would have the responsibility for governance issues. Sorry. I should have been clearer about that.

A. Okay. Certainly, as I think back, I certainly have no recollection of any discussions of that nature. I think that certainly, as this was a very rapidly evolving situation -- I mean, these were very serious allegations that had been raised. This was a deeply disturbing documentary, which raised very significant questions.

The department and clearly, you know, the Minister had intervened. I think the -- again this is -- I mean, again I suppose I am trying -- I don't clearly recall. So I am just trying to fill in some of the detail, but I think there was probably a sense that this was something that was going to be subject to a significant independent process. There could be -- if indeed there was going to be an independent process looking at this.

Q. Uh-huh.

A. And again it would be conjecture on my part and maybe that would be inappropriate, but I think that we as an organisation would be anxious not to seek to compromise or prejudice any other process that the department might want to put in place.

Q. Uh-huh.

A. And certainly what was being required of the organisation and was being directed from the highest level from the permanent secretary of the department to the chair was that the action required was to secure all records and the department's giving consideration to the next steps.

Q. You have described it as deeply disturbing and that very serious allegations were made and there were very serious issues involved. When you did see it, did you have any thoughts as to what ought to be put in place in

case there were queries from the public?

A. Again with the passage of time, I don't honestly recall that. Certainly I believe the -- I would have been surprised had there not been discussions of that nature, because again that is something which, given the range of service that the Royal provided over the years, there had been experience of other --

Q. Did it involve you, those sorts of discussions?

A. Certainly those in the more recent past that I can recall, yes. I honestly can't recall whether I was involved in those discussions at that time.

Q. Okay.

A. But certainly generally when those were of clinical concern and clinical matters, yes, I would have been involved in those, yes.

Q. Well, in due course, Claire's parents do contact the Royal.

A. They do, yes.

Q. And is that brought to your attention that they have?

A. It is, yes.

Q. And you set up or you institute a review the case notes.

A. Yes.

Q. I think there's an e-mail from you that might help. It's from you to Dr Steen and I think we see it at witness statement 177/1 at page 54. We may just have to

blow that up. It is actually the one at the bottom I think. Do you see there "2nd November"?

A. Yes.

Q. It's your e-mail to Heather Steen. Then if one looks at the second paragraph:

"... enquiry from parents in relation to the death of their daughter ... from the brief description of the case that I received there would appear to be a causal element for SIADH with the presence of a low-grade meningoencephalitis at post-mortem. Whether or not fluid and electrolyte balance was a contributory factor would need to be established."

Then you go on to say:

"Can I ask, in the first instance, to review the notes? If there is any reason to suggest that fluid or electrolyte management may have been a factor in this case, then I would suggest that you ask Peter Crean, as the clinical governance lead, Professor Ian Young, Elaine ..."

That's Elaine Hicks, isn't it?

A. Yes.

Q. "... and Brenda Creaney to carry out a case note review to determine whether this case needs to be referred to the coroner."

So was the first information gathering, if I can put

it that way, really a case review from Dr Steen with her then to decide whether she would wish to bring in those other individuals that you've mentioned?

A. No. I mean, I think -- I mean certainly what I have asked Dr Steen -- Dr Steen was the responsible clinician. She was the treating clinician in Claire's case. What I had asked her to do was look at the notes and, indeed, if there was any suspicion of any implication that fluid management may have been a factor in Claire's deterioration and death, then what I was suggesting clearly there was -- was advising, sorry -- was a number of other named individuals would assist that process.

Q. Did you have in mind that they were a pool of people from whom one would help or did you think it was appropriate that perhaps if there was an issue to do with fluid and electrolyte management that they would all be contacted?

A. Well, my -- I mean, what I had intended was certainly that the named individuals would all be contacted. Basically, as we alluded to earlier, one of the processes which certainly I led the introduction of in the Trust was that of root cause analysis, which is obviously a methodology which sort of takes a system approach and uses a problem-based methodology to

identify what problems have occurred and what the learning might be.

Clearly this was a case where Claire's parents had raised very significant concerns in relation to the cause of death. They were significantly concerned, as I recall, that hyponatraemia and fluid management would have been a -- was a factor in her death. Certainly what I was indicating here was that -- a request to Heather to have a look at the notes and to ascertain whether there was any cause for the parents' concern.

Obviously with the benefit of the knowledge we had in 2004 as opposed to that in 1996, and indeed if that was the case, if there was any suggestion that hyponatraemia and fluid management was a factor, to get together a group of individuals to go through the case notes and assist through that route.

Q. If we just deal with who these individuals were. Peter Crean, he is the clinical governance lead at the time.

A. Yes.

Q. Professor Ian Young, he is at Queen's, but also has a position at the Trust.

A. Yes. Yes, he is a professor of medicine and a clinical biochemist.

Q. Elaine Hicks. Her position at that time?

A. Elaine was the former clinical director. At that time,

she was a consultant neurologist.

Q. And Dr Steen took over from her effectively?

A. That's correct.

Q. Brenda Creaney, she is director of nursing; is that correct?

A. Not director; she was, I think, divisional director of nursing.

Q. So these were the people that you thought would be appropriate to have involved in process; is that correct?

A. That's correct, yes.

Q. Did you, in fact, know whether Dr Steen thought that there was a fluid and electrolyte management issue?

A. I can't recall at that time. I mean, in terms of the timeline on 2 November or subsequently.

Q. Do you know how it came to be that Professor Young was involved to provide an opinion on that very issue and that Peter Crean, Elaine Hicks and Brenda Creaney don't appear to have been involved thereafter -- following this suggestion. Do you know that happened?

A. I don't. Certainly, I know -- I think I can perhaps assist, but I don't know with any certainty, but certainly in respect of Professor Young, I recall that I contacted Professor Young myself. Given that I was looking for his expert independent opinion in terms of

whether or not hyponatraemia and fluid management had been a factor, he was the only one of those individuals that I contacted. I didn't contact the other named individuals.

Q. Do you know why it fell to you to do it and Dr Steen didn't do it?

A. I suppose it was a -- I mean, I was asked -- I mean, obviously all of the other individuals worked within the Children's Hospital. Dr Steen was obviously Claire's clinician at the time, but she was also the divisional director within the Children's Hospital in a managerial capacity. Professor Ian Young, you know, was independent from the Children's Hospital. He didn't work in the Children's Hospital. As a professional courtesy, I contacted him and asked if he would assist in this.

Q. The reason I ask you this is the way this appears to be framed is if those people were only going to be contacted if Dr Steen thinks there is a fluid and electrolyte management factor in the case. So if, for example, she had contacted you and said, "Well, I have had a look at those notes and actually there is nothing in that point. There isn't a problem with that, it's something else", then presumably you wouldn't be troubling Professor Young.

A. I mean, maybe if we could go back one step. I think it's in my witness statement, 269-1. I think I was asked -- I don't know if it's in the early pages that have -- whether or not I had actually considered Claire's notes. Obviously, I am not a paediatrician. I am not an expert in fluid and electrolyte management, but I had considered Claire's notes and certainly, on the basis of my consideration of those notes, I felt that there was at least the possibility that, looking at the notes from the perspective of 2004, that fluid management and hyponatraemia may have been a factor in Claire's death. Now, obviously I was not in a position to provide an expert interpretation, but certainly it was something which needed to be considered, and in my view, either we could exclude that, and if we couldn't exclude it, then we had both a statutory and a professional duty to report Claire's death to the coroner for further independent investigation.

So essentially I was asking Dr Steen consider the notes as the treating clinician, to form a view, because she was clearly better placed than I was as an adult physician and someone who had never worked with children and someone who would have been very intimately aware of other factors and clinical aspects of Claire's care, but certainly I had every expectation -- maybe that's too

strong a way of putting it -- I certainly felt that if indeed my initial consideration of the notes and my non-expert view was that that couldn't be excluded, then I felt that there was a need to carry out a more in-depth analysis of the notes and indeed that that would require a multidisciplinary input from a range of individuals.

Q. Yes. So far as you can recall, did you actually have it a little higher than it couldn't be excluded?

A. Sorry?

Q. Did you have it any higher than it simply couldn't be excluded? Did you actually have it as factor potentially?

A. Certainly what I recall at the time was I certainly saw the cause of death as being cerebral oedema.

Q. Uh-huh.

A. I recall noting from the records that fluids low in sodium had been administered and I recall that there was at least one low serum sodium in the chart. Now, I am not an expert --

Q. No, I understand.

A. -- but certainly at least from that sort of very superficial consideration of the notes -- and I use "superficial" not in any sort of casual sense, but certainly from a level of my knowledge -- I felt that

certainly this is something that needed a closer examination.

Q. Thank you. So far as you are aware, were the other clinicians ever contacted?

A. I honestly don't know the answer to that. I think -- I suspect what happened, and that's why I mentioned earlier that it may be conjecture on my part. I don't know exactly when Professor Young became involved in terms of considering the notes, but certainly it rapidly emerged, I think, once we had Professor Young's input that certainly hyponatraemia and fluid management could not be excluded as a contributory factor and clearly then events had overtaken us at that point. There was clearly a requirement then to report Claire's death to the coroner for further independent investigation.

Q. Professor Young didn't provide a written opinion and I think in your witness statement, or in the witness statement at 178/1, page 3, that's his -- we don't need to pull this up -- he says his advice was given verbally over the telephone.

A. I don't certainly recall --

Q. Oh, well, let's pull it up. 178/1, page 3.

THE CHAIRMAN: You don't recall that?

A. I don't recall whether the information was conveyed by telephone or whether it was subsequently at a meeting.

I mentioned this in my own witness statement. I do recall a meeting in and around when I was asked -- I certainly recall requesting a meeting and, from memory, I do recall a meeting in and around 6 November, which was prior to the meeting with Claire's parents. So I certainly met with him at that stage to discuss his expert opinion and interpretation.

Q. What Professor Young says is:

"My recollection is that this advice was given verbally by telephone and that no specific written advice was provided to him."

That's to you. Does that recollect with you not recalling you ever having received written advice?

A. I thought the question you were asking was in relation the telephone conversation that -- this is in relation to written advice.

Q. Yes.

A. I certainly did not receive written advice from Professor Young, if that is the question.

Q. Yes, it is. Given the view that he formed and the significance of that view, did you think that it would be appropriate to receive that in writing?

A. I think, I mean, that didn't occur to me at that time to receive that in writing. I certainly didn't request it in writing. I have to say it didn't occur to me to

request it in writing. I suppose I felt that what there was now was a requirement to refer Claire's death to the coroner for further independent investigation to determine what the cause of death was and certainly, as indicated in my own witness statement, which you may wish to pull up, in relation to coroner's inquest -- the referral to the coroner -- I felt that was the appropriate thing to do at that stage. So I think events rapidly overtook us. Once we had identified that there was a clear requirement to report the death to the coroner, then that's what we did.

Q. Yes, that's correct. You did do that. I am just wondering because there has now emerged, between the recollections of you and Professor Young, some slight differences as to exactly what happened and so forth in relation to this. Probably not very significant differences.

A. Sorry. The differences are?

Q. Let's do them quickly since --

THE CHAIRMAN: I agree with you; they are not significant.

MS ANYADIKE-DANES: We can move on.

The issue was, because these sorts of things can happen, is it not always prudent to have these sorts of things reduced to writing, but we can move on.

One of the issues was whether the decision had

already been made to report or refer the matter to the coroner, or whether during the meeting with the families, or the family, they were going to be asked about that, their view was going to be sought as to that. That seems to be a point of difference. The reason why I ask you is: surely the family's -- let me just give you the point. Surely the family's view as to whether it should or should to the be referred to the coroner is irrelevant.

A. Absolutely. I think -- maybe if I could -- I mean, I wouldn't quite put it in those terms. Well -- I mean, I think that I was very sensitive to the fact that we had parents who were distraught and I understood, from what information been communicated to me by Professor Rooney, who were both dignified but upset and distressed following the documentary in relation to the similarities to Claire's death. They had raised genuine concerns. I certainly was not going to refer Claire's death to the coroner without them being aware that the Trust now had decided and directed that that would happen. I mean, if I could refer to my witness statement 261, page 7, if I may.

Q. Of course.

A. And I think if we also pull up the minutes of 7 December, if we could, in the second box, 089-003-007,

I think at page 7, at (e), you see my response --

Q. Yes.

A. -- which I have indicated. I think also if you -- if we go across to the minute of the meeting of 7 December as well -- I am just trying to find it -- it's 10 is it?

THE CHAIRMAN: That's Mr and Mrs Roberts' list of issues.

A. Apologies.

THE CHAIRMAN: Don't worry. I know where you are taking us to, you just have slightly the wrong reference.

A. Apologies. Certainly, if we were to look at the meeting of 7 December. Don't worry. I have given you the wrong reference. Apologies.

MS ANYADIKE-DANES: 089-002-002 is the start of it. It is on the first page.

A. I think it might actually be on page 3.

Q. I think if you go on to the next page --

THE CHAIRMAN: Paragraph 5 actually. I am sorry. It is the next page again, 004. It is page 3 of the note, but not page 3 of our ...

Q. It is in the third paragraph on this page:

"Professor Young advised Mr and Mrs Roberts that the Trust wants to be completely open about this case and therefore will have to approach the coroner for advice on the best course of action ".

So this was Professor Young saying that the Trust

was going to contact the coroner and it would then be for the coroner to decide whether to hold an inquest, which is the normal way forward.

A. I think if you go to the e-mail to Professor Steen we had up a moment ago, I think it states on the second page -- I can't remember the exact wording -- I think it also clearly states that if hyponatraemia and fluid management, can't be excluded, that we would be referring the case to the coroner. Indeed, it is also reflected in the letter to Mr and Mrs Roberts dated 17 December, 139-145-001. So I think that certainly I was absolutely clear, as I mentioned in my witness statement, just where you read the second paragraph there:

"In such circumstances, it is necessary for the Trust to report the death to the coroner for further investigation. I can now confirm --"

What I am simply advising and stating in this letter is that:

"With your permission, we have communicated to the coroner that you are content with this ..."

I was well aware in terms of previous dealings with the coroner that he would wish to be sensitive to the views of the family and, indeed, I was very conscious of the circumstances in which the family had approached the

Trust. I certainly wanted the family to be aware of the fact that we had determined that we were sending the --

Q. We are at cross purposes. I think you, in your evidence, have always been absolutely clear that once you got the information from Professor Young, this was going to have to be a matter that was referred to the coroner. The only point -- and we don't need to go into it in greater detail -- is just a finessing point as to how Professor Young thought he was presenting it to the family. I only wanted to raise that because, if things are reduced to writing, then it becomes less easy for there to be differences of view as to what's going on, but the chairman has a point. So we don't need deal with that.

A. Okay.

Q. But what I wanted to ask you about, though, was a point that Professor Young has made. We see it at 139-153-001. Thank you very much indeed. This is from Professor Young to you and this is dealing with a meeting in relation to Dr Steen. So he has met with Dr Steen in the afternoon. They have reached some measure of agreement about the role of hyponatraemia. Then it goes on. She is going to present the clinical journey, he is going to deal with fluid issues. Then he says:

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

Did you know what those views were?

A. I think my recollection of Claire's case is that it was complex. There were clearly a number of at least differential diagnoses that were being considered and indeed being actively treated. Obviously the inquiry will look at the details of those and it is for the inquiry to determine that, but it is an important point, because I think that complexity, and indeed in any clinical situation where there is complexity, there will often be a difference of level of significance to one factor or another factor. Certainly, you know, if the question is: was there significant disagreement between Dr Steen and Professor Young, no. That was not my impression, but I think that there was a difference of interpretation, given the relative significance of the hyponatraemia and fluid in Claire's death. I think it was simply no more than that.

Q. Did you understand what that difference was? That was my question to you.

A. I think in terms of -- I think that Professor -- my recollection is that Professor Young felt that it may have played a greater role than Dr Steen felt, but

certainly it was -- I mean, I think we are talking about sort of shades here. I don't think there was any fundamental or major difference of view that may well have been a factor.

THE CHAIRMAN: It was described last week as a matter of emphasis.

A. That was my interpretation and that was my understanding. I mean I know that -- I have been trying to follow some of the proceedings, but certainly that's not -- my recollection was there was no major disagreement here. What there was was, you know, shades of emphasis in terms of the relative contribution hyponatraemia played. That was not for the Trust to determine. What I felt our responsibility was was to ascertain whether or not we could exclude hyponatraemia and fluid management as a contributory factor and, if we couldn't exclude it, then we had a requirement, both a statutory requirement and a professional responsibility, which I have outlined in my witness statement, to refer the matter to the coroner because in my view it was for the coroner to investigate and determine the cause of death and the relative contributions.

Q. Do you know if there was any note made of that meeting that was ever provided to you?

A. I don't recall any note being provided to me. I mean, I appreciate with the passage of time that has been a difficulty in assisting the inquiry. I appreciate that obviously memories of what was said and when and to whom at times has been problematic. Certainly, I think it's a reflection -- meetings of this nature would not always have been minuted or noted. Clinical notes, yes, but interactions of this nature would not always have been recorded.

Q. When you hear there's a fluid management issue and that that might have played a role, that's a matter within the control of the clinicians. So that could bring with it suggestion of lack of appropriate care, potentially even negligence; isn't that right?

A. I suppose that's one possibility, yes.

Q. Yes.

A. But I think that -- Mr Chairman, if you'll allow me to expand: this was a matter which we had now referred to the coroner for further independent investigation.

Q. Yes.

A. I mean, I had made that decision. It was right and proper that the coroner investigated it.

Q. Yes. I am not --

A. Irrespective what have came thereafter, it was now a matter for the coroner to investigate with appropriate

independent expert opinions to form a view and indeed whatever the outcome of that process was was the outcome of that process.

Q. That's a slightly different point and we will get to the difference between what the Trust should or ought to have been doing and what the coroner does and when those things happen. That's a slightly different point, but at this stage, if you are told there's a fluid management issue, particularly a significant one, I think you have just accepted that that could involve negligence. So the next thing that happens after this e-mail that you have received from Professor Young is that there is the meeting with Claire's parents --

A. Uh-huh.

Q. -- on 7 December.

Dr Rooney, of course, goes that meeting. Dr Sands goes to that meeting. Dr Steen and, of course, Professor Young are there. Did you know before that meeting took place who was actually going to be there?

A. I can't be certain, but I believe I did, yes. Certainly, as I mentioned in my -- sorry -- indicated in my witness statement, I believe there was a meeting in or around 6 December.

Q. Yes.

A. And I -- in my witness statement, my recollection was

that ... I think my recollection was that both Dr Steen and Professor Young were at that meeting. Looking through e-mail trails, et cetera, I see that that was perhaps a mistaken recollection of who was present at the meeting.

Q. From a governance point of view and from the other responsibilities that you had as medical director, did you have a view as to who you thought it was appropriate should be at that meeting?

A. I mean, certainly, and again I've mentioned this in my witness statement, what I'd asked was that Professor Rooney would act to support and liaise with the family.

Q. Yes.

A. I felt it was important there was a single point of contact with the trust.

Q. Uh-huh.

A. Professor Rooney was someone who you knew and respected professionally in her role as clinical psychologist and had been of assistance in terms of assisting many patients on some very difficult and challenging issues.

So I directed that she would act in that capacity to continue to liaise and support the family. I indicated that I wished her to be at the meeting and I indicated that I wanted Professor Young and Dr Steen. I believe,

although again I may be mistaken in my recollection, but I recall that Dr Steen suggested that Dr Sands be present at the meeting.

Q. Yes, you are correct about that.

A. As I recall -- and that's why I assumed -- tried to put back together again that Dr Steen was present at the meeting on 6 December, or in or around 6 December, because my recollection is that Dr Steen had suggested that because Dr Sands knew the family and knew the family and remembered the family from the time that Claire was in hospital.

Q. Did it occur to you that if there was even a potential issue to do with negligence, it might have been helpful to have had another consultant clinician there? I mean, Dr Rooney is playing a very specific role. She is there supporting and assisting the parents and she is going chair the meeting as well. Professor Young is playing a very specific role from your point of view. You have brought him in for specialist advice and he is going to explain the view he has formed which has triggered your decision to refer to the coroner. He is going to explain that to the family. Dr Steen and Dr Sands -- Dr Steen was her consultant and Dr Sands was partly involved in her treatment, but given there might be a potential issue -- didn't know at this stage, but

there might be -- did it occur to you it might be appropriate to have another consultant clinician there?

A. It didn't in all honesty, but I suspect probably my rationale was that -- and again obviously it is a matter for the inquiry -- my understanding certainly from the case note review was that we couldn't exclude hyponatraemia and fluid management as a contributory factor to Claire's death. We needed to refer her death to the coroner for that to be confirmed or not.

Q. Yes.

A. My understanding was that the issue and the vulnerability in that that may have created those circumstances was that the practice as it was at that time in relation to the administration of intravenous fluids, particularly in children and particularly the use of hypotonic fluids.

Q. Yes.

A. So in relation to -- I did not at that stage feel that although again it remained to be determined by the coroner, that there was likely to be issues pertaining to clinical negligence. However, I accept that that -- your analysis that that may well have been the conclusion following, you know, the coroner's inquest or whatever the coroner's verdict was. Indeed, I suppose with hindsight, there may have been other issues that

arose as a result out of the coroner's inquest. At that time, my understanding was that it was an issue which had arisen as a result of clinical practice throughout the UK at that time in terms of the use of intravenous fluids. That was my understanding, but I accept the point that you are making.

Q. Thank you. Just give me one moment. (Pause).

So there is a meeting and the minutes are taken. Did you see Dr Rooney's minutes of the meeting?

A. I can't recall whether I saw them, to be honest. I am sure you probably -- I don't know if there is an e-mail suggestion that I did. I don't honestly -- I don't recall seeing the minutes, but I may well have been copied in on them.

Q. Well, would you have wanted to know what happened?

A. Oh, yes. Let's be clear of this: I was kept fully informed by Professor Rooney and, indeed, I indicated that in my letter to Mr and Mrs Roberts on 17 December.

Q. If you were being kept informed in the way that's recorded in the minutes -- if we pull up 089-002-002, you can see that Dr Rooney felt that there were questions that Mr and Mrs Roberts felt still remained unanswered regarding Claire's death and that:

"They will be addressed and that the Trust will meet with them at any time [it goes on] to help them in any

way possible and the Trust wants to be completely open about the case. We will be happy to meet Mr and Mrs Roberts."

That's the tenor of what's happening there and you wouldn't demur from that?

A. No.

Q. That indicates that they still had questions, not withstanding having the meeting with those people present to try to help them with the queries. They still had questions at the end of this meeting, and you would have appreciated that.

A. Certainly from memory I was aware that following the meeting there was a letter came that from Mr and Mrs Roberts requesting -- with some further questions seeking some further clarification on a number of issues. I don't recall at the time -- sorry. I have no recollection, but I note from the e-mails, because I have looked at those e-mails on -- that are available, that communication between Professor Young and Professor Rooney in relation to that and how best to address those questions and whether to write and answer those questions or to arrange to meet with the family again. So I can't recall being aware, but certainly, as I have read through those, I feel -- I don't recall with clarity, but I have no doubt that I would have been

aware of that, yes.

Q. Well, did you see the letter that came back from Mr Roberts, which is really -- in fact, you just pulled it up thinking it was Dr Rooney's minute, but really setting out what -- summarising what he says happened and indicating the queries that remained for them. Did you see that? I can put it up. In fact, I should do that.

A. I can't recall whether I saw it. There is no reason why I wouldn't have seen the letter, but I can't recall actually ...

Q. I understand. Let me pull it up. It is 269/2, page 13 and if we can pull up page 14 alongside it. So there we were. It is from both Claire's parents. It summarises, in point form, the information that they gathered and includes in that under those headings the further queries that they have. If you didn't actually see this letter, presumably the issues that it raises would have been communicated to you.

A. I honestly can't recall in all honesty. I think that -- I mean, I was being kept appraised of this.

THE CHAIRMAN: Can I take it then, if you were being kept appraised, that you would have known from Professor Rooney, probably most directly from Professor Rooney --

A. Most probably, yes.

THE CHAIRMAN: -- that there had been a meeting, that Mr and Mrs Roberts had come back with a list of queries and she was going to liaise with Dr Steen and Professor Young in responding to those?

A. I certainly would have been aware of that, yes, but again I can't recall the specifics or the details of the letter --

MS ANYADIKE-DANES: I understand.

A. -- not having been at the meeting or indeed being familiar with the clinical details, I wouldn't have been in a position to comment on that or ...

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: I understand, but if we deal with it as a matter of process, you would have known a meeting happened. Minutes were taken of the meeting and the upshot of it was the parents had responded, they still had further questions and issues and you were aware of that.

A. Yes and it would have been highly irregular in the circumstances if I had not been kept informed or aware --

Q. And irrespective of what was happening with the coroner, presumably in the requirement to be open and so forth with the family, you would have wanted their queries to

be addressed in so far as they could be.
A. Yes. Absolutely.
Q. In one -- although you didn't see this or can't recall seeing it -- you have, of course, seen it since, haven't you?
A. Yes, I have.
Q. You will be aware, as one goes through it, that there was more that concerned Claire's parents than just the matter of hyponatraemia. If I give you an example.
A. Well, I see paragraph 4, yes: anticonvulsants and antibiotics.
Q. If one looks at paragraph 10, for example, you can see there -- well, actually if one looks at paragraph 6 -- let's go to that. Paragraph 6 is an issue as to how accurate was the information they were being given as to the seriousness of Claire's condition. You can see that:
"During that time we were not unduly worried about Claire's condition and no indication or concern was directly expressed by any doctor."
So that's a concern as to communication between the clinicians and the parents, which doesn't have anything to do with hyponatraemia, but it is a matter to how you keep parents informed. Then it goes on:
"If Claire's condition was considered as dangerous

or serious on Tuesday the 22nd, why was this concern not urgently highlighted to my wife and I? Why was Claire not admitted to intensive care if her condition was serious?"
So that's another issue as to whether she should been admitted to intensive care earlier. That's a separate issue. Then if one goes down to 10, where I was taking you to, they ask -- you see that paragraph is about three separate but unnumbered paragraphs. About halfway down the first one they talk about how they:
"... struggled for over eight years to understand and accept how an unknown viral infection could be the cause of Claire's death and are again devastated to realise that hyponatraemia now appears to be a more accurate cause. Will the cause of Claire's death be reviewed by the Belfast Royal Hospital?"
That's one issue. They want to know what the hospital is going to do about that. They already know you have referred it to the coroner. Then they ask the question:
"Why did it take the broadcasting of a television programme to raise issues and concerns regarding the death of our daughter?"
That's an issue that requires, they would consider,

an answer. If it was the intention that the Royal would provide answers in so far as it could to these concerns of the families or any family, then how was that going to be addressed? How were these broader concerns, so far as you were aware going to be addressed? You dealt with the hyponatraemia one, but how were these broader concerns going to be addressed?
A. I think if I take a step back, because I think there's a point of context, chairman, which I think might be helpful in terms of understanding the issues at that time.
Q. Uh-huh.
A. At this time -- I think if you go back to my e-mail of 2 November, I certainly had at least a sense that Claire's death required to be reported to the coroner. Obviously, that remained to be established from the case note review. Subsequently, that was established and we subsequently did that. At that stage the public inquiry had also been announced. At that time there was also a police investigation ongoing in relation to the allegations that had been made following the UTV Insight documentary, and if could I maybe call up some e-mails which -- sorry. Maybe if I call up witness statement 269/1, page 9, it may be the next one. Apologies, chairman. I seem to be giving you -- I think it is

page 13. Apologies. Yes. Just the middle paragraph, about halfway down 27 there:
"My experience with Claire's case ..."
I mean, at that time right across the UK and indeed locally there was quite a significant view in relation to coronial processes in terms of the investigation of hospital deaths and death certification, as you will have been aware from the loose(?) review which extended into Northern Ireland, the subsequent Home Office paper. Indeed, there were local plans to review the coronial system at that time. The difficulty in the -- in Claire's case is that there were a number of potential issues here in terms of parallel investigations and the potential for that, particularly in relation to investigations that were now underway or would be shortly underway, subject to the view of the coroner, the potential for police investigations thereafter, depending on the findings of the coroner, and indeed I had, I think, a real, you know, sense that -- from certainly Mr and Mrs Roberts at that time that they wished this inquiry to consider the death of Claire. So it was quite clear that this was -- this case and the context in which it was happening was very difficult and, as I have highlighted there on page 13, it was certainly not a situation I had encountered before.

I had been a medical director in the Trust for two years at that stage. There was no guidance in relation to what course of action to take in such circumstances.

In terms of which investigation had priority, I was very conscious of the potential to compromise or prejudice any subsequent statutory investigations, whether that would be as a result of the PSNI investigations or indeed as a result of investigations of this inquiry. If you look at -- if I could call up perhaps -- I think it might be helpful to illustrate the context -- witness statement 262, pages 68 and 70, and I think we will see in the first of those there's an e-mail from me to the department. I think it's the -- sorry. I don't know if you can go back through the sequence of that. Sorry. That is the reply. Anyway I suppose this makes the point, essentially, on 13 October, I was writing to the department in relation to another case indicating that there was a need for clarity and guidance in relation to deaths which required more than one organisation to be actively involved in an investigation of the circumstances of those deaths.

Clearly, as an organisation, when such incidents occur, our priority is patient safety. Our priority, as I indicated when I was medical director in the

organisation, was to seek to investigate those deaths, to ensure lessons were learned, to ensure that we could prevent a recurrence.

Claire's death was somewhat unusual in that the death had occurred in 1996. It was now being brought to my attention. As a result of the parents -- and that is absolutely correct -- raising concerns, it had been referred to the coroner, but there was no guidance in relation to how such complex investigations should be conducted to ensure that any patient safety issues were identified and that learning was disseminated, to ensure we didn't prejudice or compromise any police investigations or indeed subsequent investigations by this inquiry.

Again you can see here that I'm requesting -- I think you can see it in the earlier version of this e-mail -- that we needed a memorandum of understanding between all parties, which allowed us to proceed to ensure that those responsibilities of each consideration were met without compromising any other investigations. Sorry -- if I could finish, please, because I think it is an important point.

Q. Of course.

A. I think I have referenced this also -- sorry, chair.

THE CHAIRMAN: I am just clarifying with you. The reason

why you are referring to that is because -- if you give us page 69 as well, please -- this is when you talked about going back through the trail [OVERSPEAKING] -- this is the bottom half of page 69.

In effect, one of the sources of this concern is:

"At a recent inquest, an internal root cause analysis been used and, from the Royal's perspective, had perhaps added to the complexity or difficulty of the inquest."

One of the tensions here is: if you want people to speak freely in terms of root cause analysis, will they speak freely if that is not a privileged document and then ends up before the coroner? In a sense, it is a variation on something we have been hearing about over the last number of weeks about grand round reviews and so on, where people may not speak freely if they then realise they or their colleagues are going to be criticised.

A. The point is not in relation to one of privilege. You see in the bottom paragraph there on page 68 I am very clear that we had sought advice. There is no issue of privilege. I am saying it would be counterproductive, indeed difficult, to claim privilege. The point is these documents are publicly available in the public domain. My concern was that we were actually going to

lose an essential tool for analysing when things went wrong, when harm occurred to a patient, i.e. root cause analysis. If indeed, and I don't think there was a clear understanding of what a root cause analysis was designed to do, the process, the methodology, and I suppose the point that I was making in relation to my e-mail, that the root cause analysis is an approach -- a problem-based approach to identify the learning, and the point I was making was it would not be something which would stand up to the rigors of a judicial or legal process in terms of an examination of what was within that and, in this particular incident, the case of root cause analysis was used to cross-examine witness -- to question -- sorry -- I beg your pardon -- to question witnesses in the coroner's inquest. My concern was there was clearly a need for parallel investigations in some instances. We, as an organisation, to protect and safeguard patient safety would be required to investigate patient safety incidents in real time, irrespective of whether or not that case had been referred to the coroner in real time, because we need to identify a learning. Clearly there may be circumstances where that case may be also investigated by the police and the exchange and response from Ian recognises the fact that things have -- I think he mentions the word

"have moved on", "rapidly escalated", and the need to have guidance out to the Health Service on what to do in these very difficult and challenging circumstances.

I suppose in my response back on the 27th, I refer to root cause analysis. I refer to the need to ensure that we keep all of those interests in our minds in the way forward. Now I think the department did expedite and take forward the development of that memorandum of understanding. It is outlined on in my witness statement 269, on pages 335 to 337. I think it is important to consider that because I think it provides an important context. I mean, there were ongoing discussions from October -- my recollection is October onwards -- in terms of what have would be required within that --

Q. Can I ask you this?

A. Sure.

Q. Firstly, at that time, October 2004, there was no PSNI investigation into Claire's case.

A. No, there wasn't. Not that I was aware of, no.

Q. Nor for that matter had Claire's case been accepted as a case to be investigated under this inquiry.

A. That's correct, yes, although certainly, as I mentioned earlier --

Q. No, that's what they wanted.

A. Yes, that's what they clearly wanted.

THE CHAIRMAN: That's what Mr and Mrs Roberts were specifically asking for.

A. Yes.

MS ANYADIKE-DANES: Then if we come back down to the detail of what's in Mr and Mrs Roberts' letter, I will address the parallel investigations in a minute with you, but if we deal with what's in the letter, there are things in that letter that are not the sorts of matters that a coroner would investigate, but they are matters that are governance matters and which the Trust might want to be able to furnish an answer to the Roberts.

For example, issue in relation to paragraph 10: why did it take a father to watch a UTV programme to bring this to the Trust's notice? Why did it happen in that way? Well, that's something that you could legitimately be asking the clinicians, "How did that happen?", and it is not necessarily something that the coroner is particularly concerned about, if one thinks about the legislative basis of what the coroner's process is about.

A. Sure.

Q. And there may be other things like that. For example: why was it that the communication or the recording of communication with the parents wasn't better, which is

an issue that is flagged up. That's paragraph 4. That's not something the coroner is going to make findings about.

A. I accept, yes.

Q. The coroner wants to know the statutory remit that the coroner has. So those sorts of things are things that were important to Claire's parents and what I'm asking is --

A. Yes.

Q. -- would it not have been possible to say, "Now some of the things you are asking", if it be the case, "that we don't really want to address at the moment, because the coroner is going to investigate that, and we would not want to do anything at that would hinder the efficacy of his investigation, but you have asked us some other things and we are going to into those things and see what answers we can provide you about those concerns". Would that not have been a possible strategy?

A. It would have been a possible strategy, yes. I think it was the complexity which I've sought to describe, which --

Q. Yes.

A. -- I think is certainly unique in my experience. I certainly never encountered a situation like that before, nor indeed since, and certainly foremost to my

mind was a distinct possibility at that stage, given that there was already an ongoing police investigation into the allegations arising out of the UTV documentary, that there was a distinct possibility there would be a police investigation potentially into Claire's case and a distinct possibility this would be a matter this inquiry would consider. Indeed, that was minuted at the meeting of 7 December. The Trust offered to facilitate referring the matter to this inquiry.

Q. Yes.

A. So that's something I was very alive to and I think the issue of the memorandum of understanding is very relevant in that context.

Q. I appreciate that and I was just asking if there was not a way of in the spirit of addressing distraught parents who had had to find for themselves, if you like, the position and bring that a number of years afterwards only to hear what they were hearing, whether it would not have been possible to assist them with some of their concerns, but if I can bring up the answer that Dr Rooney, as she then was, provided to the parents. That can be found at 089-006-015. I mean in relation to this paragraph 10. There you can see.

So paragraph 10, if you recall, dealt with, apart from other matters like, "Will the cause of Claire's

death be reviewed by the Belfast Royal Hospital?". It is also asked why it took the broadcasting of a television programme, etc. Then if you see how it's dealt with in paragraph 10.

So the case has been brought to your attention. A review of Claire's notes was carried out. Independent advice sought from a Queen's University professor of medicine. I am going to come to that in a minute. As a result of that, the coroner has been fully informed:

"It will now be now be up to the coroner to further review the medical aspects of Claire's case as he feels appropriate."

And:

"The coroner had not been informed at the time as it was believed that the cause of Claire's death was viral encephalitis."

But what's not there is these things that are not really germane to her cause of death and so forth that is going to be within the coroner's purview. There is no independent case as to how that's going to be addressed for the Roberts. Even to say, "We can't actually deal with those bits at the moment because we are afraid it is too deeply implicated in other things that the coroner is going to look at". So there's no guidance on that part from [sic] the family.

A. And the date -- sorry. That was 25 January in that letter; is that right?

Q. This is Dr Rooney's letter and this is 12 January.

A. Oh, 12 January. Sorry.

Q. Yes.

A. I accept the point you are making. Mr and Mrs Roberts, when I now again consider the letter that you have put up, certainly were raising a range of other issues --

Q. Yes.

A. -- which were separate from what had actually caused Claire's death.

Q. Yes, and there might have been a way to address those.

A. I accept there may have been a way. Just to reference what I said earlier, there was a degree of complexity --

Q. I understand.

A. -- which by way of context ...

Q. Yes.

A. But I accept there were other issues that they were raising, yes.

Q. Thank you.

Now in terms of Professor Young's own position, Professor Young, of course, was a professor at Queen's but he was also a Trust employee. Is that something that, in the spirit of transparency, that might have been disclosed to Claire's parents?

A. I am not certain. I mean, I wasn't at the meeting and I don't know how Professor Young was introduced or introduced himself.

Q. I don't think the minutes disclose that he is a Trust employee.

A. Yes. I mean, I have to say I had sought Professor Young's advice because he was someone I regarded and someone who was regarded -- and indeed I think he is described in his evidence -- someone who was clearly -- had both clinical expertise and academic experience in clinical biochemistry and particularly fluid management.

Q. This is not an issue as to his competence and expertise. I beg your pardon. I am asking a very specific question. Did you not think you could have disclosed to the parents that he was also a Trust employee?

A. I didn't think there was an issue in relation to that being disclosed or not being disclosed. To be honest, I did not consider the fact he was a joint appointment between the Queen's University and the Royal Hospitals as something that would have compromised his ability to provide an independent opinion to me. I had known Professor Young for quite a number of years. He was someone I had the highest regard for his professional standing. I knew his professional integrity. I knew

when I requested an expert opinion from him that I would get an independent expert opinion and therefore I did not feel his employment status was a factor I should have given consideration to when approaching him for said opinion.

THE CHAIRMAN: You made the point earlier that he had not been involved in Claire's case before and, from his evidence, he had barely any involvement with any children in the Children's Hospital. So while he does work for the Trust in a limited regard while he is also working for Queen's, the extent to which he is involved in anything in the Children's Hospital was negligible.

A. Yes. Again he was -- that was the point I made in my witness statement. He was independent from anybody involved in the case previously and independent from the Trust. I appreciate there is an issue around perception and --

Q. We need not take that any further. You can see there is an issue of perception. We don't need to take that any further.

Can I put to you some criticisms that the inquiry's governance expert has made in relation to the meeting and maybe you can assist with them?

A. Sure.

Q. Or at least give you the opportunity address them since

they are there in his report. One sees them at 238-002-015. There we are. I think if one goes down, I think one can pull them up as:

"Consideration should have been given to commissioning an independent written report of a paediatric neurologist."

And that:

"Professor Young may not have been regarded as independent."

Well, we don't need to go further in that.

That:

"His views should have been reduced to writing, especially in the light of his disagreement with Dr Steen."

You have answered that. You said it was a shade of difference. Then he has queried about whether he was the correct choice, but you have expressed your view that's and you have said why:

"An external expert should have provided a written report and should have attended the meeting."

That is the suggestion.

The clinical paediatric lead --

A. Sorry. Can you just highlight that? I can't see that on this page.

Q. I think may follow?

A. I am on 015. Sorry.

Q. No.

A. Maybe I am incorrect. At paragraph 61; is that right? Sorry.

Q. Yes. There we are, but you have given your view as to why you thought Professor Young was appropriate?

A. I think -- there is an additional point, if I may make it here --

Q. Yes.

A. -- which is I think my understanding -- and again it's obviously it's a matter the inquiry will consider -- that the vulnerability here may indeed have been the practice in paediatrics at that particular point in time right across the UK in relation to the use of intravenous fluids. I think that my view was that, contrary to Dr MacFaul's view, that indeed in seeking an independent expert opinion from Professor Young, who was not a paediatrician, but indeed that was perhaps more appropriate. You know, he had the relevant experience and indeed I think as a non-paediatrician he had all the relevant expert knowledge in relation to whether or not fluid management had played a part and his view would not have been coloured by what was practice at that time or not. Again, that was another factor that I did give consideration to from

recollection.

Q. The fact that Dr Hicks wasn't present. I think I have asked you about that and you've given your view and you didn't think that that was particularly necessary.

A. I don't think that's the answer I gave. I think you asked did I know why they weren't present or involved.

Q. Oh, I beg your pardon.

A. I said that was in relation to my e-mail of 2 November.

Q. Yes.

A. I said that I didn't -- I approached Professor Young. I don't know if Dr Steen approached the others that I had suggested. My recollection is that events rather overtook us in terms of -- we had Professor Young's opinion in relation to hyponatraemia has been possibly a contributory factor and, in such circumstances, I decided that the right course of action was to refer it to the coroner --

Q. In my shorthand that's what I meant. You no longer thought it was necessary in the way you had prior to receiving Professor Young's opinion.

A. Well, by that stage -- clearly she had not been involved up until that point. I mean, I would have known at that point. Clearly she had not been involved and it would have been inappropriate, I would suggest, to introduce

her into that meeting at that stage.

Q. It would have been inappropriate to have introduced her into that meeting?

A. I mean, certainly this was a meeting -- are we referring to the meeting with the parents.

Q. Yes.

A. She hadn't been -- I mean, she had not been involved up to that date or to that time. She had not been involved -- I mean, I had suggested she would be involved in the case in open view. She had not been. The meeting was taking place with the family. She was not someone who was known to the family. I don't think it would have been appropriate for her to be present at that meeting without being involved in the case note review, having any opportunity to consider the notes or indeed having any former meeting or association with the family. That's the point I was making.

Q. Well, as I say, you have given your view, and I am not sure that the chairman feels it necessary for me to expand on that with you.

THE CHAIRMAN: I don't.

MS ANYADIKE-DANES: Can we go now to the handling of the complaint? Did you regard the communications from Claire's parents as being a complaint?

A. No, I didn't.

Q. Why?
A. Certainly my understanding of the concerns that they were raising -- they were significant concerns, but did I not -- I think they were genuinely seeking answers. I didn't have a sense that it was a complaint. I know that sounds a little bit of an arbitrary distinction, but certainly at that time I did not have a sense that they were making a complaint. I suppose also at that point in time the complaints process was what the complaints process was. It has subsequently been reviewed and changed.
Q. Did you not think that they were expressing any dissatisfaction at all?
A. Yes, I know that's the definition within the 1996 policy.
Q. Well, if that's the definition, didn't you think that they were expressing a dissatisfaction requiring a response? In fact, if we pull it up, what I am taking you to is "Complaints: listening, acting, improving. Guidance on the implementation of the HPSS complaints procedure (1996)", and it is at 314-016-019. It defines a complaint as "an expression of dissatisfaction requiring a response".
A. Uh-huh.
Q. Is that not what they were doing, expressing their

dissatisfaction as to what had happened and requiring a response.
A. They were certainly raising concerns. They had not written a formal complaint. They had not --
Q. Yes, I know they had not written a formal --
A. Certainly they were raising concerns around Claire's care. Can I maybe draw up another document, which I don't think, Mr Chairman --
THE CHAIRMAN: If you do that in just one second.
I presume the phrase "expressing dissatisfaction" is set no doubt that way so that when people who are outside the Health Service system and don't know what the right form or the right mechanism is to make a formal complaint, if they write in in terms which can be understood as a complaint, that is accepted as a complaint.
A. Yes.
THE CHAIRMAN: So it is do away with a degree of formality and expectation, which would be inappropriate, so that they can't say: actually, they might have written in a letter of complaint, but it is not formally a complaint, therefore we will not treat as such. The purpose of this procedure is to move away from hairline distinctions so that expressions of dissatisfaction were treated as complaints.

A. I take the point you are making, Mr Chairman. That was not the experience of the complaints procedure at that time. I think there were very significant complex clinical matters being raised here, I suggest, I was going to draw your attention to my witness statement, 269, pages 151 and 152, if I could, please. Just for context, this is the "Making amends" document. This is a document -- I accept it's a consultation document in England, but there was no -- it is one of the documents which arose during my e-mail search to assist the inquiry.
At paragraph 25 there, it obviously lists the impacts in relation to individual patients and relatives following harm occurring in the Health Service, and again, at paragraph 29, it lists the impacts in relation to healthcare staff as well. It does make specific reference to how the Health Service, certainly in England, responds and that is in paragraph 26 there. You know: lack of coordination, confused communications. If you read down to paragraph 27, again I think it probably puts the complaints process in the context that it was at around that time:
"Trying to get an explanation through the complaints system or making a claim for compensation currently adds to the frustration and trauma for patients."

These were very complex issues that the Roberts family were raising in relation to Claire's death. I don't think at that time that the -- and this is a personal view from my experience of the complaints process at that time -- that the complaints process was the appropriate process or mechanism by which to address those concerns. We did --
Q. Was this offered to them?
A. Sorry.
Q. Was it offered to them?
A. Again, I have only become aware of this following through some of the communications in preparation for the inquiry. I'm aware that there was a conversation -- at least I have seen sight of an e-mail now between Mr Walby -- I think it is 139-161-001 -- following the completion of the coroner's inquest. I think the coroner -- again I don't recall this, I have to say, but I had understand that at the conclusion of the coroner's inquest the coroner had indicated there were other matters which were rightly and properly matters to be considered by the hospital complaints process. I think here we see on the left an e-mail from Peter Walby to Pauline Webb basically indicating the conversations that he had with the Roberts family suggesting that they write to the Chief Executive.

That would be normally the mechanism by which a complaint would be --

Q. Sorry, Dr McBride. Is that not the point? Mr Roberts has aired the same sorts of concerns that one sees in his letter of 8 December, and they are being perceived -- certainly by the coroner -- as in the realm of the hospitals' complaint procedure.

A. And I think --

Q. Sorry. What I was going to then ask you --

A. Sorry.

Q. -- if that's the case, should not the Trust have simply recognised the reality of what they had, which was parents who were expressing dissatisfaction with what had happened, both in terms of their daughter and also the relationship with them. They did want answers, and if they had not formally called it a complaint, was there any reason why those who deal with these matters simply could not have said, "Well, you know, here's a complaints form", or whatever is the necessary thing that puts them into the process?

A. I accept that certainly there's a responsibility on the organisation to inform families of those processes. It's not for families to ascertain or find their way into those processes. The responsibility for that is absolutely clearly for the Trust.

Q. And who should have done that?

A. Well, I think certainly advice was given to Mr Roberts. I think certainly --

Q. No, this is 2006.

A. It is 2006.

Q. Who should have done that in 2004?

A. I mean, I was basically adding -- the point I was making earlier was I think if we look -- if you look at the range of issues which were raised by the Roberts family, the primary issue -- and there were other issues -- I accept that on reading through the letter -- but the primary issue to my mind was what had caused Claire's death. I accept the point that there were other issues and whilst the guidance complaints document does state, you know, that the complaints [sic] process can continue whilst the complaints [sic] process is continuing.

If you look at the actual document around paragraph 2.1, it does state that this is not a comprehensive piece of guidance.

THE CHAIRMAN: I think, doctor, the problem is this: I entirely accept it was probably complicated in late 2004. This inquiry had been established. The police were already looking at Lucy's death. It didn't -- it took them until well into 2005 to decide to look at Adam's and Raychel's, but being aware that the police

were looking at one death, I can entirely understand how it can be at the back of your mind, "Well, this police investigation might expand", and there are issues which would complicate the picture, but from what I've read and heard from Mr and Mrs Roberts, one of their big concerns, which has caused them a lot of added grief, is an unfortunate and perhaps entirely unreasonable sense of guilt on their part that they went home on Tuesday night.

A. I have heard that come across.

THE CHAIRMAN: That was raised by them as the sixth point in their letter following up the meeting led by Professor Rooney.

A. Yes.

THE CHAIRMAN: And it wasn't really dealt with at all in their response and it is taken partly because of the process, which this inquiry has taken -- which has been too long. It has taken them until now to hear that issue aired and to get some response on it.

A. Yes.

THE CHAIRMAN: The question I am getting to is this: even if you can take one or two points and alleviate the family's concerns or express some degree of acceptance that things weren't as good as they could have been, isn't that arguably better to do that at an earlier

stage so that to the extent we will ever get peace of mind, the process starts a bit earlier?

A. And I absolutely accept that and that certainly came across very poignantly from Mr and Mrs Roberts, the fact they weren't there when they felt they should have been there, but then again they didn't understand the fact they should have been there and how unwell Claire was and I have heard that said.

The complaints process as it was -- and I suppose that's the point I was trying to make -- right across the UK, I don't think was fit for purpose at that point in time for investigating the nature of the complex issues that related to Claire's death. Bearing in mind the complaints process is steered towards -- and still is for that matter -- local resolution. So this was an issue which would have been investigated and considered and these issues would have been considered as a matter internally within the organisation.
I thought they were a range of very complex issues.
I don't think that in the circumstances you describe -- you have said those complexities. My sense was that it would have been very difficult to progress any of these through the complaints process. For instance, there is now clarity -- Mr Chairman, if you want me to go on --

THE CHAIRMAN: Go on.

A. The review of the complaints process does now make clear -- it makes very explicitly clear in -- the 2009 complaints process makes very clear that with the agreement of the coroner, that those aspects of complaints which are not subject to consideration by the coroner's inquest, the point that Ms Danes was making, as well, can be considered by the organisation with the agreement of the coroner while the coroner's in1uest is ongoing.

That clarity was not there in the earlier document, in the 1996 policy document. So I think the complaints process has evolved. If this were now, then clearly those issues certainly could be -- certainly a greater degree of certainty being examined in that -- then it brings me back to the memorandum of understanding, Mr Chairman. I think that is relevant because again following the completion of the coroner's inquest -- sorry -- actually prior to the completion of the coroner's inquest, the draft MOU, memorandum of understanding, between the Department of Health, the PSNI and the Court Service had been circulated to the Health Service for consultation. That was in October 2005. I think it might be relevant, if time permits to, consider that document. The reference I have --

Q. Before we consider that -- because that takes us ahead

in time -- and I am not saying it is not relevant -- please don't misunderstand me -- to consider it, but if we stay with what the guidance was at the time -- in fact, this is where I thought you were going to take us to, which is in that same "Complaints: Listening, acting, improving" document at 314-016-010. So when you have a complaint, this has a specific provision in relation to the coroner's cases. You see it at 418 and it says:

"The fact a death has been referred to the coroner's office does not mean that all investigations into a complaint need to be suspended. It is important for the Trust or the practitioner to initiate proper investigations regardless of the coroner's enquiries and, where necessary, to extend these investigations if the coroner so requests."

So that seems to suggest that there was in 1996 a way of proceeding with certain elements and even to do that in conjunction with a discussion with the coroner, just as in the same way you discuss with the coroner whether, for example, parts of a body might be released for transplant.

A. Sure.

Q. The Trust and the clinicians are able to discuss matters with the coroner and they do. So what I was asking,

which was following on from what the chairman had said, was if you can see some discrete issues that are troubling the family and aren't necessarily bearing on the thing that the coroner's investigation covers, why not try to address those in the interests of confidence-building and transparency? Because what seems to be clear from this family is that there was a loss of trust, apart from anything else just because of the way circumstances brought them to the Royal to understand what happened to their child.

So if you are in that situation, isn't there all the more reason to try and see if we can't address some of the things that are truly concerning them, which are unlikely to compromise the coroner's investigation? This seems to provide some support for being able to do that.

A. The policy document and reference 4.8 provides scope to do that. If you then look at the supporting guidance, which went along with that document, which is April 2000, I think the practicalities of that at an operational level were not, at that point in time, clear. I mean there are many things that policy documents state. It is quite another matter on how you give effect to the scope that was given in that policy and the document does make very clear -- and you are

absolutely right -- that the importance of this document is about that it's exercised in the spirit of which it is intended. That was a point that the chair was making as well.

Q. Yes.

A. I would say, however, that we did review the complaints process for the simple reason -- and that was at a later point in time -- I accept that -- because there wasn't clarity around this particular issue and the department has provided greater clarity around this particular issue in terms of what aspects. I accept there was provision to do that. There wasn't clarity in terms of guidance and in terms of what aspects.

Q. I understand that, but given this particular family and its circumstances, would it not have been possible to discuss with the coroner and at least set out what they were trying to achieve: if, Mr Coroner, you feel that is going to be a difficulty, we can go and tell the family this is what we would like to do, but we can't do it at this moment in time. That is something that the family have and is part of rebuilding the trust the family originally had in their clinicians.

A. I accept what you are saying. My sense from the meetings that had occurred following making contact with the Trust again in 2004 was that those meetings had been

conducted in a way which -- I thought certainly they had confidence that we were being open and transparent. Now whether -- I appreciate the point you are making --

THE CHAIRMAN: I think some degree of confidence, some degree of help was obtained by Mr and Mrs Roberts. There may be an issue about how much confidence was gained from meeting Professor Rooney and being in contact with her, but it helped up to a point at least. Okay.

MS ANYADIKE-DANES: Can I ask you now -- we sort of --

THE CHAIRMAN: The stenographer has been going from 1.45. Can we take ten minutes, please?

MS ANYADIKE-DANES: Thank you. Sorry.

(3.32 pm)

(A short break)

(3.42 pm)

(Delay in proceedings)

(3.50 pm)

MS ANYADIKE-DANES: Dr McBride, in the interval I was asked to put to you a very discrete number of points that arise out of the evidence you have already given. If you have been reading the transcript, you will know this is something that happens. We try to keep up with people's issues so they don't all come at the end in a clutter of things that don't particularly hang together.

The first is this question. It is a very net point about the referral to the coroner and the family's understanding of that.

If we can first pull up the minute, 089-002-004. This is Dr Rooney's minute of the meeting of 7 December. If you look at the penultimate paragraph:

"It was agreed that another meeting can be arranged to give Mr and Mrs Roberts time to think about the matter and any further questions they may have. Professor Young stated that the Trust, in the meantime, would not contact the coroner until Mr and Mrs Roberts had decided what they wished to do. He added that the coroner would obviously look at the case with a wider view [and so on]."

So their take from that is that the Trust is not contacting the coroner unless and until they have heard from them. That's it, rightly or wrongly. That, I take it, is not what you intended to be communicated to them.

A. If that's what's communicated, I have certainly no reason to dispute what is documented in the minute. It certainly was not my intent.

Q. We can see your intent. I think that's at 269/1, page 20 and it is (b). Could we have those two things side by side? I beg your pardon. Answer (b):

"While I do not recall the exact detail of this

meeting or the sequence of events ..."

THE CHAIRMAN: When you do that, the stenographer types down everything you say, which means -- it is the last four lines.

MS ANYADIKE-DANES: I'm so sorry. It is the last four lines. If we start with:

"I determined that in light of Professor Young's opinion, the Trust would now refer the case to the coroner. I asked that Mr and Mrs Roberts should be informed of this decision at the meeting."

That is the meeting of 7 December. You are very clear in your evidence that's what you wanted to have happen.

A. Yes.

Q. What actually is recorded as having happened is the penultimate paragraph of that minute, and the Roberts --

THE CHAIRMAN: Sorry. The minute is a little bit ambiguous in this because on the left side of the screen 089-002-004, the third paragraph which starts:

"Professor Young advised ..."

The next line is:

"... and therefore will have to approach the coroner for advice on the best course of action."

So those two paragraphs don't read perfectly together.

MS ANYADIKE-DANES: They don't, but they do seem to make more sense when you see what the Roberts actually did in their letter of 8 December.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: If one then pulls up 269/2 at page 14, and then you see right down, the penultimate paragraph:

"It is clear from our meeting on 7 December that senior medical staff are aware of the shortcomings ..."

Then they say:

"We therefore requested Claire's case is referred to the coroner for urgent investigation."

Their view -- and I will stand to be corrected -- is the reason they did that was they believed that what they were being left with was the decision as to whether it should go to the coroner or not. So that is how they had interpreted what is recorded, which is no longer up at the moment, but what was record in that minute.

A. I can understand that interpretation. I mean, if it would be helpful, I don't know if I could pull up an e-mail which I think you displayed earlier, which is I think the one of 2 November from myself to Dr Steen. I think it is 141-003-001. That's dated 2 November 2004.

Q. Yes.

A. I think if you go on to the next -- sorry. I beg your

pardon. It is the -- that doesn't end there. It's the next page following that. Sorry. Just reading from the top, there is a paragraph missing. This is dated 2 November:

"We should also advise the family that if we establish --

THE CHAIRMAN: You are away from the microphone.

A. My apologies:

"We should also advise the family that if we establish a clinical issue which would suggest similar circumstances to those cases previously reported that we will be referring their daughter's case back to the coroner, but will advise them in advance."

Certainly I was very clear from the outset that if there was any consideration at all or indeed we couldn't exclude hyponatraemia or fluid management as a contributory factor to Claire's death, then we had a very clear obligation.

MS ANYADIKE-DANES: I appreciate that and, as I said earlier, when asking about this, your evidence has always been clear about that. What's being highlighted -- and I am being asked to draw it to your attention -- is a potential communications issue. So they felt, the family, that the decision rested with them, the burden and obligation and decision rested with

them as to whether the case should be referred to the coroner. That's the only point that I am making.

A. Sure.

Q. Which is why I had originally said -- you have written it in e-mail, so it is difficult to know why it wasn't clear, but there seems to have been some breakdown in communication as to what was communicated to the family or what the family understood from what was being told to them.

A. I accept that from the point you are making and, obviously, the points that have been read, but again I was -- I also sent an e-mail on 15 December, which is relevant to asking that -- inform Mr Walby that I had asked ...

Q. From their point of view, just to follow on from that, these are all issues to do with how the Trust manages the clarity of its communications with families -- particularly when the families may be in quite a distressed state -- to make sure that families actually have understood what it is that you are trying to communicate. In this case, the minute actually doesn't help.

A. No. I accept that.

Q. Yes.

A. I mean, I think that was the point. I accept that

point. I think that was my rationale for ensuring that Professor Rooney was present at all of those meetings.

Q. I understand.

A. Because again the medical staff present were communicating the clinical information. I felt it was vital there was someone present who understood what was being asked, how it was being asked and the information that was being relayed was being done in a manner that was readily understood by the parents and actually done in an empathetic way. But I accept the minute does give some question in terms of ambiguity there, but certainly there was no ambiguity in terms of -- or indeed as I had communicated it to those at the meeting around 6 December.

Q. The other thing I have been asked, just in fairness, to point out, when I was dealing with the issue of a complaint and whether certain things could have been taken up and dealt with independently of the coroner's investigation or inquest rather --

A. Yes.

Q. -- that I was asked to point out that the Trust had left open the possibility of the family coming back, if they wanted to do that, and that, in fact, Mr Roberts had drafted a letter which he never sent, coming back, and I suppose the point is to make that if the family had

wanted to pursue it in that way, that it might have done so. So I make that point in fairness, which is proper, but if you will take it from me, the point I was addressing was not so much that, but what the Trust's own systems should have done when it recognised the sort of concerns that were being addressed, but in fairness, I point out the fact that the Trust had left their door open, if I can put it that way.

A. We had, but certainly I don't feel at any time the family should feel in the situation where it is for them to take the lead. I think it is our responsibility to ensure that we are supporting and facilitating and it is our responsibility in ensuring that that door is open and ensuring Mr and Mrs Roberts knew the way through that door and through the appropriate channels. I accept that.

Q. Then I just want to -- it really leads on from the question I was asking about the complaints procedure, and the possibility of addressing that simultaneously, if I can put it that way, with the coroner pursuing his inquest. That is there is a question as to the extent which you could have and maybe should have investigated Claire's death, and if there is, at what point you should have been doing that.

A. Yes.

Q. I know that, in a way, matters moved on with Claire after your tenure, if I can put it that way, but nonetheless while you were there, did you form the view that Claire's death was something, whatever came out of the coroner's inquest, that should have been investigated by the Trust?
THE CHAIRMAN: Sorry. The time sequence for this is in October/November 2004 and the documentary has been broadcast and Mr and Mrs Roberts have contacted the hospital. Okay.
MS ANYADIKE-DANES: Yes, Yes.
A. I think the answer to that is certainly it would have been my wish to have investigated Claire's death. The question was of how and when.
Q. Yes, I understand.
A. I think there were a range of complexities. I don't want to go into the detail of that again.
Q. Yes.
A. I think we have covered that. So I think it was a question of how and when as opposed to if.
I mentioned the memorandum of understanding. I think it is relevant and we will maybe come to that in due course.
THE CHAIRMAN: We will certainly do that before you finish this afternoon. Okay.

A. Yes.
MS ANYADIKE-DANES: Then can I just put it in this way: in some respects, we have covered some of this territory in relation to complaint. Can I put it this way: if I had asked you about whether you considered that perhaps there was a potential for a negligence issue, just when you heard that there was a fluid management concern, if I can put it that way, you said, yes, but it wasn't really at the forefront of your mind. By the time you are writing to Mr and Mrs Roberts on 17 December, which is 089-005-010. I think it is coming. There you go. By the time you are writing, you have formed the view, if you see the second paragraph --
A. Yes.
Q. "Our medical case note review has suggested that there may have been a care management problem in relation to hyponatraemia. This may have significantly contributed to Claire's deterioration and death."
A care management problem is a way of saying negligence, is it not?
A. I don't accept that.
Q. Sorry. Maybe that was too sweeping. A care management problem can certainly import negligence.
A. There -- I mean, after investigating what the particular problem is, if indeed that's a departure from accepted

standards and practice, then it has that potential.
Q. Yes.
A. But certainly it would -- it's not, you know, equivalent to clinical negligence, no.
Q. Well, I suppose if you were the family receiving something that referred to a problem in the way that your child's care was managed and that problem is something that could have significantly contributed to your child's deterioration and death, I think you'd be getting the message that there was something under the control, perhaps, of the Trust that has gone badly wrong.
A. I think -- it's -- having re-read the letter, I think it was an unfortunate expression to send to parents in terms of -- to Mr and Mrs Roberts. I don't know. I am sure they probably considered that and said -- asked themselves what actually I meant by that. I think I perhaps could have put it more clearly, but certainly the inference was -- and again I have covered this in my witness statement -- that there was a concern around the management of hyponatraemia and the administration of IV fluids. I mean, that was clearly what I was indicating.
Q. Yes.
A. But I should have been more specific rather than using essentially what is medical jargon and it is perhaps not

the best way to communicate that concern.
Q. In fairness, Dr McBride, that might have done because, by that time, Mr Walby, who has sort of been involved in matters also in relation to this case in 2004, had formed the view that if they had instituted a claim for medical negligence, his advice would be to settle it and to set it and to settle it --
THE CHAIRMAN: The timing is wrong.
MR McALINDEN: That was Mr Walby's view coming out of the inquest, but certainly not in 2004.
THE CHAIRMAN: That's Mr Walby's view coming out of the inquest, is it not?
MR McALINDEN: Yes.
MS ANYADIKE-DANES: Yes.
At that stage, after the inquest, to settle it because of the blood test, because a blood test ought to have been done earlier and, if it had been done earlier, it might have disclosed low sodium levels, which could have led to a whole chain of care and so forth that might have avoid her deterioration and death. He forms that view after the inquest. So at that stage I have asked you about the investigation into Claire's death in 2004.
I am not sure you were entirely there at the end of the inquest. Were you still in post.

A. I left -- I took up my new post in September. I think I left the July or August. I had a period of leave, but certainly, yes, I was there at the time of the inquest, yes.
Q. Is that something you think should have generated an internal investigation into Claire's death?
A. Which? Sorry.
Q. The fact that Mr Walby had formed the view, in the light of the evidence at the inquest, that there was essentially negligence?
A. I wasn't aware that that was Mr Walby's view.
THE CHAIRMAN: What's unfortunate, doctor, is that Mr and Mrs Roberts didn't know. Mr and Mrs Roberts have never sued. They have made it quite clear over the last couple of weeks that they are not going to sue, but what I understand really took them aback last week was to hear Mr Walby saying for the first time that when he came out of the inquest, he thought in terms that a medical negligence case was open and shut and, if the parents intimated an indication to sue, he would advise the Trust to settle immediately.
A. I must say I had no discussions of that nature with Mr Walby at that time. As a matter of fact, I think, irrespective of what Mr and Mrs Roberts determined, it is completely to my mind, you know, in terms of clinical

negligence, it is not relevant. I mean, at no time had they indicated, that I was aware of, their desire, as you have suggested, to pursue that route. They wanted answers to questions. So I must say that I can understand their concern and distress at hearing that. It certainly wasn't something that I had heard until reading through the transcript of the minutes. So it wasn't something that I was -- is certainly wasn't in my consciousness at that time.
MS ANYADIKE-DANES: That's very helpful. I am not for one minute suggesting in any way that you should have had in mind that they might institute proceedings. I think you are quite right. There has been absolutely no suggestion they would have and their evidence is they wouldn't have. That's not what they wanted to know.
A. Absolutely not.
Q. I was taking it from a slightly different perspective, which is to do with the role of the Trust in the deterioration of their child's condition and her death. And if a view had been formed about the role of the Trust, is that something that you think was appropriate to have led to an investigation into her death over and -- an internal investigation, leaving aside what the -- what the coroner had done for the statutory purposes, an internal investigation into the Trust --

sorry -- by the Trust.
A. I mean, as I have said, I think, a few moments ago it was a question of when and how as opposed to if. I mean I think there were clearly matters which I certainly felt we should investigate.
Q. Yes.
A. I wasn't aware -- I mean, if indeed Mr and Mrs Roberts had come back or indeed we had proactively sought to engage with them again following the coroner's inquest and indeed it certainly should never arise that there are circumstances where it is incumbent on the parents to approach us.
Q. Uh-huh.
A. If indeed there were unresolved concerns, then clearly following the completion of the coroner's inquest, when the cause of death had been determined and the contributing factors had been determined, at least as the coroner saw it, and clearly, as we now know, there are a range of other significant shortcomings that this inquiry happens to have uncovered, which were not known at that time, but clearly in terms of the responsibilities for the Trust, I don't think that the responsibilities to investigate had the -- irrespective of what process that we used, no longer existed if indeed there were matters which the coroner had raised

which were of significance or if there were matters that the Roberts were still dissatisfied with.
The point I made in my witness statement at 269/1, page 11, is important. Whenever we carried out the --
Q. I was going to take you to that. I am glad you have pulled that up. If you look at number 22, we have asked a series of questions: did you consider these things?
A. Yes.
Q. To which your answer really is those concerns that relation to other aspect of Claire's care had not been brought to your attention following the case note review.
A. No.
Q. And to your knowledge, essentially, what the coroner 's expert witnesses had identified was fluid management and if the coroner's investigation had disclosed those sorts of things, then you would have addressed them. That is essentially it, isn't it?
A. Yes, or indeed also the other point I would make is if indeed our own case note review had identified anything.
Q. That's where I want to go first. That's where I want to go to first. Let's look at that point about having it brought to your attention following the case note review.
Primarily, the case note review was being conducted

by Professor Young because he had the benefit not only of having a specialism in the particular area you thought was of concern, but he was to a degree independent because he hadn't been involved in the care of the child and, you know, he wasn't associated with the case. That would be fair, wouldn't it?

A. Well, as I had indicated earlier, there was more than Professor Young involved in the case note review. Dr Steen was involved in the case note review and again, as I alluded to earlier in my e-mail of 2 November, I had advised that others should be involved. Those others were not, in due course, involved. I don't think there was anything --

Q. That's the point.

A. Sorry.

Q. If I may help with that. The point is: that to the extent that anybody looked at the notes and records -- I mean anybody who had the sufficient expertise to do so -- it is Dr Steen, who was the consultant and who may be -- let's put it -- vulnerable to criticism arguably, and it is Professor Young, but Professor Young was only looking at the case notes for a particular purpose. He is only really looking, as you put in your original e-mails, for whether there was an electrolyte issue, was there hyponatraemia, something of that sort. So all

these broader questions as to whether there was a drug overdose, whether the recording was adequate, whether the level of clinicians were appropriate, what was the availability of EEG and CT scans, all of those sorts of things, Professor Young wasn't involved in that. In fact, he is absolutely clear that he was not looking at things from a broader base. He was looking at things from a very specific point of view.

In terms of the actual care, Dr Steen hadn't been involved directly in the care but, as I say, you might think that she was hardly independent to look at the passage of Claire's time at the hospital from the perspective of those sorts of issues. So the fact that the case note review has not disclosed these broader things, maybe that shouldn't have led to "and we don't need to look at it."

A. I understand the point you are making. I certainly advised what I expected to happen. That didn't happen in terms of the range of individuals that were involved.

Q. I understand.

A. My recollection is that events sort of rather quickly overtook us in terms of we had Professor Young's view that he could not exclude that hyponatraemia and fluid management wasn't a contributing factor to Claire's death and may have indeed contributed to it, and in

those circumstances, as I said -- and I also indicated in that e-mail of 2 November as well -- I mean, I was very clear what our responsibility and obligation was to do at that time, which was to report Claire 's death to the coroner for an independent investigation, but I accept the point you are making.

Q. Let's take a very simple point. The family wanted to know why she wasn't referred to PICU earlier. That's not something the coroner is going to look at in particular. It was a concern for the family. And if when the coroner -- sorry.

UNKNOWN SPEAKER: [Inaudible: no microphone].

A. If an admission to PICU would have had a material difference to the outcome in this case, it is a central issue that the coroner would have looked at if it had been raised.

MS ANYADIKE-DANES: I can see that. Given that was still a query that the family had raised in their letter to you of the 8th -- I am just picking up these sorts of things that one can distil from their letter. It has not come out of the case note review. It is not mentioned in the coroner's verdict and in the proceedings, but it is not really addressed for the family. All I am suggesting to you is, at the end of that process, should you really have been saying:

because these issues have not come to light from those two different processes, then we shouldn't look at them?

A. I mean, certainly -- and as I again have indicated, I answered question 22. My primary consideration in this was obviously patient safety. If there were issues which had been identified in either the case note review or the coroner's inquest which had wider considerations -- if we set aside Mr and Mrs Roberts and their concerns for a moment -- then absolutely, irrespective of the complexities -- and we have mentioned those already -- I certainly would have at that point, you know, conducted an investigation or root cause analysis into those circumstances, but no other issues were raised. My understanding -- and indeed of the case note review -- was that the issue that had been identified was thought to relate to the practice in the use of intravenous fluids in children at that time and, in particular, in relation to the use of hypotonic fluid.

Q. Dr McBride, because you would wanted the case notes to be looked at by a broader group, if I can use it neutrally --

A. Yes.

Q. -- than appears to have been the case, did you think that the case notes had been considered from a broader

perspective than they, in fact, might have been?
A. Certainly that was my advice.
Q. Yes.

A. I certainly -- when I got the case note review back, I don't believe that I was unaware of the fact that others had not inputted into that process.
Q. I understand. I understand.

A. Certainly, my expressed wish and my advice was that the others would be involved, but, as I say, I believe events overtook us.
THE CHAIRMAN: I think the question, to try to bring this together, is this: the coroner's inquest has become an increasingly intensive exercise over the last ten years or so.
A. Yes.
THE CHAIRMAN: But it is still different to an internal investigation.
A. Yes.
THE CHAIRMAN: Because an internal investigation would pick up issues like, for instance, communication with the parent, which is not critical to the coroner. It might pick up other issues too. It might pick up issues about
So whether in 2004, or as you are

going to the inquest in 2005 and 2006, I think the single broad question is: would it not have been a good idea to have an investigation into at least some of the issues, irrespective of the fact that the coroner's inquest was due to be held in the relatively near future?
A. In advance of the coroner's inquest?
THE CHAIRMAN: Yes, because some of those issues will not be developed at the inquest.
A. Again, Mr Chairman, obviously -- I suppose my thinking at that time was that the issues -- I accept the point Ms Anyadike-Danes has made in relation to the other concerns the parents have raised. My consideration at that stage was all these issues were so intimately intertwined in relation to the contributory factors to Claire's death that my sense was that, you know, given we were now some eight years following her death, we needed to establish with certainty -- maybe that's not the right word, with certainty -- we needed to establish definitively the contributory factors and indeed that was a matter for the coroner's determination.
Now I accept the point entirely that there is a question following the conclusion of the coroner's inquest. Once the coroner had made his determination in terms of the cause of death and the contributory

factors, there was an opportunity there. I do accept that. There were a number of other complexities at that time which we have discussed previously.
THE CHAIRMAN: Of course, from your perspective one is you were no longer there --
A. Well, that wasn't the --
THE CHAIRMAN: -- after --
A. Well, that's one, but I was there at the time of the conclusion of the coroner's inquest, which was I believe early in May of 2006.
MS ANYADIKE-DANES: Yes.
A. So I was there, but again it goes back to -- and I mentioned this on a number of occasions -- the complexities of the investigation of cases of this nature, particularly when one or more investigative process is underway, whether that's a police investigation or whether it's a coroner's investigation or indeed the need for an organisation to carry out an investigation. There wasn't guidance at that time, but the memorandum of understanding had been issued in October 2005. I think it is pertinent.
THE CHAIRMAN: Let's look at that now.
A. I think it probably gives a sense of some of my thinking and analysis at that time.
THE CHAIRMAN: Let's go to it now Dr Walby [sic] because

I said we would go back to it.
A. I think it is 269/1, 335 to 337. The earlier page I think gives the circumstances in which it applies. I think -- but I think the particularly relevant paragraphs here are in relation to paragraph 18 and possibly also on the next page. If we could see the next page as well, which I think is 336. We will deal with that. Paragraph 26 runs over the page.
THE CHAIRMAN: Let's stay where we are. Let's pick up the first point. Is it paragraph 18 you want to pick up on?
A. Paragraph 18. Bearing in mind this was out for consultation in October 2005. I mean, this was the issue I alluded to in relation to the e-mail correspondence of 13th October and my further e-mail of 27 October 2004, flagging up concerns around complex considerations in terms of deaths such as Claire's where one or more organisations are involved. Paragraph 18:
"Organisations continue to ensure patient safety or client safety."
Again, I felt that I had that assurance in that we had done the case note review and no other issues had been identified and the vulnerability as I understood it in relation to Claire's care was practice as it pertained at that time. Again, might I just highlight:
"... but not undertake any activities that might

compromise any subsequent statutory investigations."

At 18.

MS ANYADIKE-DANES: Dr McBride, that's talking about until the preliminary meeting. Where you were previously, which is 334, I think, which starts -- this whole section is called "Coordination of investigatory activity". That tells you what to do when you have more than one investigation involved and you see it at 14. When that's the case, you are supposed to move on and have a preliminarily meeting. It is in the course of the preliminarily meeting when you can resolve how things can proceed without the compromise and all paragraph 18 is telling you is: maintain the status quo, if you like, until you have been able to sort that out in the preliminarily meeting.

A. Miss Danes, that's the point I am making. Again, this guidance was only issued by the department in 2006. There was not guidance in relation to how to deal with these very complex cases. What there was in October 2005 was a consultation document.

Q. Uh-huh.

A. Indeed, where this information was shared in terms of the department's thinking, a recognition of the complexities involved here, and the department's thinking and the work they were doing with the PSNI, the

Court Service, to actually develop this. So certainly I was very much aware. I mean, if we go to paragraph 26 of that document, because I think it is relevant as well, I think -- it might be -- it is over the page actually, I think, on the next --

THE CHAIRMAN: If you can put ups 336 and 337. Thank you.

A. I mean, my -- I mean, I was aware of this document, this consultation document in October 2004. It was prior to Claire's inquest and, indeed, I was involved in some of those discussions with the department and coroner at that time in terms of the development of this, as were other medical directors in Northern Ireland at the time because we realised there was a complex issue and there was no guidance anywhere in the United Kingdom at this time in terms of advising trusts to deal with complex cases such as that, but if you read paragraph 26:

"In such circumstances, the conduct of any further Health Service investigation will need to be discussed by the reached ICG(?) ..."

Remember there were no arrangements in place, there was no guidance until February 2006:

"... So that the necessary further investigation by the trusts [shall we read] can be conducted in such a way as to avoid the danger of prejudicing the police, coroner, and other investigations, by interviewing

members of staff who may subsequently give evidence at court."

As I was saying earlier, I think where this is relevant is once the coroner's verdict in relation to Claire's death was made -- and I have mentioned this in my witness statement -- with the benefit of hindsight -- I had no -- I had every realistic expectation that all statutory processes, when I referred Claire's death to the coroner back in 2004 --

MS ANYADIKE-DANES: In ease of you, the reference in your witness statement is 269/1, page 13.

A. I had every reasonable expectation that any statutory investigations would be completed in a reasonable timescale. Now, given a range of complex factors which certainly, you know, I am not necessarily fully familiar with, that took, I think, much longer, as the chairman mentioned earlier, than any of us would have wished, and the fact that, you know, here we are in 2012 and Mr and Mrs Roberts are still seeking answers to those questions. I think that is not acceptable. I think that context and that draft guidance which was out for consultation, I suppose, is relevant in the fact that it informed my thinking in relation to how we might proceed here. There was -- I think it was an opportunity and I think the opportunity -- and again this is why

I mentioned it and I indicated so in my witness statement. I think there was an opportunity towards -- following the coroner's inquest.

Q. To do that?

A. Even though -- and indeed, at that time, we were aware that there were police investigations ongoing, we could have met with the police team. We could have used this guidance which was published in February 2006, although it had only just gone out. So we had no familiarity with the use of it, and indeed we could have discussed whether or not it would have been possible to carry out an investigation at that time.

Q. Yes. No, I understand that and, in that part, the penultimate part, "with hindsight and experience", I think you are identifying something of that sort in your witness statement.

The point I was asked to put to you, though, is: once you had raised the fact that there was this document, which I think you have said you were part -- well, you were involved in its development. Let's put it that way. So you knew what was happening, and the point that I'm asked to explore with you just briefly is: even though the guidance was not finalised, so you can't say it is now guidance that we all have to try to pay some heed to, the intention was there that it would

be something like that because you all knew what the issue was and whether or not you could not have subjected Claire's case to an ad hoc arrangement where you could, on a one-off basis, if I can put it that way, have met with the relevant persons and ensured you could move forward without compromising anybody's investigations. That's just the issue I have been asked to put to you.

A. And I think that's the point that I am alluding to there at 27 in terms of that paragraph, "with hindsight and experience", because I think that there was an opportunity there to use this guidance, even though, as I say, it had not been road-tested, as it were. It would have required the agreement of the PSNI. It also, Mr Chairman, if I might suggest, it may have required some liaison with this inquiry, because obviously at that stage we were aware that the coroner had been in communication with this inquiry.

THE CHAIRMAN: It is a pretty frightening experience to go back through the years, Dr McBride, but we were stayed from 2005 until 2008 because of the police investigations. So if anything had been done in two thousand -- and it wasn't until we resumed in 2008 that I added Claire's case to the inquiry.

A. Okay.

THE CHAIRMAN: But there was at least the very strong potential after the inquest and after the police investigations for Claire's case to be added.

A. Yes, and I accept that.

MS ANYADIKE-DANES: I have just two more areas that I would like to have your assistance with.

A. Sure.

Q. One of them is -- it rolls on quite nicely. One of them is the whole area of assistance to the coroner. There are two -- the point really relates to the statements to be prepared for the coroner.

A. Yes.

Q. If you've read the transcripts, you will know that there is an issue over the amendment to Dr Webb's statement. Dr Webb --

A. I have attempted with other commitments --

Q. That's a lot of transcript to read!

A. I have other commitments to keep up, but I haven't been able to --

Q. The matter is quite net. And that is that Dr Webb's original signed statement -- he produced a statement for the coroner. At that stage, he was no longer with the trust; he was now in the south.

A. That's correct.

Q. He produced a signed statement -- and we don't need to pull it up, but one sees that at 139-098-021.

A. That's correct.

Q. And in that statement, he includes the statement:

"I made the mistake of not seeking an intensive care placement ..."

Maybe I will pull it up so it is not unfair.

THE CHAIRMAN: You had better.

MS ANYADIKE-DANES: 138-098-021. Can you see that?

THE CHAIRMAN: It is the bottom paragraph.

MS ANYADIKE-DANES: And it is struck through. There you see:

"I made the mistake of not seeking an intensive care placement for Claire before I left the hospital."

You can see that. This is Mr Walby's correction. And he strikes that through and substitutes for it:

"Although I did not seek an intensive care placement [et cetera] I am not sure whether she would have met the criteria."

That reference I made to the mistake is signed by Dr Webb and sent you to be transmitted, presumably, to the coroner. Dr Walby amends that. He explains why he does it --

THE CHAIRMAN: I think to be fair, we have to say to Dr McBride that Mr Walby's position is that he received

this statement. He thought it was inappropriate. He made the alteration, which is set out there in pen, and Dr Webb accepted that and then sent a revised version back to the north and it was the revised version which was received by coroner. So I think, in fairness to Mr Walby, he did not refuse to accept or dictate this amendment, but he suggested it and Dr Webb accepted it; okay?

MS ANYADIKE-DANES: I was just going to go to that and give you the quote:

"I think it is not clear that it was a mistake and would I allow others to judge that if they wished."

That was in the communication that Mr Walby sent back. The reference is 139-096-001. We don't need pull it up. I was going to give you that. He explained why he had done that. In Dr Webb's evidence, he accepted that and he included that revision, signed the document, and sent it back.

What I was going to ask you about is: there is a protocol about taking a witness's statement and one sees that at 133-003-002. I was going to pull up paragraph -- yes. Can we go to perhaps the next page of that, 003? There we are. Sorry. Can you see paragraph 7, which is the penultimate paragraph:

"Once a statement is signed, it must not be altered

without the express approval and consent of the witness [and so on]."

This was sent out to all chief executives and it says, at the top, 14 November 2002. What I wanted to ask you was: were you aware of this document as part of your role of assisting the coroner and so forth?

A. I honestly can't recall with the passage of time whether I considered this document then or was aware of its existence. I certainly wouldn't have -- I never had recourse to refer to it. I can't, with all honesty, say that I had recourse to refer to it during my time as medical director or that I considered it. I know that's not answering your question in terms of was I aware of it --

THE CHAIRMAN: Let me ask you this in a slightly different way. We know from Mr Walby's evidence and, before him, Dr Murnaghan that they had quite a lot of interaction with the coroner, if you'll pardon the phrase. They were the link men at different times. To what extent did you have direct contact with the coroner? To what extent were you a link man?

A. I wasn't. I mean, I certainly had occasional contact with the coroner. I believe I met him when I took up my post in 2002. Certainly the coroner would have communicated to me following a coroner's inquest in

terms of matters he felt were relevant and matters he felt needed to be addressed. I can't recall whether that was direct communication with me or if it was, you know, written communication or whether those were matters he was communicating to the department in relation to some matters arising from a coroner's inquest that needed to be addressed and I was copied into that correspondence.

THE CHAIRMAN: But in terms meeting him in advance of an inquest and agreeing to get statements from people or who might have be an expert witness did you --

A. At no time would I have been involved in meetings with the coroner in advance of inquests. At no time would I have been involved in collecting statements, commenting on statements, or facilitating statements. That -- I didn't --

MS ANYADIKE-DANES: Did you know that as part of his role -- Mr Walby also had a role as a litigation manager, or he was in litigation management.

A. He had a variety of roles and that was certainly one of them.

Q. Were you aware that, as part of his role, he would, from time to time, do this, look at the statements that were being sent? In this case, it happened to be because Dr Webb was no longer within the employment of the

Trust, so he is sending it up from the south. Were you aware he performed that role? He looked at statements and suggested amendments and revisions and so forth.

A. Certainly I was aware that the coroner requested that Mr Walby assist in the collection of statements and gathering of statements.

Q. Yes. I meant this aspect of it, really.

A. In terms of suggesting revisions --

Q. Revisions and so forth.

A. I mean, I think that, you know, I would have -- I suppose I've not previously considered this document. I've not seen Dr Webb's statement and I've not seen the proposed change.

Q. I understand.

A. Certainly I would not have expected any changes that were material to the letter other than those that were maybe one of formatting or --

Q. It might be argued --

A. Sorry?

Q. Sorry. It might be argued that removing a reference to you believing that you had made a mistake about something, particularly actually as you now know that that reference to PICU is something that actually the family had expressed a concern about themselves in the 8th December letter ...

A. I mean, well, I was considering that and I was -- you know, the same question I suppose that you are posing now: was that a material change or isn't it?

Q. Yes.

A. I mean, I suppose I was thinking that rightly those are matters for the coroner to consider and obviously what should be of value to the coroner is factual information. I suppose one could argue that -- I mean, you could argue it either way that, you know, what Dr Webb was perhaps providing more than factual evidence was providing an interpretation of what his actions were and perhaps what he thought his actions should have been, and obviously if indeed that was the case, then one would have expected during the inquest at some point in time that that would have arisen or indeed may have been shared or been discussed at the coroner's inquest, but again I haven't seen that before --

Q. I understand.

A. -- and I am not sure I can make any further comment on it, to be honest.

Q. No. That's fine. The final points that I would like to ask you about the coroner's process is that the coroner issued a best practice or at least referred to best practice in a letter dated 30th January to you I think, and that's -- the reference is 129-007-001, and --

A. Can we have the following page?
Q. Yes, of course. I was just going to put that up. 002. There we are.
A. I think there's a following page as well, but anyway two at a time, yes.
Q. We will --
A. Sure.
Q. -- remove one of these as we work through it and get rid of it that way. So what he is referring to is best practice, and what had previously happened is as he describes in that rather long first paragraph about how statements were taken. Then he says that it has been put to him that this approach:
"... did not constitute best practice, as the police should interview those concerned as soon after the event as possible and, where necessary, seize medical notes" and so forth.
"I agreed that in future I would agree to a police officer interviewing those involved. The present system would be discontinued."
Then as you have referred to the next page, is there a particular part of the next page you wanted to highlight?
A. Well, it was just that -- I mean, the letter was addressed to me, but it was also copied to all other

medical directors in the trust, which I think is an important point.
Q. Yes, yes, of course. What I wanted to ask you there was it becomes clear from communications from I believe it's Mr Walby that actually the new system that the coroner has envisaged would come into practice and the present system be discontinued didn't actually happen and that continued on for quite some time and indeed continued on over the period when the statements in relation to Claire's inquest were provided to the coroner.
What I wanted to ask you about is what, if anything, did you think you should put in place to reflect the coroner's concern that what was happening at the time was not best practice, and that he wanted the present system or believed that the present system should be discontinued?
A. I mean, my personal interpretation of that --
Q. Yes.
A. -- you know, those are matters for the coroner. I mean, if the coroner wishes to conduct his investigations in a certain way, then that's for the coroner to take that course of action and, you know, it's not for us to have a view or otherwise on that or indeed to seek to action that. As you have indicated in the question, he subsequently didn't action that.

Q. Well, the coroner has -- I mean, I was actually coming at it from a slightly different perspective. The coroner has referred to that as best practice, because there's an underlying concern about not doing things in that way.
A. Yes, yes.
Q. That's the quality of the evidence that you receive and so forth. Sorry.
MR McALINDEN: I wonder how far -- my learned friend has said that the coroner has referred to it as best practice. That might well be the content of this letter. The facts are that up until the present time the coroner still requests the Belfast Trust to collect statements for inquests. That is up to the present time. The system didn't change before Claire's death and it hasn't changed after Claire's death. So if this is an issue which is a live issue at this investigation, then it is certainly an issue that should be addressed to the coroner and should not be addressed to Michael McBride.
THE CHAIRMAN: There are two points. First of all, the letter doesn't actually say that this is best practice. He says -- it says:
"It was put to me that this approach did not constitute best practice and I agreed therefore in

future I would do something else. The present system would be discontinued."
That hasn't been done between the coroner and the police, as I understand it.
MR McALINDEN: At all between the coroner. To the best of my recollection it certainly hasn't been done in relation to the Belfast Trust or in relation to any other trust in Northern Ireland.
THE CHAIRMAN: But if it is to be done, it has to be effectively --
MR McALINDEN: It's an action for coroner; it's not an action for the trust.
THE CHAIRMAN: It's an action for the coroner in conjunction with the police and through them to the trust, but the second issue is I think in broad terms there is a number of issues. Particularly we may be coming to more in respect of the aftermath of Lucy's case. I at least have a view about the extent to which this inquiry established by the Department of Health gives me a remit to investigate the coroner's practices.
Miss Danes.
MS ANYADIKE-DANES: I'll move on.
THE CHAIRMAN: In fact, it might be a lesson -- it might be an issue coming out of the inquiry report, which, Dr McBride, might I suggest end up falling on your desk,

about whether there's a need to look -- to look back at this issue, because -- to see if the coronial service with Mr Leckey now as the senior coroner, whether that is still the view, and if it is, what's to be done about it, and if it isn't, how they have moved away from it, but there are a number of issues on the edge of this inquiry which involve connections between the Department and its various trusts, on the one hand, and the coroner, on the other.

A. Okay.

MS ANYADIKE-DANES: Yes, and from your -- from the trust point of view presumably concerned -- if one's thinking about the quality of the evidence, which is actually what the whole thing is really driven by --

A. I accept that, yes.

Q. -- so if you're considering -- if that's the issue and that you have a concern that there might be a tension, if I can put it that way, between the same individual who is there as a sort of a -- has a litigation role and to manage that aspect as best as they can for the trust, but on the other hand they're also charged with getting out the information in the -- to the best possible standard for the coroner, there's a tension there and I suppose -- sorry. There is a potential tension there.

A. Yes.

Q. What I am inviting you to consider is, irrespective of whether the coroner had specifically instituted a new system, recognising that that's the issue that's involved, did the trust seek, if we are not involving police officers, because that system hasn't been established, can we make sure that maybe we have an independence to the way the statements are taken, if I can put it that way?

A. Again I would just answer that as I answered previously. I mean, this was a letter simultaneously. You have to understand it was a letter -- communication with the Department. This was a letter that was addressed to me. It went to all the trust medical directors. I actually on considering that felt this was an action for the coroner. I did not feel that there was -- you've got to bear in mind that the -- Mr Leckey at that point was one of and still is one of a number of coroners, and I suppose there needed to be -- I wasn't certain when I read that whether that was his view. I don't think he was the senior coroner at that point.

THE CHAIRMAN: He wasn't. He was the Belfast coroner.

A. He was the Belfast coroner.

Q. There were other area coroners.

A. There were other area coroners. So I wasn't sure whether that was his view; it was a collective view; it

was an approach that was going to be taken by the coronial system. There as a whole -- certainly my view was that that -- if that was the case, that needed to be communicated, coordinated. There were some issues in the letter, I -- you know, which -- in relation to -- and I appreciate that the comments are qualified by "in certain circumstances and in certain deaths" in terms of, you know -- and indeed it would apply in certain circumstances. Potentially the hospital environment may be treated as a scene of crime. There are all sorts of issues in relation -- it takes us back to the memorandum of understanding again -- in relation to both the integrity of the evidential basis of information that the coroner needs in relation to conduct investigations into the cause of death, the integrity of the evidential information which the PSNI or indeed the Health & Safety Executive may require to actually form an informed view, and I think this -- my recollection is that this got subsequently taken forward in the work to development -- to develop the memorandum of understanding between the Department, the PSNI, the Court Service and the Health & Safety Executive.

Q. Yes. It could be landing on your desk. Just one point. In fairness to you, you produced a document that might clarify matters. It's called "Models" -- you probably

remember it -- "Model for Learning Lessons" --

A. I did, yes.

Q. -- yes, on 27th April --

A. I did.

Q. -- 2006. If we just pull up, just to make the point that you're dealing with now, 269-2 at page 348, there you see it, "Sources of information for learning lessons". If you look at sort of 9 o'clock, you can see that in there is -- leaving aside the RQIA, you have got coroners in there. So at some point presumably somebody is thinking about, "How do we draw together those sources of info..." --

A. Yes.

Q. -- "potential sources of information in the interests of learning lessons and disseminating information better and perhaps avoiding -- you know, minimising the risk of incidents occurring again. I mean, I'm not asking you to explain how you do it now, but is that the thinking, that you knew that people were thinking there ought to be some way of integrating those sources of information?

A. Well, this is the document that I led on development of whilst Medical Director in the trust, recognising that we learn lessons from a variety of sources, you know. Again you will see complaints which we've discussed: near misses, adverse events, root cause analysis and

external reviews, whether those are by the ombudsman, by the coroner, or by a range of sources, and it's about ensuring that we're capturing all of that learning and then translate that into action. I think if you look at the page before that in terms of what the purpose of this was, I mean, this was -- this arose out of an analysis. You know, in terms of the learning organisation I think it's probably reflective of the fact of what we were doing as a trust at that time. I think the previous page -- sorry. I don't know if we can see the previous page. You know, para 2.1. The terms "lessons learned", these are often, you know, bandied about, you know, "learning lessons", "lessons learned", but unless actually you can -- you know, as I say, unless you can demonstrate that those are actually translated into tangible actions within an organisation to ensure that whatever contributed to something which happened previously, whether it's an adverse incident or whether it's a complaint, then indeed that organisation isn't learning and isn't putting in place effective mechanisms to ensure that that vulnerability is addressed.

That was the purpose of this work. We triangulated a number of sources of information from root cause analysis that we had carried out at that time into --

indeed into some patient deaths, and we had shared those, as I have indicated in my witness statement, with a number of bodies, with RQIA, with the Department, as relevant. So we were an organisation which was seeking to ensure that we were learning from the experience of sometimes when things went wrong --

Q. Yes.

A. -- and actually incorporating that into -- into action.

Q. Then the final point I think I indicated to you, the serious adverse incidents. I think -- I hope we can deal with this reasonably quickly. In 2004 there was a circular issued relating to it, and I think one can find that at 061-2 at page 425. I hope so. There we are. At paragraph 15 this is:

"The Department will expect urgent local action to be taken to investigate and manage adverse incidents."

Now the Chairman has heard information from a number of different clinicians, and there seems to be some consensus that ultimately what happened in relation to Claire could be characterised as a serious adverse incident and, in fact, the trust did make that report later on.

A. Yes.

Q. This is a question of timing. So there's no issue that that was its character. This is a question of timing.

That's what I'm coming to. So there was that circular in 2004 --

A. Yes.

Q. -- but the Department does not refer this as a serious adverse incident to -- sorry -- the trust doesn't to the Department in 2004. So then comes another circular in 2005.

A. Yes.

Q. One sees that at 068-001-251.

A. Yes.

Q. This is actually reiterating the previous one and it's underlining the need for HPSS organisations to report serious adverse incidents in line with PPM0604, which is the document that we were just looking at. Now it wasn't reported in 2005 either.

Now a key objective in all of this, of course, is that lessons are learned from adverse incidents and the quality of services is improved, and it may seek ... -- well, that's the purpose of it, and also because the Department may seek clarification, and they may want to do something further. Not to be called up, but the reference to what I've just been citing is 139-045-005.

Then we asked and we know there were no investigations into Claire's death prior to 2004. That's okay, but if you then find out, "Well, when was

the reference of an SAI made in relation to ..." --

A. 28th March 2006.

Q. Exactly. I'm just going to ask you very briefly about that. One sees the actual report, 302-164-003.

A. Yes.

Q. There it is. So that's the date when it happened, 28th March 2006. As I understand it, though -- well, firstly, why was -- why did you wait until then before it was made, despite the earlier requirements?

A. I mean, I think it is relevant. I'm sorry. Apologies if this seems like a rather long answer. We were reporting it in 2006 --

Q. Uh-huh.

A. -- using that SAI format because of the matter of public concern, and the reason and the rationale for reporting at that time was the recognition that, given the imminent coroner's inquest, there was likely to be matters arising that would cause public concern. We hadn't certainly and weren't sharing it with the Department at that stage, because we felt that there was matters that warrant regional action to improve safety or quality. Again it goes back to the point I was making earlier in relation to the case note review. Notwithstanding the problems which have been identified as a result of this inquiry, leaving those aside for one

moment, certainly neither as a result of the case note review or indeed the coroner's inquest -- and I appreciate, you know, you made the point earlier, which I accept, in relation to the coroner's -- coronial system and its function. No -- there were no matters that were identified that suggested that there was any additional learning at that point in time in respect of Claire's care other than hyponatraemia and the use of hypotonic fluids.

Now I accept -- and I think I've said this -- I would accept that the intention of the 2004 circular -- what the Department's intention was that an SAI should have been submitted at the -- at that time in 2004 and I accept that. I think there are -- there are other matters of context which I think that are important.

I mean, if we call up, if I may, 139-058-001 and also at the same time 139-044-001, just to highlight this is my being alerted -- the first of those -- sorry -- is at the bottom -- the last sentence -- sorry -- there is my being alerted by Mr -- well, I'm copied in actually, copied into an e-mail from Mr Walby, indicating the impending or imminent coroner's inquest. Again you will see at -- that that -- which is what I understood to be the case, that the Department had been

informed back in 2004 whenever we reported Claire's death to -- to the coroner, and again you see the e-mail of 4th April, again which I think is relevant.

So my understanding at that time was that the Department was aware of -- and my recollection is that the Department was aware of Claire's death. I accept that the fact that the coroner has contacted the Department, or indeed I may have had a conversation with the Department, did not obviate the need, I say with hindsight, for the trust to submit an SAI report, and that was clearly I think now in -- reflecting on the 2004 circular, the intent of that circular.

I think there are a number of other pertinent points, if I may, Chair. I think if you look at the -- so that was my understanding, that the Department was aware, but we had not formally completed the pro forma and sent that into the Department. That's correct.

MS ANYADIKE-DANES: Just before you move on can I just ask you this: when you say the Department was aware, was it -- did the Department ever get the correspondence that the Roberts had sent in raising their issues?

A. No, no.

Q. Or the minute of the meeting with the --

A. No, and indeed to this day wouldn't. I mean, I think we --

Q. No. Sorry. I'm just dealing with the awareness point. So what -- the Department would not have been aware of those broader issues which, in fact, are part of the broader issues that make it the sort of thing that you should be referring as an SAI?

A. Well, I mean, I -- I mean, I think this is -- I mean, I think that we just -- I think it is important to consider this in the context. This was a circular which had gone out in July of 2004.

Q. Uh-huh.

A. This was the introduction of a new process and arrangement, and indeed the process and arrangement such as it was prior to that would that be that the organisations would contact the Department. So, for instance, if a matter arose prior to the introduction of the circulars that, for instance, I or another trust Medical Director felt was relevant, had perhaps regional significance or regional learning, we would have picked up the phone and spoken to the Department about that.

THE CHAIRMAN: Like Altnagelvin did when Raychel died?

A. Yes. Okay. So we were here in the middle -- we were in the transition between what was custom and practice and now the Department saying, "Actually we now think we need to do this differently".

I think the important point here is that had we

submitted an SAI at that time -- and I accept with hindsight that's what the Department's intent would have been --

Q. Yes?

A. -- and indeed it would have certainly -- we were sending it up clearly in 2006, because public concern -- we were referring to the coroner. We knew in December 2004 we were referring it to the coroner. When you re-read the circular, it does state "at the time of discovery" and I accept that. There was no ... -- there was no mechanism regionally in relation and indeed within the Department at that time, nor indeed for that matter anywhere else in the UK. I mean, yes, there was "Do no harm" 2001 NPSA established, but if you look at the assessment, the National Audit Office assessment of how effective that had been at that time, again it shows the difficulties and challenges in introducing a regional system.

THE CHAIRMAN: I missed this a bit --

A. Sorry.

Q. -- because it seems to me that the Altnagelvin report to the Department had dramatic effect. The Altnagelvin report to the Department of Raychel's death had a pretty dramatic effect of leading to the development of a committee which put together hyponatraemic guidelines, which, as you rightly said earlier, put us ahead --

A. It did, yes.
Q. -- within the UK on hyponatraemia. So there's a -- there's a pretty pertinent and reasonably recent example of a report which -- which had major benefits to the -- to the children in Northern Ireland.
A. And I accept that. I think the wording of the 2... -- I mean, I think -- I mean, the point I would make is if you read in detail maybe, and I think it is important that we read in detail the 2005 circular in terms of the developmental nature of these arrangements that were being taken forward, the 2004 circular, and it says so at paragraph 7, if we look at the 2004 circular, was seeking to build on existing incident reporting systems which were in trust. There was no regional system at that point in time. If you actually look at the -- sorry. I don't know. Isn't it WS061/2, is it?
Q. You want the 2004 circular?
A. Yes, please.
Q. Sorry. I beg your pardon. It is WS061/2 at page 425.
A. I mean, I think there is -- I mean, if you -- maybe -- could we start from the start of the circular, please? Sorry. I don't know what the page number is. Apologies. Paragraph 2.
THE CHAIRMAN: Go back one.
MS ANYADIKE-DANES: Go back one. Right.

A. The page before, is that paragraph 2? Oh, sorry. There it is.
Q. No, paragraph 2 is there.
A. Yes. I mean, this circular clearly indicates that this is interim guidance. If you look at the final paragraph, which I think is paragraph 19, it says that the Department would keep this under review and welcomes feedback. So this was very much initiating arrangements for adverse incident reporting in Northern Ireland and this was interim guidance.
Q. The -- sorry, Dr McBride.
A. No, it's okay.
Q. The fact is the Department wanted these things to be referred to it, and for that matter it wanted them to be referred urgently, and it defines serious adverse incidents.
A. Yes.
Q. So the point that I am making to you is that was a requirement, that you had to do that in 2004. Then they followed it up in 2005 --
A. Uh-huh.
Q. -- and you ultimately do it in 2006. When one looks at what you actually say on your report in 2006, and if we just pull up that, 302-164-003, if you leave out the first sentence under "Briefly explain", which is that:

"The HM coroner has obtained independent expert reports."
And for that you might say, "We had obtained an independent report in Professor Young", everything else there could remain absolutely the same whether you were doing that in 2004 or 2006.
A. Again I wanted to make this point and it is about wording. I think if you look at the document, this was a new system that was going out, and indeed if you look at the 2005 circular and the 2006 circular, it makes clear the development nature of these arrangements. We had -- over a 21-month period the Department issued four circulars in relation to SAI reporting. They issued one in July 2004, which we were just looking at, one in June 2005, which you've referred to.
Q. Yes.
A. Indeed, there's important aspects other than reaffirming. There's aspects recognising that there was a need to clarify definition in relation to what constituted an SAI. It alluded to in 2005 the arrangements the Department was putting in place at that time, and indeed you had a further revision of the definition of an SAI and a new pro forma in 2006. Then in September of 2007 you had the first regional guidance in relation to SAIs, definition of SAIs. So this was

very much -- either 2004 --
Q. I take the evolving points, Dr McBride. I do take that, but it's with the -- sorry -- it's with the benefit of hindsight. At the time -- you don't know how many more of these you're going to have. So one lands on your desk in 2004. That's the requirement that you're supposed to notify.
A. Sure.
Q. Why don't you do it, otherwise the argument that you're positing is that anybody who's got a potential SAI sits tight to wait to see how many revisions we'll have in our ongoing process.
A. No. Sorry. That's not the point I'm making at all, Miss Danes. If we look at paragraph 2 again -- and I think this is an important point -- there is a hierarchy of priority that the Department is clearly -- is clearly setting here. As you would expect, the Department must be informed immediately about incidents which are regarded as serious enough for regional action.
I made the point earlier in relation to Claire's case note review. The point that we had ascertained was that there was thought to be a problem in relation to paediatric practice and the use of intravenous fluids at that time. There was no additional regional learning that was identified in the

regional -- in the case note review at that time. So immediate action with incidents which were regarded to be serious enough for regional action.

When we submitted the SAI report in 2006, it wasn't because we felt that there was further regional action needed. That regional action had been taken, as the Chairman reminded us of, in 2002 with the Department saying, "Here is guidance. Make sure that this guidance is implemented". If we then go -- sorry.

THE CHAIRMAN: Does that mean that the reason -- to try to summarise it, the reason for reporting it at that stage is because the inquest is just around the corner?

A. It was on grounds of public concern.

Q. Yes, and the public concern is -- the concern is, "We're probably going to get a lot of publicity in the fairly near future about this inquest, because it's another hyponatraemia inquest".

A. Well, I think that therein lies the point, but I think when the circular went out -- things have changed now -- we -- there was concern in the service -- and I am only reflecting what was the case at that time -- that this circular conflated two things. One was which is about serious adverse incidents, when something goes wrong and in the immediate aftermath of the serious adverse incident. So when something happens in the service,

that the trust makes a decision as to whether or not prior to even full investigation that that's something that requires the Department to be aware of, because there's significant regional learning.

The other element of this which was included was the Department to be made aware of issues which were likely to cause public concern. Now clearly there is an overlap between those issues which may require regional action because there's a patient safety issue and issues which might cause public concern. Clearly an overlap, but also this was being used to -- and again if we come to annexe A, and we will come on to it in a moment, it was also the vehicle that the Department was using at that time for it to be made aware of anything that was likely to arise in -- in -- of concern in the media.

MS ANYADIKE-DANES: Dr McBride, the only thing that had changed between 2004, when you got the first circular, and now when you're submitting your report in 2006 is the proximity of the inquest --

A. Yes.

Q. -- because everything else is the same.

A. Yes, exactly.

Q. Yes, exactly.

A. I accept that.

Q. But when you were in --

A. That's the point I'm making.

Q. When you were in 2004, you already had a matter of public concern. You'd had a documentary identify three deaths relating to this particular condition and now you knew there was potentially a fourth.

A. Sure.

Q. In fact, not potentially. The expert that you had brought in told you, you did have a fourth.

A. Yes.

Q. So that -- that element of public concern --

A. And I --

Q. Sorry. Bear with me.

A. Sorry.

Q. -- is already there and you know that it's going to the coroner. So once you've got all those things in place why are you not referring it to the Department?

A. And I was seeking to explain that, and I've already accepted the point, Miss Danes, that with hindsight it was -- certainly it was the intention of the circular and it should have been done, and I make absolutely --

Q. I understand.

A. But there is -- I mean, I think there's an important context, if I may be allowed a few more minutes. If you look then at the next sentence, it also draws attention

to the need for the Department to be informed, not immediately informed, but to be informed. Okay? So there's a difference of emphasis where a matter of such seriousness that it is likely to cause public concern. Okay?

Now if we then move to paragraph 16 of the same circular --

THE CHAIRMAN: 425.

MS ANYADIKE-DANES: I think that's -- yes, I believe so, Mr ...

A. Okay. In addition -- and it clearly defines those circumstances which would be a serious adverse incident --

Q. Uh-huh.

A. -- and it says if a senior manager considers it likely so, the senior manager is to use judgment.

Q. Uh-huh.

A. If you then go to -- and I think this is where the confusion arose, certainly at least in my mind -- if you go then to annexe A of the same circular, it gives some examples.

Q. I'm not sure I have that.

A. Sorry?

Q. I'm not sure I have annexe A -- sorry -- in terms of a reference, but I can get it now.

THE CHAIRMAN: 427, is it?
MS ANYADIKE-DANES: It's 427. There we are.
A. Okay. Now I'm not saying this is correct or otherwise in terms of interpretation, but I'm just pointing out some of the internal inconsistencies as I interpret it at least in that document.
If you look at examples of serious adverse incident ...
Q. Yes. We have some of those, do we not, in Claire's case?
A. I'm sorry. I'm not sure what you're referring to, but just in reference to -- in relation -- in reference to this -- in relation to examples, "Court proceedings", the third paragraph down:
"Any incident which might give rise to serious criminal charges, impending court hearings, including coroner's inquest."
I suppose what I was doing was making the link, making the judgment that the likelihood -- and the fact that the SAI was reported -- Chairman, you're absolutely right -- because of -- was of likely public concern. What I was making the link to was the inference in paragraph 2 of the hierarchy of priorities that the Department was affording to the reporting of adverse incidents. Those issues of public concern did not

require immediate but needed to be drawn to the attention of this Department. Indeed, as you see in this paragraph, it is suggesting:
"... impending court hearings, including coroner's inquest."
So that was context in my judgment, as per paragraph 16, that I felt the public concern was likely to arise, and indeed it was in that context that when I got the date of the coroner's inquest, that I immediately informed the Department --
Q. Yes?
A. -- but again it was in the context of my -- and I've mentioned this in my first witness statement, 269-1 --
Q. Yes.
A. -- that my understanding was that the Department was aware of this incident, but we had not I accept formally completed the SAI report.
THE CHAIRMAN: How was it? Do you think is this through your meetings that you described at the start of your evidence with the CMO, or grapevine, or what?
A. No. I mean, certainly -- my understanding was that the Department had been advised by the coroner, and I have a recollection -- I cannot be certain, and therefore -- but my recollection is that I had a conversation with the Deputy Chief Medical Officer at that time,

Dr Ian Carson. That's my recollection. I may be incorrect in that recollection. It's clear -- I think the inference from the e-mail of 4th April may well be that certainly Dr Carson had no recollection of that conversation --
Q. Dr McBride -- sorry. Go on.
A. -- and indeed if I was having it informally, then indeed it was -- you could argue that it was not appropriate conversation or a matter on which to be relaying information of that nature. Indeed, as I've said already, with hindsight the SAI -- it certainly was the intent of the Department that the SAI should have been submitted in 2004.
MS ANYADIKE-DANES: Well, then just finally, if one looks at the last sentence in that first paragraph before there's a listing of examples:
"Where there are any doubts about an incident it should be reported."
That's a precautionary principle. If you are in any doubt, report.
A. Yes.
Q. Can I just ask you one -- this is my final question and it really is a query about information, if I can put it that way. After you sent or -- sorry -- after the SAI report was sent in --

A. Yes.
Q. -- it wasn't you who did it -- there were some e-mail requests for information. Can we pull up, please, 269-2, page 9? There we are. You can see it. It's from you to Dympna Curley. It's dated 31st March 2006 and it says:
"Dear all."
So there's others who are in that line:
"The Department has been informed as per circular HSS and have requested a further background briefing, which I will provide."
Can you recall what that was about?
A. Again it's back to the --
Q. Sorry?
A. Sorry. I beg your pardon. Sorry. My apologies. I think it's back to -- and again that would still be the case today, that the -- to my knowledge that the Department may require some additional information. Clearly what we are submitting to the Department is a pro forma and --
Q. No. They've actually requested it. That's what I mean. It's not that they may do. They've actually requested a further background briefing, and you said you are going to provide it. That's why I was asking you what was it and did you provide it?

A. There was certainly no written briefing provided. Certainly what would have been custom and practice at that time would have been that there would have been a telephone contact made and a conversation would have been had. I don't recall that conversation being made or that conversation being had, but that would have been the normal course of events. I suspect that explains the e-mail between 28th March and then -- obviously there was a conversation that happened, and I would infer from that between myself and the Department -- and then you see the subsequent reply of 4th April from Mr Walby, but again that's me seeking to try to --

Q. I understand. Everything is trying to do that.

A. I am struggling to put together the strands of information that's there.

Q. You probably will not have it now, because you have moved on, but is that the sort of communication that would be recorded in writing somewhere?

A. Now absolutely.

Q. And then in 2006?

A. Most probably not. Sorry. 2006?

Q. Yes.

A. Oh, I would have thought more probably.

Q. Well, should it be? Let's put it that way.

A. Absolutely certainly, yes.

Q. Thank you very much.

A. Certainly it would be now.

Q. Thank you. Mr Chairman, I have nothing further.

THE CHAIRMAN: Okay. Are there any more questions for Dr McBride?

MR McCREA: I think so. We are just taking some instructions.

THE CHAIRMAN: Okay. If you can wait for five minutes, doctor, we will tidy up any questioning and get it finished this evening, if you don't mind. Thank you.

(5.15 pm)

(Short break)

(5.20 pm)

MS ANYADIKE-DANES: Dr McBride, there is only one question or one issue that I have for you. I wonder if we can pull up 139-046-001 and have next to it 002. Right. The only reason I pulled up the 001 is so that you can see the date of that e-mail. So the date is 28th March 2006 and you are Ccd into it. Do you see that?

A. Yes.

Q. Okay. Now can we pull off that 001 and put up 302-164-003? There we are.

A. Okay.

Q. The information that you are being CCed into, which is from Peter Walby, that's the information under the "Date

and Brief summary of incident" on the SAI report. Do you see that:

"The inquest into the death of ..."

And so on?

A. Yes.

Q. The bit I want to take you to is where it says -- it is the tail end of the first line in the second paragraph:

"... Claire Roberts' parents contacted the hospital and a review of the notes -- and after a review of the notes it was considered in retrospect that the known hyponatraemia which was treated may have had a part to play in the medical condition ..."

Leaving that aside, you can see that is -- also appears under the "Date and Brief summary of incidents". You can see that:

"It was considered in retrospect that the known hyponatraemia which was treated may have had a part to play in the medical condition leading to death."

Okay?

THE CHAIRMAN: It's in box 2. Working up from the bottom, the last three lines.

MS ANYADIKE-DANES: Thank you very much indeed. So this is an e-mail that comes in or goes off, I should say, first thing in the morning of 28th March and this incident report is being sent off on 28th March as well.

The question for you is: did you understand that what had happened was that there was known hyponatraemia in relation to Claire, which had been treated? Was that your understanding of her clinical path, if I can put it that way?

A. Again it's difficult to think back. I mean, my -- I can't recall -- I mean, I accept that point you were going to ask me, and then I forwarded this on to the Department. Obviously my responsibility is to make sure that I was forwarding accurate information on to the Department.

Q. Exactly.

A. My understanding that -- I think it's my recollection of the information coming out the case note review was that Claire had hyponatraemia.

Q. Yes.

A. I certainly -- I'm not certain if I'm aware of this now from reading the following transcripts.

Q. I understand the difficulty.

A. I find it very difficult. So I'm not clear in my own mind at this juncture whether or not the -- I think the crucial phrase here was "treated".

Q. There is two actually. "The known hyponatraemia", which sounds as if that was something that was known at the time as opposed to something that was discovered when

you looked at it eight years later for your case review. That's one, and the second is that it was treated.

A. Yes. I mean, I think obviously it's a matter for the inquiry to determine whether or not it was treated or not. I have heard a range of views. My understanding -- well, I am not sure honestly what my understanding and recollection was at that time. I didn't note anything unusual about that, I have to say, but then again I wouldn't have been expert in the -- in IV fluid management.

Q. Then whose job is it -- this is being presented --

A. No, I appreciate that.

Q. No, no, I understand that.

A. I accept that point.

Q. This is being presented to the Department.

A. No, I accept that point.

Q. So somebody presumably has the job and the responsibility of making sure the Department is getting accurate information --

A. Yes, absolutely.

Q. -- particularly on the key issue, which is this whole hyponatraemia question. So one way of reading that is that they knew about the hyponatraemia at the outset, if I can put it that way, and it was treated. If that is a way of reading that, then that might be an issue that

would be disputed, the extent to which all that was done, and I know you say, well, it is for this invest... -- this inquiry to establish --

A. Yes.

Q. -- whether it was known and it was treated, but I'm not really at that stage.

A. No, I appreciate that.

Q. This is being presented to the Department. So somebody has satisfied themselves that that is an accurate account of what happened.

A. Sure.

Q. I'm trying to find out who had that responsibility and how was that done?

A. In terms of -- you know, again you can interpret that in another way. I mean, in terms of hyponatraemia there is a -- well, in the loosest sense there's a low serum sodium. I'm not an expert in biochemical markers, but certainly, you know, Claire had a low sodium. It's I suppose debatable, and again it genuinely will be a matter for this inquiry, and I have heard some of the expert witness evidence in relation to whether there was a reduction in fluids, or wasn't a reduction in fluids, or whether there was a planned proposed production. I think that's open to interpretation I think is all really I can say.

Q. Exactly. So where does the information come from? Who is responsible for getting the information to put on that form, make sure it's accurate and submit it to the Department?

A. I mean, ultimately -- sorry. This isn't a trite answer, but ultimately it's the responsibility of the trust. It's ultimately --

THE CHAIRMAN: You are accepting the information provided to you by Mr Walby, who you know had been involved in --

A. Yes.

Q. -- liaising and preparing the trust representation for the inquest. On foot of the inquest he comes back to you, provides that information, which you then report to the Department?

A. And, as you ask it in that way, I see the point that you are making.

Q. Yes.

A. I mean, I had no reason to believe and still don't have any reason to believe that that information would have been anything other than factual, as indeed we understood it to be. Whether or not it actually is factual, as you say, is a matter.

Q. Yes.

A. I certainly -- I certainly would have read it. I certainly wouldn't have forwarded it without thinking.

I certainly --

Q. That's fine.

A. -- didn't spot any inconsistencies, but I accept the point that you're making, and indeed I did forward. So therefore I have a responsibility in that respect.

Q. Yes.

MS ANYADIKE-DANES: Thank you very much. I have nothing further.

THE CHAIRMAN: Okay. Thank you very much.

Mr McAlinden, have you anything for Dr McBride before he finishes?

Okay. Doctor, that brings your evidence to an end. Thank you very much for a long day, and you are now free to leave if you want unless there's anything else.

A. If I could add on a personal note obviously I'm not the Medical Director in the Royal any longer, but I am certainly very mindful of the fact that, you know, it's been sixteen years, as we have mentioned already today, since Claire's death, certainly eight years since I was made aware of Mr and Mrs Roberts' concerns, and it is actually eight years to the day that I referred Claire's death to the coroner. So I am very conscious of that.

I certainly didn't anticipate at that time that the -- they would still be seeking answers to very straightforward and reasonable questions, and obviously

this inquiry has highlighted that there are a range of complex factors and, as is so often the case, there were things that should have happened that didn't, things that happened that shouldn't against the context of some underlying causes and environmental issues, which obviously are properly a matter for this inquiry and for you, Chair, in due course.

I mean, certainly all that I would want to add is that certainly if any decisions that made at any point in time delayed the Roberts getting those answers, I am sorry for that.

THE CHAIRMAN: Thank you very much indeed. Thank you, doctor.

(Witness withdrew)

DISCUSSION OF HOUSEKEEPING ISSUES

THE CHAIRMAN: Gentleman, I won't keep you much longer than another minute or two, because I anticipate there might be a few problems on the roads tonight.

We're starting tomorrow morning at 10 o'clock with Dr Steen I think. Is that right?

MR FORTUNE: Yes, sir.

THE CHAIRMAN: Okay. Thank you.

I have received two papers in the last half hour. There is a paper, Mr Green, that you've provided, which is by way of a submission about what I should do in

relation to Dr Sands.

MR GREEN: Yes. I don't want to say anything about that now. It's -- I just thought sooner rather than later so that you had ample time to think about it. I have copied Mr Quinn in and asked Mrs Conlon to copy all the interested parties whose e-mail addresses I don't have in. Miss Danes and my learned friend Mr Quinn have been copied in. It is perhaps appropriate they have an opportunity to read it and think about it overnight before anything else is said about it.

THE CHAIRMAN: Right. Well, I think that the other interested parties should see this submission this evening. It is copied and it can be handed out in the next couple of minutes. Okay?

MR GREEN: Thank you very much.

THE CHAIRMAN: Mr Quinn, then from your instructing solicitor I have received a three -- two and a half page letter which is along the lines of effectively supporting -- setting out issues which you want to be developed with tomorrow's witnesses, and I presume that's a reference to Dr Steen?

MR QUINN: Yes, mostly Dr Steen.

THE CHAIRMAN: We'll consider this overnight. Dr Steen gave some evidence about this this morning.

MR QUINN: She did.

THE CHAIRMAN: I am reluctant to go back over this again tomorrow, but I will consider it tonight. Dr Sands is coming back tomorrow to deal with this specific allegation. I am interpreting this for the moment as points which you want to be picked up and developed and tested by Ms Anyadike-Danes in her questioning.

MR QUINN: They are points that will appear in our submissions.

THE CHAIRMAN: Yes.

MR QUINN: They are points that were developed by Mr and Mrs Roberts after hearing Dr Steen on various issues. So therefore we couldn't have been prepared for the points -- most of the points. They are points that perhaps in fairness should be put before they are put in the submissions. That's the only reason why we sent them. We don't think that there will be much developing of them. Dr Steen has already put her case very, very straightforwardly. So there's not much more can be developed out of that, but those are the issues that we see may need some touching upon tomorrow.

THE CHAIRMAN: Right. Well, I don't see this -- I see this as slightly different from Mr Sands' -- Mr Green's submission on behalf of Dr Sands, which really for those who haven't seen it is an invitation to me to consider the allegation made against Dr Sands and then

effectively make a ruling on it before Christmas. Now that I interpret effectively as a submission on how I should reach a conclusion and when I should announce that conclusion on that issue. So in a sense -- in a sense that's procedural. Right?

MR QUINN: It is.

THE CHAIRMAN: Your submission is in a sense factual, that these are the points which you want Dr Steen and Dr Sands to be tested on.

MR QUINN: Yes.

THE CHAIRMAN: So in a way it is directly lines of questions which you would like Ms Danes to ask. Isn't that right?

MR QUINN: Exactly. That's why we produced it.

THE CHAIRMAN: Okay. Well, that being so, I think that -- is it -- would you agree it's appropriate for these lines to be shown to the representatives of Dr Sands, Dr Steen and the trust?

MR QUINN: Yes. No objection to that.

THE CHAIRMAN: We will also arrange that in the next few minutes. Mr Fortune?

MR FORTUNE: Sir, I was about to ask for sight of the document.

THE CHAIRMAN: You're getting it.

MR FORTUNE: Can I just say this, having heard my learned friend? I was not aware that Dr Sands had a case to

put. Dr Sands is here to assist you, sir, to answer questions. As far as I know this is not supposed to be an adversarial contest, although at times it may seem a bit like that.

THE CHAIRMAN: Well, I am arranging for Mr Green's paper to be circulated tonight, because it is a suggestion about how I should deal with this element of the inquiry by effectively virtually an immediate report, and that -- we can consider that tomorrow.

Mr Sephton, just one point for you. There was an issue which came up last week in a document which we have asked for Dr Webb's response on. Can you help us with that? Are we going to get a response and when?

MR SEPHTON: I don't know when, sir. The letter has been sent to Dr Webb for his comments. There was a delay because the documents were not picked up until Friday I think, but it's on its way.

THE CHAIRMAN: Well, I would be -- since Dr Webb has made a wonderful degree of recovery, which I am very, very, pleased about obviously, I would be very grateful if you could find out if you could -- see if you could find out if we have some word back tomorrow from Dr Webb, because it's a -- in the scheme of things it is not an irrelevant point. Okay?

Thank you very much. Tomorrow morning, 10 o'clock,

ladies and gentlemen. Thank you.

(5.40 pm)

(The hearing adjourned until 10 o'clock tomorrow morning)

--ooOoo--

I N D E X