Tuesday, 18th December 2012

(10.00 am)

(Delay in proceedings)

(10.22 am)

Housekeeping and timetabling discussion

THE CHAIRMAN: Okay. I am sorry we started a little bit late today, ladies and gentlemen. There was some business to sort out from the papers that came in last night.

I think the order today is we are going to start with Dr Steen. At some point, Mr Fortune, if and when Dr Steen needs a break, we will move on to Professor Lucas. Then we will come back to Dr Steen and finish with Dr Sands; is that okay? Right.

MR FORTUNE: It depends how long Professor Lucas is going to take --

THE CHAIRMAN: Yes.

MR FORTUNE: -- because I am not sure that Dr Steen will be up to sitting in the afternoon.

THE CHAIRMAN: Well, let's see. Professor Lucas is available into the afternoon, so let's see how the morning develops. Okay?

Before we do that I said yesterday or I gave a message yesterday that I would confirm what the schedule is between Christmas and Easter. What I will

do is I will do that now and then we can go into Dr Steen's evidence. If anybody has anything to say afterwards about what I am about to say, they can pick that up either later on today or tomorrow, but I don't want to delay today's evidence any longer than it is already delayed.

I have already announced that we will sit in the week beginning 14 January to complete some outstanding evidence which primarily relates Adam's case, but in the cases of Dr Carson, and particularly Mr McKee, it runs into Claire's case. So in that week of Monday, 14 February --

MR FORTUNE: February?

THE CHAIRMAN: Sorry. January. Thank you. 14 January, we will hear from Professor Rating and Professor Kirkham. We are trying to arrange Professor Kirkham to give evidence which would then be followed by Professor Rating. At the moment, that's a bit difficult. So I cannot yet confirm which days they will be sitting -- they will be appearing in that week, but we will try to do them in that sequence. That week, we will also then do Mr McKee and Dr Carson and then Professor Mullan, who you may remember from some months ago was the governance expert for the inquiry in Adam's case. So that will be the week of 14 January.

Beyond that, we have to vary the running order. As you know, our intention has always been to move on from Claire's case to the aftermath of the death of Lucy Crawford as the way into the case of Raychel Ferguson. While we are about 90 per cent of the way through the preparation of the Lucy aftermath segment of the inquiry, there is an issue which has emerged in the last two weeks, which we have to resolve first. It is unlikely that we will be in a position to resolve that before 20 January. Accordingly, I am going to switch the two segments of the aftermath of Lucy's death and Raychel clinical. The effect of that will be that from Monday, 20 January, for four weeks, I will hear the evidence in Raychel clinical.

MR QUINN: Is that the 28th, sir?

THE CHAIRMAN: From Monday, 28 January for four weeks. There will then be a one-week break, which will be the week of 25 February. Then from 4 March, for four weeks, we will deal with the aftermath of Lucy's death.

I should say now before you all start lining up those diaries, those four weeks for Lucy will take us up to Thursday, 28 March, which is three days short of Easter Sunday because it is an early Easter in 2013. So it is four weeks from 20 January for Raychel clinical, a one-week break and then four weeks from 4 March for

the aftermath of Lucy.

As you will realise, what is left after that are three areas which have a thread running through them: One is any governance issues in Raychel's case; the second is the role of the department; and the third is Conor Mitchell's case to the limited extent that we are looking at Conor's case from the aspect of the implementation of the hyponatraemia guidelines.

As you will see from the tight schedule through January, February, March, we will need some time after Easter to finish the preparations for those three elements, which will be taken -- which will run together. It is therefore most likely -- this will have to be confirmed -- that they will be taken together from Tuesday, 28 May. The Monday, 27 May, is a Bank Holiday. So we will start on Tuesday, 28 May and run through to Thursday, 4 July. So I will leave that with you for now.

I should say that in Raychel's case the clinical papers will be distributed this week. Interested parties were identified and notified on 8 November, that's six weeks ago, and we have not heard anything other than to say they are all still represented by DLS. The papers will go to DLS this week. It is then up to the doctors and nurses who have been identified to

advise if they have separate representation. Okay.
MR LAVERY: Yes.
THE CHAIRMAN: If we need to come back on anything about that later, we will do so. In the meantime, let's push on with Dr Steen.
MR GREEN: Just one matter. Dr Sands is here. He is in a side room gathering his thoughts. He is finding the whole process very trying and would like to be called sooner rather than later. So I wonder, if it wouldn't inconvenience anybody else, if he could be called perhaps as soon as Dr Steen finishes her evidence. I am conscious that we have Professor Lucas at the back, but ... Dr Sands is, as I say, find it trying and a shorter rather than longer period on the starting blocks would be much appreciated by him.
THE CHAIRMAN: There is a certain logic to that in the flow of the evidence. We will start with Dr Steen, we will go for maybe an hour and a quarter until 11.45. Then we will take a break for the stenographer. If there is an agreement about the order of witnesses, I will take that agreement, and if there isn't, I will deal with it after the break; okay?
MR GREEN: That's very helpful. Thank you very much.
THE CHAIRMAN: Dr Steen.

DR HEATHER STEEN (continued)
Questions from MS ANYADIKE-DANES (continued)
MS ANYADIKE-DANES: Good morning, Dr Steen.
A. Good morning.
Q. Dr Steen, yesterday formed a slightly different order of dealing with matters in the sense that you were rather helping us with things that you were prepared to concede were deficient in the care or the arrangements for the care of Claire or fell below the standard that you would have expected.
A. Yes.
Q. And I think you ran through a number of points, which I don't need to recap this morning, but just formally speaking, if I can deal firstly with this: you have provided a witness statement on governance aspects. The reference for it is 224/3. It is dated 6 November 2012. It is not as full a statement as perhaps we had invited from you, but it was doing the best you could in your circumstances to get us something in writing to be shared amongst the other interested parties. So recognising it is perhaps not as full as it might be, do you nonetheless adopt that as your evidence, subject to anything else that you might say in this oral hearing?
A. I do.
Q. Thank you. You also have a CV; do you have that with

you there?
A. No.
Q. Ah. Well, I am sure that can be furnished. We saw your CV previously, but we perhaps weren't looking at it entirely from the point of view of governance issues, if I can put it that way. The reference for your CV is 311-017-001. I am not going to go through the clinical aspects of that because you have already helped us with that during the clinical phase of the hearing, but just to ask you about certain matters. You did become clinical director at some point; can you help us with the date of it?
A. Can I -- is there anything else on any of the pages?
Q. About clinical director?
A. Yes, medical management posts. No. I think it was when Dr Hicks stood down, there was a period where there wasn't a clinical director for a few months and then I took it up. I think that was approximately 2001.
Q. I can -- the best we can do on this is this first page --
A. Yes.
Q. -- where you say that:
"Between 1999 and 2010, I took several medical management roles, including clinical director for paediatrics."

A. Yes.
Q. So that gave us the spread. We wanted something a little more particular than that.
A. In 1999, I took on the role of sub-director for ambulatory services. So I supported the clinical director for out-patient services, A&E and acute medical paediatrics. Dr Hicks then stood down, I think, in 2001. The clinical director post was a very onerous post. Nobody particularly wished to take it on and there were some discussions. I agreed to take it on with the understanding that additional support would be put in and the Chief Executive then undertook a reorganisation, not purely because of what I had said, but I think he recognised there needed to be reorganisation within the service, and he introduced divisionalisation. He divided the Trust into divisions. Now, from a medical management perspective, what really helped with that was he identified additional support.
MR FORTUNE: Can we slow Dr Steen down? I anticipate the stenographer is having some difficulty.
MS ANYADIKE-DANES: Sorry.
THE CHAIRMAN: I think what you had said was:
"From a medical management perspective, what really helped with that was the Chief Executive identified additional support."

Okay. Right. So those are the circumstances in which you took the job on. Let's leave it at the moment from some time --

A. No, we will take it further. So the additional support was that he developed divisional directors who had 50% -- five sessions -- divisional medical management and also some performance management, and that helped support the entire medical management structure within the Trust. And I took up the divisional director's post -- I think it was 2002. Others can correct this -- for women's and children's services and then Dr Paul Jackson became clinical director in children's. Then under revision of the trusts in 2007, again there was a restructuring, and the roles were changed again. A lot of the direct management issues went out of the medical managers' posts and they became much more what we called associate medical directors and, for a period of three years, I was associate medical director for women's and children's services.

MS ANYADIKE-DANES: What you said, about how others might be able to help, actually Dr Hicks herself has tried to help. In her transcript of 11 December -- we don't need to pull it up -- at page 16, lines 4 to 14, she thinks you took up your position -- at that time she was referring to it as "clinical director" -- in March 2002.

A. Uh-huh.

Q. Would that sort of fit with what you are thinking?

A. Yes.

Q. Thank you. Irrespective of whether it was clinical director -- sorry. Maybe I should just clarify that with you. The slight reorganisation that gave rise to the divisional director post, did that happen around that time or some time shortly after 2002?

A. I think I was in post about a year before it happened.

Q. So 2003 roughly then?

A. I mean others -- this is --

Q. I understand.

A. -- Royal Trust business and it should be clearly documented, the process and the dates somewhere -- sorry. I am sure I shouldn't have asked for more documentation.

Q. Anyway, so you were there with the particular, if I can put it that way, managerial role that a clinical director has from 2002 onwards --

A. Yes.

Q. -- would that be fair to say?

A. Yes.

Q. Thank you. Just so we have it, that means that you were in post round about the time that the hyponatraemia guidelines were being introduced.

A. That's correct.

Q. Do you actually remember that happening?

A. I just remember two little bits out of the whole thing. There had been -- there had been a lot of discussion around hyponatraemia, a lot of discussion about what was happening. There was awareness that there was -- the department were developing the guidelines and I think some Trust staff may have been involved in those early guidelines, and they came out on a page, an A4 page, that would be put up in every notes.

I actually remember Bob Taylor coming down to Allen Ward and putting it up in the treatment room in Allen Ward.

Q. He was part of that group. Did you know that at the time?

A. I probably did at the time. He actually put it up in Allen Ward and drew everyone's attention to it. We also incorporated -- the junior doctors at that stage had an induction programme.

Q. Uh-huh.

A. So when they came and started with us in August, there were two to three half-days where we took them through some processes, et cetera, so that they had an induction into working in the Children's Hospital. That went into -- that page went into their induction process and

IV fluids were then part of the induction process.

Q. Would it have fallen to you to ensure that a degree of prominence was given to those guidelines, that there was some system in place for monitoring and evaluating their compliance with them? Would that have been part of what you would have done?

A. Part of my role and the manager's role and the nurse manager's role.

Q. And if it was part of your role together with the other two that you mentioned, what actually did you do to set up a system to ensure that?

A. I can't remember. I am sorry.

Q. Was there a system established?

A. I can't remember. I am sorry.

Q. And the reason I am asking you this is, apart from the fact it was part of your role -- I don't know if you were here when Nurse McRandal gave her evidence. Her evidence was that then in Allen Ward the nurses were not measuring urine output.

THE CHAIRMAN: Sorry. Now.

MS ANYADIKE-DANES: I mean at the time when she was giving her evidence, you know. Why I was asking you that is because that would indicate that the guidelines -- the 1992 guidelines -- forget about the fact they were revised in -- the 2002 guidelines -- forget about the

fact they were revised in 2007 -- were not being monitored, measured appropriately.

If we pull up the guideline itself, it is not a very good depiction of it, but it is 069A-088-358. Okay.

THE CHAIRMAN: Do you want to refer to it to show that the guidelines say specifically that output is to be measured?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: I don't think there is any dispute about that, doctor. Part of the guidelines is that urine output is to be measured; is that right?

MS ANYADIKE-DANES: Just in case you can't remember --

A. I can't remember, but if it is there, it is there.

MS ANYADIKE-DANES: What it says it:

"Fluid balance must be assessed at least every 12 hours by an experienced member of clinical staff."

Then it has "intake", which we are not concerned about.

A. Yes.

Q. Then it has output:

"Measure and record all losses (urine, vomiting, diarrhoea, et cetera) as accurately as possible."

And what Nurse McRandal was saying was that even now in Allen Ward, they were putting "PU", passed urine.

They were not measuring -- whether by weighing nappies or some other sort -- the urine output.

If you were there when the guidelines were published and issued by the Chief Medical Officer and would have been part of the team responsible for ensuring that they were being implemented, and then questioning how it can be that in 2012 in Allen Ward they are not following a particular aspect of it.

A. I'm unsure why Allen Ward haven't followed the process completely correctly. My understanding was that the nursing staff had been recording the fluid output. I can only suggest that the make-up of Allen Ward's patients were such that there's very few patients on total fluid replacements. I don't know. The nurse managers perhaps can answer that better.

Q. Well, I appreciate you may not be able to remember, because I know you have some difficulties with that, what exactly you did in 2002, but you were still with that managerial role as divisional director with responsibility for women and children up until as recently as 2010.

A. No. Divisional director until 2007.

Q. And then --

A. Associate medical director for women's and children's services.

Q. So associate medical director until 2010. So should you not have known whether or not the guidelines are being complied?

A. And my understanding was, from aspects of any audits that were carried out -- and including the RQIA inspections -- that people were satisfied with the guidelines. So it was a surprise to me to hear Nurse McRandal saying that that aspect has not been carried out because we have been inspected. The Trust has been inspected by RQIA and I am not sure that that was raised as an issue.

Q. Well, we can go back and look at what the RQIA found in terms of the validation in relation to these guidelines in 2008 and 2010, but in any event, any process that you put in place for auditing the implementation and recording that should, if that was what was happening, should have identified that.

A. Yes.

Q. Thank you. Can you help with this? So far as you are concerned were there meetings, were there plans for how to implement, educate and monitor the guidelines?

A. There may have been meeting and plans, but I can't give you details. There certainly were meetings and plans. The governance structures were being developed much more strongly, and I remember one small bit of work that

I was doing with one of the chief pharmacists where we wanted to do small workshops on drug prescribing as well as IV fluid prescribing, child protection. We wanted to do more of that, so certainly I know there was ongoing work being done. At the same time, there was a lot of work being done in trying to develop our IV fluid guidance, our IV fluid input/output chart, and there were contributions being made regionally towards that to try to improve the documentation, because our IV fluid charts were not adequate to allow us to document accurately all that was happening.

Q. Yes. How involved would you be in your -- this is taking some time away from Claire, I understand that, but now we have -- this is what your position is. How involved would you have been in any decisions that the Children's Hospital would have made as to how they used Solution No. 18?

A. Certainly as clinical director I would have been quite closely involved with that and Solution No. 18, in 2002/2003, was being restricted right down. Again somebody else can give you more detail than I can, where we used it -- we restricted it right down to PICU, the renal unit and I think oncology because of their specific concerns and some of the complications of their drugs and there was a -- over a period of time, the

whole provision, the type of IV fluids we had in the ward were all changed so that the -- the fluids come in a bag and there is lots of different types. You have it with extra sugar, extra sodium, extra potassium. So you can have different combinations. So there was a lot of work going on identifying what times of fluid bags we needed, how we were going to get them into the wards, keep them clearly needed, make sure the fifth-normal solution was being monitored closely and only available in certain circumstances.

Q. I see that. Did the Children's Hospital, and clearly the premiere children's hospital in Northern Ireland and a teaching hospital at that -- did it share that knowledge with other hospitals: this is what we are doing?

A. People were sitting on the working party, so there was information being shared across the working party about processes, and I think I attended about two meetings of that, but other people attended --

Q. I don't mean about developing the guidelines. I mean about in the response to that, attitudes to what you would do about controlling the use of Solution No. 18. Was the position that the Royal was taking in relation to that being communicated to other hospitals and trusts?

A. I will think it probably was through the working group. I don't know. I'm not sure.

Q. Okay. Then --

MR FORTUNE: Perhaps we could find out from Dr Steen whether members or clinicians of other hospitals sat on the working group because, in that way, we may get a better picture.

MS ANYADIKE-DANES: Thank you. You said you attended two.

A. I think when the working group was first set up, Jarlath McAloon took it over. There was only one anaesthetist from the regional centre on it, which had caused some concerns because the district general hospital fluid needs are not as complex as when you come to a regional centre, where you may have total parenteral nutrition, two different types. It just wasn't. So I asked for further representation. I can remember attending I think two meetings in Dundonald House and then I think Peter Crean took a role and various other members took a role. I think Bill McCallion, I don't know, may have taken a role in surgery, but there was much more sub-specialty input to that working group.

Q. Do you actually recall attending -- I think you said you attended two. Do you recall that?

A. I think I attended two.

Q. Were there clinicians from other hospitals?

A. Yes, there was anaesthetists and a paediatrician, I think, from every hospital and maybe a couple of A&E consultants from across the Province. I mean, the membership of that group will be documented somewhere.

Q. Was there any intention to get it representative, so you'd have people from Altnagelvin and so forth?

A. Yes, I think there was -- I can remember some faces around the table. The membership of that will be well documented somewhere.

Q. Thank you. Sorry. I took you out of the way, really, because I had not appreciated that you had quite that role and for quite that long, if I can put it that way.

If I can now move to things specific to Claire and try and move roughly in chronological order, but taking it from the point where we had more or less left off, if I can put it that way, when you were giving your evidence in the clinical phase. I want to ask you about the cause of death --

A. Yes.

Q. -- as a first point. Dr Webb expressed the view that the cause of death was, and it is as he recorded it in the notes:

"SIADH, hyponatraemia, hypoosmolality, cerebral oedema and coning following prolonged epileptic

seizures."

When you came to write the death certificate, how did you go about determining what was the cause of death to complete that death certificate?

A. I have no recollection. I can only assume it was following discussion with Dr Webb. Dr McKaigue can remember some discussions that took place around the time. It was what we thought was the process. The encephalitis hadn't been proven, which is why we had been seeking a limited post-mortem. You can say the status epilepticus hadn't been proven, but Dr Webb was convinced that had a role in it.

Q. Yes.

A. I think when you look back, the hyponatraemia was seen as a consequence of the other underlying processes and they have was not put in. It obviously would be put in now just --

Q. Was there any reason why you didn't frame it -- if you were to a large extent dependent on Dr Webb's characterisation of what had happened, because you hadn't really been involved with treating Claire or had actually seen her to examine her, if you were dependent on him, is there any reason why you didn't characterise in just the way that he had in the notes and records?

A. I have no recollection. We had a discussion. I am sure

we had a discussion and that's where we moved forward.
Q. Well, did you form an independent view from looking at the medical notes and records or was your view really from the discussions of those who had actually treated her?
A. I have no recollection.
Q. You don't know?
A. I would -- in reconstructing it, I strongly feel that there was discussion with Dr Webb about the way forward, not only around post-mortem, but also cause of death, and the conversation, discussion with the parents.
Q. Well, maybe I can put it in this way: I think you said that you didn't know about the encephalitis point because that was one of the things that you believed you might learn after the brain-only autopsy.
A. Yes.
Q. You weren't going to learn anything more about the status epilepticus.
A. No, not unless there had been hippocampal changes, I believe.
Q. On the back of the certificate of cause of death -- I think you refer to it as "a wee box".
A. Yes.
Q. There is a box that indicates, that if you receive further information, you may revise.

A. Yes.
Q. It is a very blurred copy, but we can see a sample like that. 269/1 at page -- if we pull up pages 113 and 114. Take those two together. Well, let's look at that. That's the --
A. Front.
Q. -- front of it. You can see how it is framed. There is the (a), which in this case would have been the cerebral oedema and then there is the (b), which in this case was the status epilepticus.
A. Yes.
Q. Then if we pull up the 114 and flip that around, you see it is quite blurred, but that's the sort of thing you are talking about; is that right? (a), if we just see that.
A. Yes.
Q. That's on the back:
"(a) Will you be in a position to give further information for a more precise statistical classification, eg as a result of post-mortem or other reasons? Yes/no."
I think you indicated "yes".
A. Yes.
Q. So you were prepared, effectively, to look again at the

classification of the cause of death in the light of the post-mortem evidence --
A. Yes.
Q. -- or information, I should say.
A. Yes.
Q. Did you? Did you revisit it in the light of the post-mortem report?
A. Revisit the registration of death?
Q. Yes.

A. I don't think we did. I can't find any documents -- I have no recollection. I can't find any documentation to say whether it was fed back to the register of deaths or not.
Q. Is there any reason why having ticked that you didn't do it?

A. Not particularly, no. I obviously didn't think about it at the time and neither did Dr Webb.
Q. Is it possible that that completely passed you by, that you were going to look at that again?

A. Yes. I remember on one occasion the registrar actually came back to us and asked for information. When I ticked that, the register of deaths had actually come

back to me, but I am -- I don't know what happened in this case.
MS ANYADIKE-DANES: Sorry, Mr Chairman.
MR SEPHTON: I wonder if we can find out who "us" is, please.
MS ANYADIKE-DANES: I was going to go there.
THE CHAIRMAN: Well, go there, please. Who do you mean the registrar came back -- you mean in another case, not Claire's case?
A. In another case, the register had come back to me when I had done that asking for further information.
Q. So this is not something that happened in Claire's case so far as you can recall?
A. No, not that I'm aware of.
Q. Thank you. Can you then help with exactly what you thought, on the evidence, was the cause of Claire's death in 1996, what you thought then?
A. I think looking back on what happened, I believed that she had a viral infection which had triggered seizures, that may have caused encephalitis, that it resulted in SIADH, which in turn had resulted in hyponatraemia, which had exacerbated the cerebral oedema, which had exacerbated the SIADH, which got us into a vicious cycle.
Q. Did you appreciate at the time that Dr Webb himself

didn't regard the viral infection as a very strong possibility, if I can put it that way?

A. I've no recollection. Dr Webb was aware of what was happening and was also aware when we fed back to the parents what was happening and I'm not aware that he strongly felt the virus was not a problem.

Q. Not he "strongly felt"; he didn't regard it as a very strong possibility.

A. I can't remember.

Q. Well, let me ask you this then: where did you get your view that what had triggered all of this was a viral infection? Where did that come from?

A. The raised white cell count, the low-grade pyrexia -- temperature -- at the time that she came in, the history of vomiting illness.

Q. And you formed the view that that would be enough to indicate that she'd got some sort of viral infection of a sufficient degree to set off that chain of events?

A. Yes.

Q. Well, if that's the case, were you surprised that that wasn't actually being treated until 5 o'clock?

A. I think the only treatment you can do for viruses is herpes simplex. Herpes simplex encephalitis, my understanding is it is a flitting -- her picture would not have been typical of a herpes simplex encephalitis.

There is a huge number of viruses that can cause encephalitis, but when it was considered, then the acyclovir should have been considered.

Q. Sorry?

A. When it was considered.

Q. When what was considered?

A. Herpes simplex encephalitis as an option. So once Dr Webb felt the herpes simplex, although most unlikely, was an option, then the acyclovir should have been given.

Q. Have you seen any evidence in the notes that he thought herpes simplex was an option?

A. He had asked for acyclovir to be given -- it is only functional against herpes simplex.

Q. But it is not actually diagnosed as herpes simplex in the notes.

A. No. Acyclovir works across a very narrow spectrum of viruses.

Q. Did you ask him how he had got to herpes simplex?

A. No, I have no recollection.

Q. Wouldn't you want to know? You are the person who is now going to take responsibility for formulating the death certificate. You have to form a view as to what caused this child's death at a slight disadvantage because you have not actually examined her, nor have you

had any particular in-depth discussion about her, as I understand it, until that moment in time. So do you not try to do all you can to bottom out what these differential diagnoses are so you can be certain in your mind so not only can you write the death certificate, but you can advise that this is not a case for the coroner?

A. I have no doubt that Dr Webb and I did discuss it and that my view was that this was an explainable -- sudden, but explainable -- death as a result of viral -- viral illness triggering status epilepticus, with or without viral encephalitis, SIADH and cerebral oedema.

Q. I understand that. I am just trying to take you, piece by piece, to see where you got that information from.

So if you had discussed it with him, as you think you must have done, then are you saying that you would have -- you are likely to have asked him how he treated her, in which case, if you did, that should have disclosed, "The reason why I was prescribing acyclovir at 5 o'clock was because I had formed the view that the kind of viral infection she had was herpes simplex"?

A. He wouldn't have had to say that. I would have known it from looking at the notes. Acyclovir he -- in the notes -- I mean, he writes:

"Query encephalitis. Unlikely. Acyclovir."

That's the one virus that we can treat. We can't treat all the other viruses. So he is covering his options. He has considered that as the one virus he could treat and he has covered his options and advised the child be treated.

Q. So it is not he has formed the view it is herpes simplex?

A. No.

Q. Since you can't treat any other virus, let's administer that and, if it is that, at least it is being addressed?

A. It is being treated. I think that was his approach.

Q. If that's the logic, then you would be doing that shortly after 11 o'clock because that's when the notes indicate that Dr Sands, following his conversation with Dr Webb, thought it was encephalitis/encephalopathy?

A. Yes, and I think Dr Webb --

THE CHAIRMAN: The timing depends on when Dr Sands and Dr Webb spoke.

MS ANYADIKE-DANES: Some time after that.

A. And I think Dr Webb maybe gives some evidence on this.

Q. No, I am asking: did you -- you are looking at these notes. You are trying to formulate what happened --

A. Yes.

Q. -- and reach a view as to why the child died. So to

a certain extent you are checking against what you are thinking is happening with what the notes say and whether these things are consistent.

A. Yes.
Q. That's the point. So what I am asking you about is: if you are thinking that the trigger to all this is viral, and you are thinking that, and you see that there is -- by the time you read the notes, at which point we don't know when they were -- an addition was made to them, but in any event, it is put there under the ward round. So you are looking.

A. Yes.
Q. And you are seeing "encephalitis" is there. If somebody is going to take the view, "Well, let's at least treat it with acyclovir because that's all we can treat it from", are you not trying to find out why didn't you start the one treatment you can apply for encephalitis shortly thereafter? Is that not a query you would be making?
A. That would be a query I would be making.
Q. And if you had got an answer to that, that would have -- would you have factored that into your consideration as to how strong is the view that it is viral?

A. No. How strong is the view that it was herpes virus, because acyclovir is herpes.
Q. Okay.
MR FORTUNE: I am troubled by this line of questioning because the ward round takes place some time around 11 o'clock. Dr Sands has a real concern and decides that he needs an opinion from Dr Webb. That opinion is sought some time around midday. Dr Sands leaves it to Dr Webb to attend, examine Claire and to make an entry in the notes. Is it effectively fair --
THE CHAIRMAN: Sorry. Just be clear. When you say "leaves him to make an entry in the notes" --
MR FORTUNE: Well, in the sense that --
THE CHAIRMAN: -- leaves Dr Webb to make his own entry in the notes.
MR FORTUNE: Yes.
THE CHAIRMAN: Sorry. That's fine.
MR FORTUNE: If Dr Webb is going to come and examine Claire, then Dr Sands would have a reasonable expectation that Dr Webb would make an entry in the notes.
THE CHAIRMAN: There was a bit of an issue about entries. I was just clarifying which one you are referring to.
MR FORTUNE: It is at that point more appropriately that any question of herpes simplex or acyclovir might begin to arise. By inference, to criticise Dr Sands or, indeed,

Dr Steen at an earlier stage, frankly, is wrong.
THE CHAIRMAN: I am not sure it is as black and white as that. I think it depends in part what the discussion is between Dr Webb and Dr Sands. Let's move on.
MS ANYADIKE-DANES: Thank you, Mr Chairman.
What I am trying to find out is, when you read the notes, what you were taking from the notes in combination with the discussions that you could have with the treating clinicians who were available to you? If you read the notes, then that encephalitis/encephalopathy entry appears at about 11 o'clock in the ward round note. Sorry. It did not appear about 11 o'clock; it appears in the ward round note.
A. Yes.
Q. Thank you. When you read the notes then, do you notice that the registrar, experienced registrar, Dr O'Hare, has thought about encephalitis and has struck it through?
A. I can't tell you what I thought. I have no recollection. We are now saying what would be the normal process when I was reviewing notes and the answer is, yes, I would have reviewed Dr O'Hare's notes and I would have realised the encephalitis had been stroked out. I would have realised that somebody had written

in, after the ward round, "encephalitis/encephalopathy" and I would have realised Dr Webb's input during the afternoon of the Tuesday.
Q. But is it not relevant to what you are trying -- what you are trying to work out at the moment, because you have got the virus in your mind as a starting point. Is it not relevant to know that the very symptoms you are talking about like the slightly raised white cell count and also whether she were apyrexic or not, that was information that was available to Dr O'Hare, who had examined Claire, and yet had discounted encephalitis at that stage? Is that not relevant to you forming the view that what is at the seat of all of this is a viral encephalitis?
A. I think it's a journey during the disease process. When Dr O'Hare saw the child, she had certain thoughts. When she reviewed the child, she had certain thoughts. When the ward round saw the child, there were certain thoughts. When Dr Webb saw the child, there were certain thoughts. Diseases progress and sometimes as the disease progresses the underlying cause becomes more obvious or, indeed, less obvious.
Q. Yes, and if one looks at the note that Dr Webb would have made after that -- let's just pull these two things up -- it is 090-022-053 -- and then pull up 054

alongside it, please. Yes. Sorry. Thank you very much. That's the entirety of Dr Webb's note when he goes to the ward and examines Claire; okay? As you would have been reading that, do you see anything in that note he makes that relates to viral encephalitis?

A. No. At that stage he says he didn't have a clear picture of the prodrome and yesterday's episodes and the main findings are probably longstanding, but need to be checked, and he felt that she was most likely post-seizure -- acute encephalopathy, post seizure.

Q. So there is no encephalitis there?

A. No.

Q. So, in fact, that doesn't turn up again, if I can put it that way, until the note that's timed at 5 o'clock -- 1700 hours it is timed.

A. Yes.

Q. So that's why I am really asking you where you got your certainty, if I can put it that way, that what has started all of this is a virus and viral encephalitis.

A. She had a temperature and raised white cell count of -- I think it was 16.2, 16.5. Something triggered her illness. She had vomiting. The most likely thing is a viral illness triggering the entire thing. Why else did she get a raised white cell count? Why else did she have a low-grade temperature? Why else did she start to

vomit at home?

Q. I appreciate those questions and those are, presumably, things Dr O'Hare turned her mind to and discounted.

A. Sorry. I need the note. Can we go back, because I don't ...

Q. Of course.

MR FORTUNE: 090-022-052. If you want the whole note it, starts on 050.

MS ANYADIKE-DANES: So she has the viral illness.

A. Yes, she has a viral illness.

Q. But she's taken out the encephalitis.

A. Yes. So she thought, when she saw the child and looked at those issues, there was an underlying viral illness. I am not sure many of the experts don't agree there was an underlying viral illness.

Q. But when you classify it, do you have it as just a viral illness or do you have it as viral encephalitis?

A. Well, that was the final -- that was the question that needed the post-mortem to finalise it. I think that's where I was looking. I think, looking back, because I have no recollection, but looking back, I think that was one of the questions I wanted the limited post-mortem to confirm: had the virus itself spread to her brain or was it all secondary to seizures?

Q. And if the virus hadn't spread to her brain, then what

does that do to her cause of death in your view?

A. Well, then there is the discussion with Dr Webb again. Is he content that the entire picture is due to seizures?

Q. And that is a discussion that you would have to be having with him once you got the autopsy report?

A. Yes.

Q. And was there a discussion with him like that?

A. I have no recollection, but would I assume that there was, especially before we met the parents.

Q. And would a discussion like that -- well, it could have had a bearing on the death certification, could it not?

A. Yes.

Q. So that's quite an important discussion.

A. It is.

Q. Should that not have been recorded somewhere?

A. Yes, it should have been.

Q. Because effectively -- what I think you're saying is that you would have had a discussion like that with him, and the fact that you haven't changed the death certificate means that, notwithstanding the fact that the autopsy doesn't appear to give you much evidence for the viral encephalitis element of it, that must mean that the seizures are actually the trigger for what ultimately led to the cerebral oedema, because that's

the only other thing you have got left.

A. Yes.

Q. That would therefore mean that "I don't need to change the death certificate because I have got 'cerebral oedema secondary to status epilepticus'".

A. Yes.

Q. So the very thing that you would wanted to have clarified has what I think is a viral infection. Does stay just as that -- a tummy bug, for example -- or did it develop into something more and become viral encephalitis. You have got your answer to that, effectively.

A. Yes.

Q. In terms of the encephalitis element of that it, and if that's so, and you have had your discussion with Dr Webb, it must mean that you were satisfied that he had the seizures as producing that chain of events.

A. Sorry. I have got lost a bit in that.

Q. No. Think about it. Cerebral oedema, that's your primary cause, secondary to status epilepticus.

A. Yes.

Q. Yes.

A. My reconstruction of the post-mortem or understanding of the post-mortem results was there was inflammatory change and that there was a viral encephalitis. I know

the experts have now discussed this and looked at it. I know there may be slightly different views, but my understanding going back and looking at what we did and how we acted was that we had felt there was inflammatory change in keeping with a viral encephalitis and, as such, I should have notified the register of deaths of a change in death certification.

Q. Yes, it is one or the other, isn't it?

A. Yes.

Q. If you think that how you interpreted that report was that that virus -- that change, sub-acute inflammation, that that was sufficient to tell you that there was a presence of encephalitis, then the death certificate isn't quite right, is it?

A. No.

Q. So then why didn't you change it?

A. I don't remember. I don't think there was any specific reason why not. It just got missed in what needed to be done.

Q. But that was the very thing that you had wanted the autopsy to deal with.

A. Well, it was also the very thing I wanted to be able to talk to the parents about.

Q. Yes. So it was therefore in your mind. So if it is in your mind and you are going now to explain to the

parents, "Actually we have now got some confirmation", why aren't you changing the death certificate?

A. I don't know. I have never changed a death certificate. I have provided information once when asked by the register, but I have never actually been in the process of changing the content of a death certificate.

Q. But it was one of the things you had held open the possibility to do --

A. Yes.

Q. -- because you could just have ignored that box.

A. Yes, that's right.

MS ANYADIKE-DANES: Okay. Just pardon me one moment. Sorry. (Pause).

If one just puts up, so I am clear about what you are saying now, 090-022-057 -- there we are. See that on that -- the actual bottom. That's Dr Webb's classification or characterisation of the cause of death at that time --

A. Yes.

Q. -- 4.40. Okay? He starts with SIADH, not anything viral. He starts with SIADH and then he goes in to:

"Hyponatraemia, hypoosmolality, cerebral oedema and coning after prolonged epileptic seizures."

A. Yes.

Q. So that actually fits closer, although some of the steps

are not there, if I can put it that way, with your original classification of the death certification.

A. Yes.

Q. Because you have the cerebral oedema which nobody disputes following the CT scan.

A. Yes.

Q. Then you have the seizure activity, which you refer to as status epilepticus, but it is seizure activity and he has that in there actually as part of the trigger.

A. Yes.

Q. If when now you see the report from autopsy, you certainly should have had a discussion with him about that, because that introduces a new factor, in fact, something that you thought, although you haven't characterised it in that way, might have been the original trigger, and that introduces, doesn't it, something that he hasn't got in his note? So you should have had a discussion about that because -- "Maybe we really should be changing this death certification. Certainly it will affect how we explain matters to the family".

A. Yes.

Q. So, as I say again, that was an important discussion. Either way it is an important discussion.

A. Yes, and it should have been documented.

Q. And if it's not documented, what is his explanation then for how he now regards matters if you have introduced a potentially different trigger?

A. I --

Q. To you. I mean --

A. I can't say what Dr Webb thought. I have no recollection. I do know that the two of us were in agreement on the way forward and agreement in speaking to the parents and providing the information the parents requested.

Q. Thank you.

MR SEPHTON: I am sorry to interrupt. Perhaps Dr Steen ought to be asked to deal with the proposition that Dr Webb said he didn't see the parents again and the strong probability -- it certainly wasn't put to him to the contrary -- was that he didn't talk to Dr Steen after the autopsy report came back.

MS ANYADIKE-DANES: Dr Steen?

A. Dr Webb, as far as I'm concerned, did see me with the parents and I think the two letters that were sent in March give some confirmation to that in that I write to the GP, Which was done at the time -- I write to the GP to say that Dr Webb and I had met with the parents. I then gave a brief summary to the GP and said that Dr Webb was going to provide I think -- can we get it

up? No? Do you not want to put it up?
THE CHAIRMAN: Let's put up the two letters together actually. It's 090-001-001 and then 090-002-002. Yes. Thank you: one is your letter, Dr Steen, to Dr McMillin, the GP --
A. Yes.
THE CHAIRMAN: -- and the other is Dr Webb's letter to Mr and Mrs Roberts.
A. Yes.
"Dr Webb and myself have since seen Claire's parents and discussed the post-mortem findings with them."
So that was dictated on 5th March 1997. So at time it was very clear in my mind that Dr Webb and I had both met with the parents and that the action Dr Webb had to do following that meeting was that Mr Roberts wanted a short summary of the post-mortem report, which Dr Webb would send him. Then there's Dr Webb's letter also showing the short summary.
MS ANYADIKE-DANES: Thank you. The short summary that Dr Webb provides reflects the finding of a low-grade infection, meningoencephalitis.
A. Yes.
Q. And the implications of that are something you would have discussed with him.
A. Yes.

Q. Claire is admitted to hospital around about 8 o'clock or so on to the ward on the Monday, the Monday evening. She suffers her respiratory collapse in the early hours of the Wednesday morning. It is quite a sudden turn of events; would you not agree?
A. Yes.
Q. Was that something also that troubled you as to how what doesn't appear to be a very serious set of symptoms, whether viral or otherwise, doesn't appear very serious when she is first admitted, but led to her collapse and death so relatively quickly? Did that trouble you trying to work out how this child died?
A. I am sure it did.
Q. And if it does trouble you, were you able to consider that you had a sufficiently robust explanation for what you thought was the cause of her death and how that could have actually taken hold and happened that quickly?
A. Yes, otherwise I would not have issued a death certificate, and I have seen it since. It was one of my children who I had been looking after for many years who happened to be admitted for a totally separate thing when I wasn't -- when I was on holiday. I got a phone call on holiday to say that she had suddenly arrested and died in the ward. She had what is called

a transverse myelitis. It is like an enterovirus, it is like a polio virus. She had come out with a bit of a temperature and she had just wiped out, her spinal cord, that affected breathing and she stopped breathing. So it is not unknown for young children to come in and rapidly deteriorate. They compensate -- their bodies are strong and they compensate and then they rapidly deteriorate.
Q. And -- well, I will go into it later on. Can I just ask you briefly something about the brainstem death tests?
A. Yes.
Q. I only want to pick up on some points you were not able to deal with because they were not put to you in your own evidence. Since you gave your evidence, we have had expert evidence to deal with the brainstem death tests, in particular both Dr Aronson and Dr MacFaul were of the view that Dr Webb really ought not, in the circumstances of the anticonvulsants that had been prescribed to Claire, ought not to have inserted into her notes or written in her notes that she was -- didn't have any medication of a sedating or paralysing effect. I think that is the expression that's used. I will just get the right one. It is at 6 o'clock just before he is going to do the first brainstem test. Yes.
Under "No sedating/paralysing medication" -- we

don't need to put it up. I will just give the reference. 090-022-058. So you had heard their view that they didn't consider that you could write that, that she did have medication in her system that had sedating effects, if I put it that way. Were you concerned about that? Did you discuss that with Dr Webb?
A. I think we touched on this yesterday.
Q. I am not sure we entirely did. Did you discuss that with Dr Webb?
A. Dr Webb and I would have been very careful about ensuring the criteria to fill in the brainstem deaths. Looking back, her same phenytoin --
Q. You did touch on.
A. Yes, we did.
Q. So what I am trying to ask you is:to what extent you relied on Dr Webb to tell you the likelihood of those dosages remaining present in her system as something that could have a sedating effect?
A. I would have relied, I think, to a certain extent on the midazolam. The phenytoin -- I would have been more aware that the blood level was within the upper limit of normal, but was in the therapeutic range. Therefore, I wouldn't have relied so much on the phenytoin. Also I know phenytoin used to be used a lot for epilepsy, but

it has so many side effects it is not particularly used now; it is just used for the acute episodes. I would have been comfortable with the idea that phenytoin -- actually, when it gets into a high dose, it starts to make you a bit wobbly on your feet before it starts to make you very sleepy. The phenytoin I would have been comfortable with myself.

Q. Would you have been equally comfortable to express a view on the likely sedating effect of the phenytoin and midazolam?

A. I would have relied on him to reassure me -- this is reconstruction -- that the midazolam would have been out of the system.

Q. Either out of the system or if in the system, not, in combination with phenytoin, having a sedating effect --

A. Yes.

Q. -- so you would have needed his guidance about that?

A. Yes.

Q. Is that something you would have wanted to be confident about?

A. Of course.

Q. If I can then just -- I am conscious of the time. Can we have a few more minutes?

A. Or one more session and finish it today? I can't keep, from my health perspective --

THE CHAIRMAN: Doctor, the only question now is whether -- we will finish you today.

A. Thank you.

THE CHAIRMAN: The only question is whether you take a break now and come back either immediately after the break or at 2 o'clock or whether -- do you want to think about that?

A. No. I would prefer that we take a break and get it finished, because a longer break over lunch and all won't necessarily revive me particularly.

THE CHAIRMAN: So if we take a break now for fifteen minutes --

A. Yes. Thank you very much.

THE CHAIRMAN: -- and resume your evidence at 11.40?

A. Yes.

THE CHAIRMAN: Thank you very much.

(11.25am)

(Short break)

(11.40am)

(Delay in proceedings)

(11.52 am)

MS ANYADIKE-DANES: Dr Steen, can I just revisit with you the bases on which you formed the view there was an underlying viral condition? I think, when I asked you about it, you said her raised white cell count was

one issue.

A. Yes.

Q. Then you said her temperature was raised.

A. Yes.

Q. Then you said she was vomiting.

A. Yes.

Q. If I can just address that with you. Let's take the white cell count first. That was raised -- 16.5 when it was first noted.

A. Yes.

Q. But in your note -- you make your note at 4.00 am, 090-022-057. There we are. You can see it just a little bit in the corner there. Can you see it is "WCC = 9.4"? It is down by the time you note it.

A. Yes.

Q. So whatever has happened during the day, it has actually come down.

A. Yes, and I think some of the experts have addressed that, the way in which the white cell count can change during an illness.

Q. No, I am talking from your point of view.

A. Yes.

Q. From your point of view, one of the criteria or one of the reasons why you thought there was an underlying viral condition was to do with her raised white cell

count. What I am saying is that it had been slightly raised, but it was certainly down by the time you are looking at it at 4 o'clock.

A. Yes, and that's what can happen with illnesses. The white cell count varies.

Q. If you are using that as a basis, how do you know whether the white cell count is going down because that's just a normal fluctuation of disease or it is going down because actually the child is recovering?

A. An expert --

Q. No, I mean from your point of view when you are reaching your view.

A. From my perspective, I needed to know what was causing the trigger. If we go right back to her admission details, we can see the white well count was elevated. The fact her white cell count is not elevated further makes it unlikely she had an overriding bacterial infection which pushes white cells up. Viral infections can push white cells down really low, as can bacterial infections.

Q. So it is not a very reliable base though because it can go up and down.

A. It is. If it is elevated it is elevated. If it is elevated, it is elevated for a reason. You then have to watch the fluctuations, but use it with other symptoms,

signs and tests to determine if the infection is developing further.

Q. Does that mean it should have been tested more often to see if there were fluctuations?

A. No, because I think it was felt to be viral. I think one of the questions raised earlier was why wasn't there a differential done at the time of admission and that differential would have allowed us to determine it was lymphocytic, which is the white cell most involved with viruses. A fluctuating white cell count will not necessarily affect the progress or the treatment.

Q. Okay. Let's go to the other one, which is temperature. We can see that on the central nervous system observation chart, 090-039-137. Okay. The temperature you can see where it is on the far right-hand side. Do you see the temperature there?

A. Yes.

Q. Those are the values for temperature. The actual record of it you can see it almost opposite that or adjacent to it in the middle where you can see those two raised parts; okay?

A. Yes.

Q. So there is two raised parts and then it comes down again. We know from having looked at her medication that she was actually prescribed paracetamol. So it

really only goes up on two occasions. Then it is pretty normal on admission. It goes up on two occasions, comes down --

A. Sorry. Can we go back to the A&E notes?

Q. Yes, we can. The A&E note is to be found at 090-012-014.

A. There is another page that her obs are on.

Q. Well, it is the referral. Can we pull that up alongside 090-011-013?

A. No. There is another page that gives her clerk-in details, her obs, temperature, pulse, respiration.

Q. Then that's 090-010-012.

A. Her temperature is normal there. I can only do this by going back through her notes bit by bit.

Q. That's fine. It is normal there on admission.

A. It is normal there. Then we need to go to ...

Q. Then it is normal -- apyrexic. That's normal, isn't it?

A. Yes.

Q. It is recorded on 090-012-014 as apyrexic, which is in the middle of that line there if you can see that. Then, if you look at the admission Dr O'Hare takes, I don't think one can find any reference to her having a temperature there.

A. Then the temperature, pulse and respiration chart.

Q. Yes. That's the recordings of it since 1 o'clock on the Tuesday, the 22nd.

A. But there's a previous obs chart.

Q. Yes. Let's have a look at that then.

A. Hold on. I had that just a minute ago, actually. Sorry.

THE CHAIRMAN: 090-025-072.

MR FORTUNE: [Inaudible: no microphone] that was a previous admission.

THE CHAIRMAN: Sorry.

A. The issue was had she a low-grade temperature. I think the obs you have shown show she had a low-grade temperature on the evening. Viral infections can be high temperatures, low -- she had a low-grade temperature.

MS ANYADIKE-DANES: She had a low-grade temperature which was addressed by paracetamol and then she didn't have a temperature and according -- if we just pull that back up --

A. The paracetamol would have reduced her temperature.

Q. Just bear with me. Let's pull up 090-039-137 and if we pull up next to it the temperature chart, which is 090-044-147. Right. Do you see evidence of a temperature there?

A. It was 37.3 at time of admission and went to normal and then at -- on her -- if you go to her CNS obs chart.

Q. Yes.

A. It was elevated at -- really it was normal --

Q. It was elevated at 8.00 pm?

A. No, I think it was also elevated at 6 and 7, but then spiked further at 8.

Q. Yes.

A. It is normal. I am assuming the -- if we use the other scale, the 170, the first noted temperatures were normal, and it shows it elevated at 6pm. It improved with paracetamol, but never came down to 37 again.

Q. Yes, but essentially apart from those two slight elevations, which were addressed, essentially her temperature is normal.

A. It's a low grade pyrexia. Normal temperature is 37.

Q. Well, what --

A. And there's a raised white cell count and she had vomiting.

THE CHAIRMAN: What about the vomiting, doctor? The vomiting was overnight from Monday into Tuesday.

MS ANYADIKE-DANES: Yes, we can see it at -- I am sorry. I beg your pardon.

A. Prior to admission?

THE CHAIRMAN: Prior to admission, then overnight Monday into Tuesday, and by the time you see her -- you see Claire at 3 or 4 in the morning on the Wednesday -- what was her vomiting within the previous 24 hours?

A. The vomiting it stopped I think that morning, and I am sure most people who know when they get a tummy bug, you may have profuse vomiting for a period of time. You may or may not have diarrhoea and then feel grotty for a few days.

MS ANYADIKE-DANES: 310-001-001. If we just expand that. Thank you:

"She had vomited in the afternoon prior to admission."

Then you see her recorded vomits along there. They are all indicated by the red diamonds.

A. Yes.

Q. So the last time she is recorded as having a vomit is at 6 o'clock on the Tuesday morning.

A. Yes.

Q. And those are all strong enough indications for you?

A. Those are very common symptoms, as I am sure many people in the room have had, of a tummy bug, a vomiting illness with or without diarrhoea.

Q. And no diarrhoea?

A. Without diarrhoea, yes. A gastritis rather than

an enteritis.

Q. So can I just ask you this quickly? When you formed the view that this was not a case to be referred to the coroner, is that something that you discussed with Dr Webb?

A. I think we have covered this already, and I've said that very clearly. This discussion -- Dr McKaigue has a clear recollection of the discussion at one section during the morning -- the Wednesday morning, and Dr Webb, as far as I'm concerned, would have been part of the discussions right through.

Q. I don't believe he thinks he was part of that discussion.

A. Well, I know and I'm very surprised by that. He maybe doesn't recall.

Q. But you don't recall.

A. I don't recall --

Q. No.

A. -- but he did the second set of brainstem death tests. He would have seen --

THE CHAIRMAN: Let me see if I can summarise it. Your point is if Dr McKaigue -- you don't recall, this but if Dr McKaigue remembers a discussion on the Wednesday morning about why Claire had died and what is now to be

done, you would be very surprised indeed if Dr Webb was not somehow at least aware of that discussion, but more probably part that have discussion?

A. Well, I think Dr McKaigue suggested he was part of the discussion.

THE CHAIRMAN: Yes. Okay.

MS ANYADIKE-DANES: I think one needs to be a bit careful about what Dr McKaigue says. It is 12 December, page 26, lines 2 to 18. I am not sure he says it in quite those terms. Perhaps the discussion starts earlier. I am not entirely sure that Dr Webb is saying he was part of a general discussion with you and Dr Webb as to whether the case was properly a coroner's case. We can address that later on. In any event, it is a matter of surmising because you have no recollection.

A. No. But Dr Webb was part of the process right through until the post-mortem results were received and the discussion with the parents. So just as any other doctor can raise concerns, if there were concerns raised that he was uncomfortable with, they could have been referred to the coroner at any stage as he was part of the process.

Q. Just for completeness what Dr Webb says:

"I was not involved in this discussion and do not know why Claire's case was not referred to the coroner."

That was his witness statement. For reference, it is 138/1, page 53.

A. I am aware of that. I am also aware of what Dr McKaigue has said. I am also aware of due process and our accountability as clinicians to report anything we have concerns about. Dr Webb was also part of the process right through to meeting the parents in end of February/March 1997 and would have been aware. It was in the notes what had happened.

Q. Yes. Dr Hicks, when she gave her evidence, was in the circumstances, so on the totality of things as were presented to her, was surprised that Claire's death was not reported to her. She was then your clinical lead.

A. Yes.

Q. And she was surprised that it wasn't reported to her and that it wasn't reported to the coroner. Just for reference's sake, that's at 11 December, page 53, lines 16 to 23, although we don't need to pull it up. Did you hear that evidence from Dr Hicks?

A. Yes.

Q. Are you aware of it?

A. Yes.

Q. And your comment?

A. I have said, clearly in retrospect, this should have been referred to the coroner at the time, but at the

time I believed we could explain her death and it was due to natural causes.

THE CHAIRMAN: That means that you were sufficiently confident about the cause of Claire's death that you took the view that it was natural causes, that it didn't need to be referred to the coroner and, by the same reasoning, you did not need to speak to Dr Hicks.

A. Well, I don't think there was a process in place that all coroner's cases were reported to the clinical director.

THE CHAIRMAN: No, but if you were referring a case to the coroner because of a concern, for instance, that there was some level of --

A. Medical mismanagement, yes.

THE CHAIRMAN: -- medical mismanagement or fluid mismanagement, then that is an issue you would have had to report immediately to Dr Hicks, isn't it?

A. Yes.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Was there any other issue in relation to Claire that might take you to discuss her case with Dr Hicks?

A. Dr Webb was a neurologist. Dr Hicks was a neurologist. Dr Webb was there giving advice. I don't know -- we didn't discuss it with Dr Hicks, so we must have been

reassured by what we were doing.

Q. I meant from the point of view that she was your clinical lead. It is convenient that she also happens to be a paediatric neurologist. That was also helpful.

A. Yes, so not as a clinical lead. It was not routine to report deaths to the clinical director. There was no process for doing so. The deaths were collated through the audit secretary for presentation at the mortality meeting.

Q. Okay. So in any event, you formed that view that you know you are sufficiently confident in your view that you don't need to report it to the coroner. Then comes the issue as to what kind of autopsy you are going to have.

MR FORTUNE: Before we go on, can I just go back to this discussion involving Dr McKaigue? My learned friend referred to page 26.

MS ANYADIKE-DANES: It is the wrong page, I think.

MR FORTUNE: I was going to say page 25 might be more appropriate.

MS ANYADIKE-DANES: Thank you very much for that.

MR FORTUNE: Because the witness deals with the conversation and then, at line 17, the chairman becomes involved:

"Question: Just to clear up this point, Dr McKaigue: when you were saying earlier that you had the discussion

with Dr Steen and Dr Webb in the early hours of Wednesday morning, if there was any further discussion between Dr Steen and any consultant in PICU about a decision not to refer Claire's death to the coroner, it wasn't with you?

"Answer: No."

MS ANYADIKE-DANES: Now you are on that page, can we pull up the immediately preceding page, but keep this one? Thank you. So this is the issue about -- if we start at line 10:

"Question: Did you interest yourself at that stage in what she had entered [she being yourself] on the medical certificate of cause of death?

"Answer: Yes, I did.

"Question: Given that you believed that meningoencephalitis was part of the clinical picture, that SIADH and hyponatraemia were part of the picture, were you surprised it that she [that's Dr Steen] did not put those on the death certificate?

"Answer: I was surprised that encephalitis wasn't on the death certificate."

Then that leads into the discussion that he had ad which enabled him to take the view you were the clinicians and if you had --

MR FORTUNE: In fairness to Dr Steen, read the whole of the

answer.

MS ANYADIKE-DANES: I beg your pardon:

"... but on the other hand, Dr Webb had again, I think, in his written note talked about SIADH being related to status epilepticus."

"Question: Given that you were surprised that the medical certificate issued didn't accord with your understanding, what did you do in consequence?"

Which leads on could the discussion, which ultimately has him, as I was summarising -- I hope not unfairly -- he formed the view that if the treating clinicians had seen enough evidence to enable them to form that view, then he was really seeing Claire when she was really at the end of her life, as it were.

A. Yes.

Q. But the point I was going to take you to was: whatever was the discussion, he was initially surprised encephalitis was not on the death certificate. So if you were having a discussion with him -- well, you can't remember.

A. I can't remember, and if that's his evidence, I don't think he can remember further.

Q. Okay. Thank you.

THE CHAIRMAN: It is also relevant for Dr Sands that it is Dr McKaigue's recollection that encephalitis was part of

the picture, and this is part of the picture on the morning of 23 October.

MS ANYADIKE-DANES: If we then go on to the point that I was going to ask you about, the brain-only autopsy. Dr Webb says that he's quite clear that it wasn't discussed, that it is between you and he as to whether it would be brain-only, and that's to be found on 3 December at page 226 at line 1. He literally says:

"And I'm quite clear that we did not discuss it."

I know you don't independently remember any of these things, but is your evidence you wouldn't have made such a decision without discussing it with him?

A. Yes, and he would have been aware of the process that was being undertaken when the results came back, the information that was in the post-mortem and how that was shared with the parents.

Q. You've heard the evidence from the other clinicians and the experts as to, if there's no impediment or restriction being put on it from the family, why don't you just have a full autopsy.

A. I can't remember how the conversation went. I can't understand, you know, where we got -- where our process was. I don't find parents coming back and saying that the process of autopsy is not difficult for them and I can't reconstruct what was going on. I just know that

the conversation would have been had with the parents. They can remember bits of it. Some of them, they remember only too clearly. I believe I would have discussed all the options with them.

Q. Well, that sounds like you would have discussed with them the possibility of having a full autopsy.

A. Well, yes. I think I've covered that before in my evidence as well, about the process that you would cover, about whether you can -- you are happy with the cause of death, whether you have any queries, whether those queries could be answered in a following way, and that's a limited post-mortem, a full post-mortem or whether, in fact, you are unhappy and you actually need to involve the coroner.

Q. Well, the parents being unhappy is not really the trigger for involving the coroner.

A. Well, it is actually. Anyone can report a death to a coroner. I think if a family are deeply unhappy about what the process is, there needs to be a discussion around that. It would not be the first time the coroner has been phoned because there are family concerns.

Q. I appreciate that, but the reality is that the extent to which Claire's parents can engage with you in a discussion like that is dependent on the information they receive?

A. Yes.

Q. You have the benefit of looking at her medical notes and records and speaking to the other clinicians involved. They don't. We can see what Mr Roberts says about that time. It is the transcript of 13 December, page 94, lines 7 to 17. He says:

"Yes, I do recall, after Claire's life support was discontinued, that my wife, myself and Dr Steen went into an office just off PICU and we discussed the post-mortem."

I think that means you are there and not Dr Webb, on his recollection of it.

A. Yes.

Q. "It would be a brain-only post-mortem. We were being guided by Dr Steen down that road. We'd never asked -- we never questioned about the scope of the post-mortem. We didn't ask really what had to be done. We were being guided by Dr Steen. We were asking, 'What do we do now?'. This is the process. And Dr Steen then took us through that process that we needed to try and identify the virus."

And they go on in a similar vein in their witness statement for the inquiry, but the issue is they are dependent on you to tell them whether a full autopsy is appropriate or some more restricted sort. So from their

point of view, it is not a matter of you laying out the options to say, "You can have this or you can have that". They are depending on you to say what is the appropriate thing to do in these circumstances. They have never, obviously, been in that situation before.

A. No, and I would have already discussed that with Dr Webb and we would have formed a view before I went in to speak to the parents. I think there was probably a nurse there as well. I am not sure if Dr Webb was there at that stage. He was probably still in PICU.

Q. The question I asked you was simply: why didn't you, in the absence of any form of opposition or restriction from the family -- which is quite often what happens in these cases -- why didn't you just allow a full post-mortem?

A. I have -- obviously Dr Webb and I felt that enough information could be gleaned a brain-only post-mortem.

Q. Yes. Do you think now that it would have been better to have had a full post-mortem?

A. I think probably it would, though I am unsure -- I think the outstanding diagnosis that Dr MacFaul has raised is Reye's syndrome, which would have shown some fatty change in the liver, which I think is very unlikely with her normal sugars and whatever. I think it would have been much easier if we had just gone to the coroner,

never mind a full post-mortem.
THE CHAIRMAN: It is also fair to say that Professor Lucas, who we will hear from later on today, has said in his report that the decision to limit the examination to Claire's head was not unreasonable and he has done so in many similar cases himself.
MS ANYADIKE-DANES: If I now ask you very quickly about the issue of the death certificate. The point I want to ask you very quickly about that is: is that something that you discussed with Dr Webb, Dr McKaigue and/or Dr Taylor?
A. I don't know if Dr McKaigue and Dr Taylor -- Dr Taylor I think was there on the Tuesday morning, so he wouldn't have been in PICU on, sorry, the Wednesday morning.
Q. Wednesday morning, yes.
A. He wouldn't have been in PICU on the Wednesday evening. I think Dr McKaigue must have actually come back. He wouldn't have been on. Dr McKaigue must have actually come back to do the second set of brainstem tests with us and to see Claire to the end. I have no doubt I discussed it with Dr Webb. Dr McKaigue says he is aware of what I wrote in the chart. I don't know how much conversation I had with Dr McKaigue that evening.
Q. I understand.
Can I now deal with the period immediately after the

receipt of the autopsy report? When -- if you had been there when -- I don't know. Were you there when Doctors Mirakhur and Herron were giving their evidence?
A. Some of it.
Q. I took them through some of the benefits about having discussions between the pathologists and the clinicians, which can happen in a number of cases. It can happen before you even refer it to them and they can be instrumental in the kind of autopsy that's going to happen. It can happen when they first get it and they want to make sure that they understand what it is you are wanting them to look at. After they complete, it can happen, and before they issue their final report and then following their final report. So there's any number of opportunities for discussion, depending on the nature of the case. You would accept that, I presume.
A. Yes.
Q. Professor Lucas in his report at 239-002-012 says:
"Perhaps, had there been a mortality conference after the autopsy, a bright clinician might have asked, 'But is that inflammation/encephalitis to account for what happened?'. Then the initial story would have unravelled and a focus on other causes such as hyponatraemia might have emerged."
So what he is pointing to is the benefits of, in

a multidisciplinary way, discussing Claire's death.
A. Yes.
Q. Dr McKaigue has said he thought you did present at a mortality conference; you can't actually remember it.
A. No.
Q. If you had presented, would you have wanted Dr Sands there I presume?
A. If he had -- I don't know where Dr Sands --
Q. No, would you have wanted him there?
A. Yes. I don't know where he was.
Q. And you would have invited Dr Webb presumably.
A. Well, the whole medical staff, except for those dealing with emergencies, would be expected to attend.
Q. And Doctors Herron and Mirakhur have said, from time to time, they have been invited to those sorts of meetings, particularly if they have presented a report that's likely to form part of the general discussion.
A. Yes. The timing of a case being discussed will depend on being able to get as many of the relevant people there as possible, including pathology.
Q. Yes. Just so that we know, so far as you are concerned, what happens at a meeting like that?
A. I thought we'd talked through this yesterday.
THE CHAIRMAN: Let me try to bring this to a head, because we have to get on to your 2004 evidence. If there had

been a mortality conference, and I have to say I am entirely unsure whether Dr McKaigue is right about this, he seems to have a recollection that you may have presented Claire's death to a mortality conference.
A. Uh-huh.
THE CHAIRMAN: If that had been done, then that should have involved you, Dr Sands, Dr Webb, Dr Herron and Dr Mirakhur.
A. Usually only one neuropathologist will come.
THE CHAIRMAN: One of them?
A. Yes.
THE CHAIRMAN: That in itself would have prompted a discussion that, to the extent you were taking encephalitis out of the autopsy report, Dr Herron would have said, "No, no, no. That's such a low-grade encephalitis that that is not actually a cause of Claire's death"; isn't that right?
A. Yes.
THE CHAIRMAN: So in all probability there have appears to have been no such discussion and that leads me away from believing that Dr McKaigue is right. I am not suggesting for a moment that he has been deliberately dishonest; there's just no record of these conferences and, if there had been a conference which had flagged up that encephalitis did not actually feature, that would

have led to a reconsideration of what happened to Claire; isn't that correct?

A. Yes, and there is no record, and at least now there's a record that the case has been discussed and if there were any key issues. I don't know when the neuropathologists determined that encephalitis was not part of it. I don't know if in 1997 that would have come across. The process should have been that it was presented twice --

MS ANYADIKE-DANES: That's the chairman's point.

A. Yes.

Q. In their view, when they wrote that under the commentary of the clinicopathological reconciliation, what that meant was that that was not sufficient to have contributed to Claire's death. That's what they meant by that.

A. Yes.

Q. And when they gave their evidence, they scored it on zero to ten. Dr Herron had it at one to two, possibly closer to one. Dr Mirakhur thought more like two, but in any event apparently five, according to Dr Mirakhur, is the level at which you begin to think that inflammation of that sort contributes to death in some way from their evidence. It wasn't a feature from their point of view.

MR FORTUNE: From Dr Scott-Jupp's point of view, you don't score.

THE CHAIRMAN: That doesn't take us anywhere. If you don't score, it is either there or it is not. If you don't score -- I know Dr Scott-Jupp said you don't score it and Dr Harding said something similar. Dr Harding said "it is either there or it is not". The evidence effectively is it is not there. If you take a different approach, and you do score it, it is there at such a low level it did not contribute to Claire's death. That's the evidence. The only point I am trying to get to with Dr Steen is that the -- we are trying to get through this point as quickly as we can to move on to 2004 -- had there been a discussion along the lines you have talked about, Dr McKaigue has talked about, Professor Lucas has talked about, it is most likely it would have emerged at this conference or discussion that, in fact, encephalitis is not part of Claire's cause of death. Therefore we have to -- we have to discuss between ourselves what did actually cause her death. We have to reconsider referral to the coroner. We have to reconsider perhaps the death certificate. All of that can only be done if there's a discussion.

A. Yes, and we've no evidence of the discussion.

THE CHAIRMAN: Yes.

A. And, as you suggested yesterday, if there was a discussion, then it was totally ineffectual. So either the discussion didn't happen, or if it happened, it didn't actually go into enough depth or interrogate the case to such an extent.

THE CHAIRMAN: So either it didn't happen or, if it did happen, it wasn't worth it because it did nothing -- nothing was learned despite the fact that there are clearly some things that could have emerged from it.

A. I think you summarised that yesterday.

MS ANYADIKE-DANES: And the person to present that and ensure that those threads are tied is you.

A. Myself and Dr Webb.

Q. Thank you. Then just one quick point, because Professor Lucas has referred to it in his report. Remember when we had those two letters? You are writing to the GP; Dr Webb is writing to Claire's parents.

A. Uh-huh.

Q. Both the inquiry's expert pathologists were asked about the interpretation of the autopsy report so as to present -- provide those letters. Professor Lucas' view was Doctors Steen and Webb have over-interpreted the infection pathogenesis compared with the original autopsy report comment. In other words, you have seen too much into it, that's his view.

A. Yes.

Q. Would you accept that now?

A. Well, yes, because we felt that it did indicate encephalitis, and then, of course, there is the CSF findings.

Q. Yes. So if I move on, although just on that, if you had had -- this is another matter you must have felt quite comfortable about, otherwise you would have had some conversation to satisfy yourself about it.

A. Which part?

Q. You must have felt quite confident you could write the GP in those terms, otherwise you would have clarified the point with the pathologists.

A. Yes, yes.

Q. So then if we can go to the meeting with the -- with Mr and Mrs Roberts. Firstly, you are aware of the UTV --

THE CHAIRMAN: Are we now in 2004?

MS ANYADIKE-DANES: We are now in 2004, sir. Sorry.

You are now aware of the UTV documentary because you are CCed into that e-mail that's says it going to happen at 9 o'clock the next evening. Did you watch then?

A. I can't remember if I watched it then or taped it and watched it later.

Q. But you were being CCed because of your position as clinical lead, effectively.

A. But it doesn't mean I was actually available at that time. I certainly watched it within 24 or 48 hours.
Q. You did? What did you take from it?
A. I can't remember beyond being very concerned, very worried about the content, how it would affect clinicians and parents of children. I felt it was a very worrying programme. I can't remember the detail.
Q. I understand that, but maybe you can remember the drift. Was the Trust formulating some sort of group to analyse and assess the implications of that --
A. I can't remember.
Q. -- so that the Trust could respond?
A. You would have to look -- I can't remember.
Q. If it had, would you expect to be part of it?
A. This was 2004? Yes, I would have been. I would have expected that either me or another representative from children's services would have been part it have.
Q. So a response to that is, of course, that Mr Roberts contacts the hospital.
A. Yes.
Q. And the result of that is there's going to be a meeting with them, but prior to that, do you not get contacted by Dr McBride to carry out a case note review, or if it is not Dr McBride, it is Dr Rooney?
A. Yes. Again I can't remember the detail and can't

remember the e-mail trail, but yes, I was asked to carry out a patient journey -- I think is the way it was phrased.
Q. Before you could carry out the patient journey, you would have to do a review of her patient notes and records.
A. Yes.
Q. Leaving aside you can't remember what happened in this particular case, but if you are going to perform an exercise like that, what do you do to inform yourself other than just read the medical notes and records?
A. Well, you get the medical notes and records and you try to go through them in as much detail as you can. It would also -- your focus maybe is drifted slightly by what the query has been.
Q. Yes.
A. So -- I mean, you just go through the records and you identify key issues that you think are relevant.
Q. Would you seek, for example, to talk to Dr Sands?
A. At that stage, not necessarily.
Q. Wouldn't that be part of putting it in context for you, since those medical notes, with the exception of the notes made at 4 o'clock on the Wednesday morning, none of those records are yours and you were not there to see the context in which they were being record?

A. I can't remember at this stage what the process was and what the medical director had asked us to do.
Q. No, I am asking you if you would have wanted to talk to the person who was then registrar and who had most direct contact with Claire during her admission on your -- in your paediatric team.
A. I am not sure at that stage I would have wanted to do anything other than review the medical notes and then determine whether further --
Q. Yes.
A. -- steps needed to be taken.
Q. How thoroughly would you have wanted to look at those medical notes?
A. As thoroughly as I could within a given time frame with other challenging issues.
Q. Were you given a time frame?
A. I can't remember.
Q. Thank you.
Did you know if there were going to be other clinicians looking at those notes?
A. I can't remember.
Q. So you produce a patient journey.
A. I think that was in response to -- Dr Rooney, is it? I don't ...
Q. Yes, I think Dr Rooney asks you. Just so that we have

it, the patient's journey is at 177/1, page 34.
MR QUINN: Mr Chairman, could we confirm whether or not it was Professor Rooney or Professor Young who encouraged the patient timeline -- whatever you want to call it.
MS ANYADIKE-DANES: Patient journey.
MR QUINN: Patient journey. I had assumed it was Professor Young had --
MS ANYADIKE-DANES: I think it is actually Dr Rooney.
THE CHAIRMAN: Yes, because I think Professor Young's -- his involvement was specifically being asked if fluid was an issue. As I understand his evidence, that's what he specifically said he was confined to.
MS ANYADIKE-DANES: That's correct, Mr Chairman.
THE CHAIRMAN: Once he said that, it meant Claire's case was going to the coroner. I know there is a bit of tipping around the edges about the consultation with the family, but that's effectively what his comment meant.
MS ANYADIKE-DANES: So this is yours?
A. Yes, I think so.
Q. So then -- how comprehensive are you intending this to be?
A. As detailed as I could do it. I was wanting the salient facts -- obviously, I would have wanted the salient facts to be there to be able to talk the parents through what had happened with Claire.

Q. Okay. Well, do you see that "loose motions for two days"? Can you help with where that comes from?
A. Right. We would have to -- we have been through the loose motions when I have given evidence before. That needs to have been done either from history-- that's a summation from the notes and we have discussed this before about whether there was a loose motion on the Friday. Dr Webb has written "loose motions for a couple of days", has he? I mean, that -- Dr Webb's note.
Q. Dr Webb's note?
A. Timed at 2.00 pm --
Q. At 2.00 pm?
A. -- on the Tuesday.
Q. I'm just going to that. That's at 090-022-053. Can we pull up the other part of it, 054?
A. And the next bit, his discussion with Mrs Roberts.
Q. Uh-huh. I am not sure that I see "loose motions for two days" there.
A. No, we haven't got to Mrs Roberts' bit.
Q. Sorry. That's at 5 o'clock then. 090-022-055:
"Claire had loose motion on Sunday."
I think that's what that says:
"Background from mum."
A. Yes.

Q. "And vomiting Monday."
MR FORTUNE: We also have a picture based on Dr O'Hare's note on the Monday evening, 090-022-050, of "loose motion three days ago". So if you combine the two, it is not an unreasonable summary.
MS ANYADIKE-DANES: If you combine the two:
"Loose motions for two days."
That's a matter entirely for others to comment on.
THE CHAIRMAN: I have got the point.
MS ANYADIKE-DANES: Anyway, if we then go to the next page -- sorry -- I beg your pardon -- 35, you have got the Glasgow Coma Scale entry at 7 at 14.30, but you don't seem to enter that it goes down to 6 at 4.00 and 5.00.
A. No, this was not a minute-by-minute account of Claire's admission.
Q. But 6 is the lowest she goes to.
A. Yes. At 21.30, I have got that it is 6 again.
Q. That's your explanation, that you don't have -- you are not seeking to put everything in it?
A. I am not seeking to put everything in it. It is an overview of what had happened to Claire with salient facts in it. Her coma scale went between -- I think it was 9 and 6 over a period of time.
THE CHAIRMAN: Sorry. You have got it in twice. You also

have it in the next page at 23.30.
MS ANYADIKE-DANES: If we go to page 36, you don't seem to have summarised Dr Webb's note there. Do you see it at 4.00 am in the morning? It is literally the last line in that box.
A. Yes.
Q. You haven't summarised his note. This is where he says SIADH and so forth that we have already seen.
A. Yes.
Q. That would have been a relevant entry to summarise, wouldn't it?
A. It depends how far I was taking the timeline to. Was I taking it until she was admitted to ICU.
Q. I can answer that. You take it up until 8 o'clock in the morning, which we see on page 37. So is there a reason why you don't include his analysis?
A. No.
Q. But that would have been appropriate, wouldn't it?
A. It depends how detailed I was able to do it within the time frame. It could have been included, yes.
Q. I asked you if it would have been appropriate. Else --
THE CHAIRMAN: I am sorry. We can leave that point because this could lead into a fairly unhelpful debate about whether you include everything and, if you don't include everything, what bits do you leave out and what bits

stay in? So let's move on.
MS ANYADIKE-DANES: Would you have put the second brainstem death test in there?
A. I mean, I stopped at 0800. I don't know why I stopped at 0800, but that's what I did.
Q. Okay.
A. I could have put in the high sodium. I could have put in the DDAVP. I could have -- that's where I stopped.
Q. I understand. When you actually meet the parents on 7 December, you have this with you. At least the evidence was that there were three documents that were available.
A. Yes.
Q. There was her medical notes and records, there was the autopsy report and there was the patient journey.
A. Yes, and this would have been the patient journey.
Q. And that you were, as part of your role -- which is actually to explain to the parents the treatment that she had received throughout her admission -- that was what you were going to contribute and then Professor Young was going deal with the issue of hyponatraemia; is that right?
A. Yes.
Q. Is there any reason why you couldn't have provided the family with a copy of your patient's journey.

A. No. If they had asked for it, they could have received it.
Q. You could have offered it.
A. Yes.
Q. Okay. Professor Young sends an e-mail, which I'm sure you heard if you had heard any part of Dr McBride's evidence yesterday.
A. I didn't, unfortunately.
Q. Ah, sorry. I beg your pardon. Professor Young sends an e-mail to Dr McBride, who was then the medical director, as you know --
A. Uh-huh.
Q. -- indicating to him that you and he had differences about the role of the fluids; do you remember that?
A. No, I don't remember that, but I've heard Dr -- Professor Young's evidence, and he talks about the three slices in a pie and which proportion is attributable to what and I think that any difference we had at that stage was how much was contributed to by epilepsy, SIADH and fluids. You know it was just where the pie was sliced, that there were other issues going on purely than the normal saline and hyponatraemia.
Q. Okay. Did you think when -- because by the time you get to 2004, you are the director -- you are a director yourself.

A. Yes.
Q. Did you think that it might be appropriate to have, if he could be there, Dr Webb?
A. Yes. In fact, I asked that Dr Webb be kept informed because I felt it was quite important that his opinion was taken on board.
Q. No, I mean have him at the meeting with the family.

A. Well, he was in Dublin. It would have been helpful to have him there, yes.
Q. Thank you. Did you think that given that you were involved as Claire's consultant, that it might have been appropriate to have another independent person, maybe Dr Hicks perhaps? Do you think that would have been appropriate?
A. Well, at this stage, I very much was back to being a clinician.
Q. Yes.
A. And I think the way Dr McBride managed this was me, as any other paediatrician or clinician --
Q. Exactly.
A. -- as was Dr Sands. So I suppose if you were going -- it was up to him to determine who else was to be there, but the clinical director would have been someone who had an overview and a governance role there.

Q. Yes.
A. That may have been helpful.
Q. That was the point I was getting to.
A. Yes.
Q. It might have been helpful if there had been a governance person there who could be viewing it from a governance perspective --
A. Yes.
Q. -- as opposed to you who was helping as a clinician.
A. Yes.
Q. When the parents were being taken through by you how Claire had been treated and why she had been treated in the way she had been and so on, the view that they got -- and I will stand to be corrected -- was very much that the viral encephalitis or the viral cause was still very much a feature of how you were explaining matters to them, whereas, in fact, at that time you would have known, however strongly you thought the virus was present, the evidence didn't really support a very strong presence of virus.
A. Well, the post-mortem -- our interpretation of the post-mortem had not changed at that time. Dr Webb wasn't there, but I was there and the interpretation of the post-mortem had not been brought into question. So that was one slice of the pie.

Q. Ah.
THE CHAIRMAN: Doctor, if I ask you to pause there, there seems to have been a missed opportunity in 1997 to discuss the autopsy report with Dr Herron and/or Dr Mirakhur; okay?
A. Yes.
THE CHAIRMAN: Mr and Mrs Roberts contact the hospital in October 2004 after the broadcast of the documentary. A meeting is arranged, at which they are going to be given more information.
A. Yes.
Q. Is this not a second opportunity to speak to Dr Herron and/or Dr Mirakhur, especially if there is some degree of difference, at least in emphasis, between you and Professor Young?
A. That is an opportunity. I don't know if Dr McBride considered it or not.
THE CHAIRMAN: But if you were being asked, as you were now being asked, and Professor Young -- sorry. You knew before this there was a degree of difference between you and Professor Young, maybe not fundamental, but at least one of emphasis --
A. Yes.
THE CHAIRMAN: -- or slices of pie, however you describe it --

A. Uh-huh.
THE CHAIRMAN: -- that's a point at which either or both of you can speak to Dr Herron and Dr Mirakhur and just tease out with them some of this information.
A. I, at this stage, did not want to go beyond what the medical director had asked me to do because I did not want to be seen to be influencing a process that was starting and I wanted to keep very much to do what I was asked to do, which was the clinical journey, the chronology.
THE CHAIRMAN: After the meeting when Mr Roberts immediately followed up with a list of detailed questions, did you think of going at that point to Dr Herron or Dr Mirakhur for their input?
A. No. I was being directed by Dr McBride on the way forward and what he wished me to do.
THE CHAIRMAN: That would not prevent you, I suggest, saying: this might be the time, Dr McBride, when we speak a bit more to Dr Herron or Dr Mirakhur to find out what their view was and just make sure we are on the right lines from 1996/1997.
A. Yes. I know when we went -- I can't remember all the details of the coroner's case, but I am not sure Dr Herron at that stage was contradicting the fact that there may have been a degree of viral encephalitis.

THE CHAIRMAN: Okay. Thank you.
MS ANYADIKE-DANES: I understand what you are saying, that you were being guided very much by what Dr McBride was asking you to do.
A. Uh-huh.
Q. But nonetheless, irrespective of that -- and this may be what the chairman was aiming at really -- you have your own independent obligations as a clinician under the GMC and, in fact, one that would have governed your conduct at that meeting in 2004 was this one that I am going to pull up now. It is 314-014-002. That's the one that was in operation in May 2001, carrying on, and in operation in 2004. If we go to 23, which is at 314-014-012, that's paragraph 23:
"If a child under your care has died, you must explain, to the best of your knowledge, the reasons for and the circumstances of the death to those with parental responsibility."
So would you not accept that that does require you to be absolutely sure that you are providing all the reasons that you can and describing all the circumstances that you can that relate to the death of Claire to her parents?
A. Yes, and in 1997 I think I did provide those with the information and my understanding of the information at

the time. In 2004, a process was started. There was a first meeting with the parents to try to identify issues, what other issues were ongoing. I think at the time that meeting had been in place, it was obvious the case was going to the coroner, and I was being directed by others on the way forward with investigating or managing the case. I brought the clinical information I had on the day to that meeting and I tried to follow up any questions. I actually suggested that the parents write everything down and decide what they want to do about each point because there is so much information that goes round and you start to think, "Have they asked that or have they not?". I always tell parents to write down questions when they come into their heads and then we will go through each one and go through it.
So I believe I came, on that day in 2004, with the clinical journey to talk the parents through it and then, as a result of that, answer any questions that they raised to the best of my ability and then taking it forward into the coroner's case.
Q. If that was your obligation, did you not have to look very carefully at your medical notes and records to ensure that you have properly got from them anything that might explain the reasons for and the circumstances of her death?

Previously you were under some pressure, I think, when you were dealing with matters at 4 o'clock in the morning. You were going to have to see the parents, so you had to get a view as best you could of what was happening so you could go and explain as best you could to the parents. One might see there is a bit of time pressure. You don't necessarily have everybody you might want to speak to to get a full picture. Maybe you had an opportunity to do that again when the autopsy report came in, but leaving that aside, you now know that the only reason you are looking at this is because a suspicion that something that should have happened in 1997 did not happen, which is that Claire's case wasn't maybe properly considered in ways that it might have been, and that's the whole reason the parents who have that concern have come to the hospital and the medical director has thought that sufficiently worthy of attention that he has set up what you call the beginning of a process and the next step of that, for you, is, having found the information, to do your patient's journey and so on and to meet with the parents.
If you are providing that kind of information, is it really explicable that you should have missed the dosage, for example, of the drugs?
A. The dosage of the drugs, they are not drugs I would

normally prescribe. I assume I didn't check the drug kardex, which would have given the 120 of midazolam, fully, but I missed them. Dr Webb missed them. The coroner's experts missed them. It was only this inquiry.

MR FORTUNE: And also the experts instructed by the police service.

THE CHAIRMAN: In fairness I think the criticism about missing the overdose of drugs is a stronger one to make of other people than Dr Steen. Specifically it is a stronger one to make of Dr Webb.

MS ANYADIKE-DANES: Mr Chairman, I make no criticism about it. I am simply asking if that's not the sort of thing you should be scrutinising through the documentation. I am talking about process. It's not for me to criticise at all.

A. Yes, it should be, but there would be information there that I would not be fully aware of, and the relevance of it I would not have been fully aware of. I think from the phenytoin perspective I missed the calculation, but I had the serum levels, and the serum levels are what reassured me that her phenytoin was reasonable.

Q. Yes. Can I ask: did you see the letter from Mr and Mrs Roberts of 8th of December?

A. Yes, I've seen that.

Q. So you would then be part of a process of trying to provide answers to that letter, because the whole point at the conclusion of that meeting is that if they had any queries, the trust was open to try to address those queries?

A. Yes.

Q. And indeed they did have queries, and one sees them at 089-003-006 and the next page, 007. Those are their queries. When you see those, do you not feel that you ought to perhaps have another look at the medical notes and records in order to see if you can assist in addressing some of these queries?

A. If I remember correctly, at that time Nicky Rooney was trying to do minutes of the meeting, addressing some of the issues that the parents had raised at the meeting, and then this came in as well. I think there was various information flying around as people tried to answer the questions both from -- that had arisen in the meeting, but also in this as much as possible, and we would have focused in on trying answer questions relevant to ourselves.

Q. Is that appropriate in your view?

A. I think we were doing the best we could to try to answer all this information. I know the plan had been to meet with the parents quite quickly again to actually go

through these issues one by one, but that meeting didn't take place.

Q. Well, I give you this, so that you can comment on it if you can for us. One of the -- well, I don't know it's a reason the meeting didn't take place, but the evidence that Mr Roberts and Mrs Roberts has given is that when they met with you, although they were seeing something or hearing something new from Professor Young that appeared to be giving them answers to questions that they had had and issues that had not been resolved for them, they essentially heard nothing from you that was any different from what you had told them in 1997. They didn't -- and I expand a little bit to try to get the sense of what they were saying -- they didn't seem to get the impression from you that you were now addressing that and sort of reinterpreting things and understanding and helping them understand in the light of that what had happened in 1996. Effectively they got the impression that you were wedded to your original view.

A. No. Once Professor Young reviewed the situation -- I think you used the term "fluid mismanagement", which I think is a very good term to use for Claire's case, because we had been very sure we had given her maintenance fluids, what would be given normally to a child in this way, but, in fact, a lot of what this

inquiry and the coroner's case have been about is how her fluids should have been managed because of her condition, how her U&E should have been repeated earlier. So the fifth-normal saline per se as the key issue, I don't think I put that top of the issue. What I put top of the issue was we didn't check her U&E. We didn't monitor her condition. We didn't repeat the levels and we didn't take actions early enough to make a difference.

Q. Thank you for that. Can I ask you this? Were you able to get that from the view that Professor Young had formed? When he came to the conclusion that the hyponatraemia could well have contributed to her death and explained his reasons for that, and you would have been a part of meetings and understood his explanation, what you have just characterised then is a sequence of things.

A. Uh-huh.

Q. Did you understand that as being -- as the implication from what he was saying?

A. I can't remember exactly where we got it from, but I know we clearly felt -- we looked and we saw where the U&E had been done. It had been done 27 hours I think after she had been admitted. Routine would have been 24 hours, but, in fact, because of her condition, it

should have been done earlier. I don't think there was ever, once Professor Young had reviewed her notes from a fluid management perspective, there was any query that her fluids had been mismanaged. The proportion of how the fluid mismanagement had contributed to her overall condition, the slices of the pie, were where I think the discussion lay.

Q. Did you tell the parents --

THE CHAIRMAN: Sorry. In your eyes this was a new factor which had not previously been considered?

A. No, we hadn't -- I have raised this in my evidence before. We just hadn't put it together.

MS ANYADIKE-DANES: Did you at that meeting or even when there was a response to the parent, which I think ultimately Nicky Rooney signed off on --

A. Uh-huh.

Q. -- but I think it had gone round those who were involved to make sure it was accurate, did you feel that, what you have just said now, that her fluids had been mismanaged, was something that could have been disclosed -- communicated to the family?

A. I thought it had been communicated. I think Professor Young very clearly -- I mean, I took -- when it came to the fluid bit, the decision had been made Professor Young would do that bit, so that that was his

clear opinion as agreed with the Medical Director, and I thought Professor Young had indicated that.

Q. That the fluid had been mismanaged?

A. Yes. You would have to show me the documents. I can't remember.

THE CHAIRMAN: I think the pages which are relevant are WS177-1, pages 59 and 60, which are Professor Young's contribution to the meeting. If you pick it up -- sorry. Can you give me page 59 and 60? Thank you. This is the minute of the meeting, Dr Steen. If you look on the left-hand side of the screen, page 59, halfway down the page it says:

"Professor Young joined in at this point."

A. Uh-huh.

Q. He then made a series of points, which were noted. It goes on to the next page, where he says in the third paragraph down:

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

Now he is -- if you look -- I won't read it all out, but if you look at what he says in that page or so, that seems to be the extent of what he is recorded as saying.

MS ANYADIKE-DANES: It is possible, Dr Steen, that you as

a clinician would understand that as amounting to a mismanagement of fluids, but it doesn't say that in terms, does it?

A. No.

Q. But you -- that's what you have just explained to the Chairman that you understood, and that's why I asked you, given that you are dealing with lay people here, and people who are likely still to be rather emotional about the whole thing, would that not have been appropriate, simply to say, "We think in your case very regrettably that your daughter's fluids were mismanaged"?

A. I think that we were trying to give more detail than perhaps was -- well, the parents actually -- Mr Roberts' knowledge base really was quite high. He did ask everything. We tried to get into the impact of the low sodium and the effect low sodium would have on swelling, etc. So perhaps we went about it the wrong way. Perhaps we should have made it -- we should have phrased it differently.

THE CHAIRMAN: There is one specific point which is not included in that note, which is that her -- her bloods should have been checked earlier than they were.

A. Yes.

Q. That is absent from the note, is it not?

A. Yes, and I don't know if it is part of the answers to all the questions. I don't know.

MS ANYADIKE-DANES: If one --

THE CHAIRMAN: Okay. Sorry, Mr Fortune. What's your point?

MR FORTUNE: Sir, if you look at page 61 and the second part of the second paragraph, here is Professor Young adding that:

"... with the viral infection, seizures and fluids administered, it is difficult to say what their relative contribution would have been."

THE CHAIRMAN: Sorry. That point doesn't help this discussion. That is a point where Professor Young is saying there are three issues and it cannot be said with precision the extent to which each of those three issues contributed to Claire's death.

MR FORTUNE: Yes, but if you --

THE CHAIRMAN: The point I am on is a different one, that in terms of what Dr Steen has just advised us that she realised as a result of this issue being opened up that the blood test should have been repeated. 24 hours would have been standard, but in Claire's case the test should have been repeated earlier, because she had a slightly low level on Monday night. That was not advised to the parents at the meeting on 7th December 2004.

MR FORTUNE: I accept that point, but the previous point was about fluid mismanagement.
THE CHAIRMAN: Right.
MS ANYADIKE-DANES: The issue -- well, that was your expression, that you thought there was fluid mismanagement. If one says that to lay people, that connotes to them that "In some way we were responsible for the death of your child".
A. Yes.
Q. In fact, when you gave your evidence to the coroner, you advanced things along the lines of the omission that the Chairman has just pointed out, and you said:
"Her blood tests results at 11.30 should have lead to a clinical reassessment and the test should have been repeated. Simultaneously there should have been a reduction in fluids", and so on.
You also at that stage were putting things that you were prepared to concede should have happened and didn't happen, and the only point that I'm really dealing with is if you are obligated to explain things as fully as possible in language that families can understand, should these things not have been said to the families expressly -- to the family when you met them? That's all.
A. I can only say we tried to inform and respond to the

parents' questions as much as possible, that there was a process that was in place with questions coming -- the first meeting, questions coming in from the parents, and there to be a second meeting. In the meantime documents were going round to try to complete the questions. Perhaps we could have made it clearer to them at the time.
Q. No. My point is: Should you have done it?
I appreciate you were responding to their questions, but, with respect, that is laypeople asking you out of their knowledge base something. You are the clinicians. You have formed views about these things. They don't know the standard of care that's required for these matters. You form views of deficiencies and inadequacies and you have culminated some of those in the expression "fluid mismanagement". So all I am saying is: Should you not have been offering that to the parents, who have waited so long to understand what happened to their daughter? At the very least, if you formed views of how things went wrong instead of just waiting for their questions and answering their questions, should you not have led off with: here are some things we know we failed you on and failed your daughter on and we are very sorry?
A. The process at the meeting was to take place as arranged

with the medical director and how the meeting progressed was dependent on me providing the clinical journey with support from Dr Sands where appropriate and then Professor Young talking about the IV fluids. I think we did try to raise with the parents the issue that the fluids had changed. We were doing things differently, that things had been done wrongly at the time. If it was not conveyed by that, I apologise.
THE CHAIRMAN: Doctor, you certainly conveyed the fact that things had changed.
A. Yes.
THE CHAIRMAN: What was not stated was that things been done wrongly at the time.
A. Yes.
THE CHAIRMAN: Because that paragraph, the one that Mr Fortune wanted us to highlight, makes the very point:
"There are no accurate records of the amount of fluid lost, as this would not have been done routinely at that time."
So that's making a point some things have changed so that the Roberts get the impression: well, with the benefit of hindsight, if we did things in 1996 the way we do them 2004, we would have picked up more. But what is missing from this is the point which you have said that you realised, when this meeting was taking place,

that the second blood test on Claire which should have been made in light of the reading of 132 on admission was not made until the following evening. That's the point. Anyway I've got that. That's fine.
A. Thank you.
MS ANYADIKE-DANES: Mr Chairman, I actually don't have any other points, but I suspect there might be a few.
THE CHAIRMAN: Well, if there are, they will have to be very few, because Dr Steen I think is legitimately exhausted. She has been very unwell and whatever criticisms I may make in the report, I acknowledge the fact that Dr Steen has come back from serious illness. This is the fifth occasion on which she has given evidence. I will arise for a short time for a few questions, Mr Quinn. That will be it. I hope that's understood. Okay?
(1.05 pm)
(A short break)
(1.10 pm)
(Delay in proceedings)
(1.20 pm)
MS ANYADIKE-DANES: Thank you very much, Mr Chairman. There is an issue which may have a supplemental to it.
It follows on, Dr Steen, from the points that you were making that you were trying to be open and to give the family proper information and there was an issue as

to whether, if not concessions, at least admissions of things were properly conveyed to the family in the way that they could understand, the things that you are prepared to accept constituted deficiencies or were below the standard of care that they would have wanted their child to have had. So that the area we are in.

You said you were in a process, but also Dr McBride has given the view that the questions that the family raised, he wanted to have addressed.

A. Yes.

Q. And after that meeting, the family wrote on 8 December to identify a series of things that were still concerns and queries for them. Ultimately, that letter is answered by a letter which is signed by Dr Rooney, but in fairness to, her she relies very much on the clinical information that you and others provide for her to satisfy --

A. Yes.

Q. -- the requirements of it being accurate. The letter is dated 1 January 2005, not to be pulled up, but the reference is 089-006-012. The letter travels around as she seeks to ensure that it's accurate, and there are changes which are suggested, at least on one occasion, by Mr Walby, and you would have been aware that the letter is receiving revision, if I can put it that way.

A. Yes.

Q. If I just pull up, by way of example, 177/1, page 90. I should say this is a three-page letter. So 89 is the first page.

A. I'm sorry, whose --

Q. This is a draft of the letter that is ultimately going to be in final form, the 12 January letter that goes out, signed by Dr Rooney to Claire's parents; okay?

A. Yes.

Q. So just to orient you -- I am sorry -- perhaps let's have page 89. That will orient you.

A. Who has this document gone to?

THE CHAIRMAN: These are handwritten changes by Mr Walby.

A. Sent to myself?

MS ANYADIKE-DANES: The draft goes around. At this stage, this letter has been informed, if I can put it that way, by you and others. This is it now landing on Mr Walby's desk and he makes some of these comments on it; okay?

A. Yes.

Q. So the comment that I wanted to take you to in particular is the one at paragraph 6. I only brought up the first page to try to orient you a little bit as to where it was going; do you see paragraph 6? It says:

"It is not possible to say how information regarding Claire's serious condition was not adequately conveyed

to you."

That "6" is a query that the family have, so it is an attempt to answer that query; okay?

"While the clinical notes reflect the level of medical concern, there is no note summarising the content of conversations between medical staff and relatives. However, Dr Webb has noted that he spoke to Mrs Roberts at 5.00 pm on 22 October. It is difficult to give an opinion on why Claire was not moved to PICU."

It then goes on to talk about her hourly observations. So that presumably is the position as it comes from Dr Rooney, informed as she has been by the views of you and others; okay?

A. Yes.

Q. Just so you have it, because I don't want you to be confused, I just want to give you the actual question that was formed by the Roberts:

"Why was Claire not admitted to intensive care if her condition was so serious?"

That is a question and that is what 6 is seeking to answer.

A. Yes.

Q. So as it comes to Mr Walby, it has effectively, "we don't know why she wasn't moved to PICU", which has the suggestion maybe she should have been and we can't

adequately answer that for you and that was unfortunate.

A. Yes.

Q. In fact, that is something that is reflected in Dr Webb's own statement that he signed to go to the coroner. I will just read it out to you so we don't have so many things on the screen. The reference of it is 139-098-021. He says in the final paragraph of that page:

"I made the mistake of not seeking an intensive care placement for Claire before I left the hospital on the evening of October 22nd. However, I am not sure whether she would have met the criteria for admission to PICU, as there was to problem with her airway or breathing at that point."

He goes on, but that's essentially what he is saying. So he thought that maybe there was a deficiency, that she could and should have been moved earlier. This letter is chiming or this proposed answer is chiming with that.

Then when we see what it actually turns into, which is to be found --

THE CHAIRMAN: Page 40.

MS ANYADIKE-DANES: 089 --

MR FORTUNE: 006-014.

MS ANYADIKE-DANES: Yes. Thank you. There. So it's at

6(b). Do you see that:

"With regard to why Claire was not moved to PICU, her hourly CNS observations had remained stable for a period of time and no clinical signs of further deterioration were noted."

That is, in fact, a formulation of words that results from Mr Walby's comments. It is quite difficult to see on the manuscript:

"This suggests we are critical of our failure --"

MR FORTUNE: "To move her."

MS ANYADIKE-DANES: "-- to move her. Maybe we are?"

So the point I am getting at is: if the intention was to be open and transparent with the parents, there seems to be a suggestion in relation to their query about PICU, just one aspect of her care, that maybe there was a failure there and maybe she ought to have been moved earlier to PICU, but when it comes back as their answer to them, in fact, there is a justification for why she wasn't moved to PICU. There is no suggestion that maybe it would maybe have been better to have moved her earlier on reflection. It simply says the reasons why she wasn't.

A. And who was Dr Walby asking to change this?

Q. Sorry?

A. Was Dr Walby asking me to change this?

Q. No. Dr Walby was proposing that a change was made.

THE CHAIRMAN: What is the question for Dr Steen?

MS ANYADIKE-DANES: The question for Dr Steen is: if the clinicians were clear about the concessions that they felt ought to be made, do you think this was a concession that ought to have been made, that some consideration should have been given to taking her to PICU earlier? Is that a view that you might share?

A. Yes. I am not sure Dr -- Dr Webb's statement would not have been available at this time.

Q. I understand that, yes.

A. But yes, she was -- she was a sick child. I do agree that she probably would not have met the criteria to get into ICU as they were in those days, but she was a sick child.

Q. And do you think that, therefore, some active consideration ought to have been made to perhaps getting her there?

A. Yes, and I don't know who drafted which draft.

THE CHAIRMAN: I am pretty sure I do know, actually. Let's go to 177/1, please. Sorry. If you keep up page 90 and would you put up with it, please, page 80 for the moment? Okay. If you look at page 80, paragraph 6, I am pretty sure that is Professor Rooney's initial draft

because she told us she took the lead in drafting it and then sent this to you and Professor Young.

A. Yes.

THE CHAIRMAN: So paragraph 6 is an initial draft from her. If you look at the right-hand side of the screen, page 90, 6(a) and 6(b). This is unlikely to be an area that Professor Young is involved in.

A. Yes.

THE CHAIRMAN: He was engaged for a limited purpose. Therefore it is more likely you provided that draft.

A. 6(b)?

THE CHAIRMAN: Yes, 6(b). It then appears that, at Mr Walby's instigation, the opening line in 6(b) was removed. So what you had included was:

"It is difficult to give an opinion on why Claire was not moved to PICU."

Then it continues. Mr Walby, on my interpretation, has then effectively removed the first sentence and replaced it with:

"As to why Claire was no moved to PICU ... her hourly observations had remained stable."

Does that seem to fit?

A. Yes.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Did you at any point come to know that

that had happened?

A. I have no recollection of coming to know that this had happened. I choose my words carefully because my memory is too poor --

Q. I understand.

A. -- but I'm not aware that happened.

Q. Would you have been happy with that change if it had been brought to you?

A. I think we would have had to sit down and discuss it as to why it was important to -- to re-word it in that way, because there were levels of debates and there remain levels of debates about how Claire's case should have been managed and processed. Admission to PICU was one, and I don't -- I personally don't have a concern saying, even at this stage, to parents: you know, perhaps she should been moved to PICU and we should reflect on that and look back on that. These are possible reasons why she was not moved but is it fair to ask why was she not moved? That's a fair question.

Q. Would you have preferred that to be the version that goes to the parents?

A. I would have because I think that allows the debate and thoughts in the parents' mind to proceed. I mean, it allows parents to think, "Right well, why did they not do it? Okay. These are the reasons. Do we accept

that? Do we not?".
MR FORTUNE: Sir, I am not aware of any e-mail that indicates, certainly to Dr Steen, "These are the amendments I have suggested. Signed Peter Walby. What do you think? Are we now agreed?"
THE CHAIRMAN: I don't think we have that in the e-mail trail. Maybe that didn't happen.
MR FORTUNE: Well, there is no evidence, but ...
MR QUINN: Mr Chairman, I am very mindful of the time. There is one particular question arising out of this letter and it will take 30 seconds.
I wonder if 089-006-0013 could be brought up, which is the final letter that went out to the Roberts in January 2005. I just want to ask through yourself, sir: given the doctor's earlier concession in relation to fluid mismanagement, can she comment on paragraph 5(a), the last sentence:
"It is not possible to say whether a change in the amount and type of fluids would have made any different in Claire's case as she was very ill for other reasons."
Given the concession that was made, that does seem rather unusual.
A. I think at that stage we had not been to the coroner's court. We had not got the expert witnesses. We had Professor Young's preliminary view of the fluid

management. I don't think we were in a position at that time and at that part of the process to be able to say which bit of the pie was giving what. It was different by the time we'd got the experts' reports in. We were in a different situation. We also have heard although her likelihood of death if her sodium had been managed would probably have been less, I'm not quite sure if it would have made a difference. I am not sure if it would have made a total difference. It would have made a difference.
THE CHAIRMAN: Let me say I take the evidence as being that had Claire's fluid and sodium been controlled better and properly it, would have removed that element of her illness from the equation.
A. It certainly would. It certainly would.
THE CHAIRMAN: That leaves an issue as to exactly what else was wrong with her. Mr Roberts has expressed his opinion on that last week.
A. Yes.
THE CHAIRMAN: I fear I am not as -- sorry. Mr Roberts expressed an opinion last week. I am not sure that anybody has said it's absolutely certain that Claire would have lived, but there is no doubt that her prospects of surviving would have been greatly increased had the fluid issue not been part of the equation.

A. And I don't have a problem with that.
MS ANYADIKE-DANES: Dr Steen said she was unclear about the e-mail traffic or maybe Mr Fortune said that, it is at 177/1, page 71. If you pull up next to it page 70, you can see this is -- right down at the bottom, that's dated 8 December. This is the query I think -- Mr Chairman, you have already had this in evidence about trying to find out when the blood test was taken for the result that appeared at 11.30, but on the right-hand side you can --
THE CHAIRMAN: I think it is page 70, in the middle of the page, where Professor Rooney says:
"This is the final version. I will send it out today."
MS ANYADIKE-DANES: Sorry. It is to Heather Steen.
A. Sorry. Could you show me where --
THE CHAIRMAN: Dr Steen, if you look on the screen, the left-hand side is page 70. The middle of that page is from Nichola Rooney, dated 9 December, just after 9.30 am.
A. Yes.
THE CHAIRMAN: It is to you and it is indicating that you are getting the final version of the letter.
A. But it doesn't say that Peter Walby has seen it.
MS ANYADIKE-DANES: No. This is the final version --

A. Yes. I am not sure --
Q. -- with the change.
A. Yes.
Q. That's the point.

A. Yes. Well, if that's the way it is, that's the way it is. I'm not aware of what the final letter at that stage was. I don't know if there were further changes. I don't know when Peter Walby made that note.
THE CHAIRMAN: No, that's the wrong letter. The meeting had only taken place on 7 December. So that isn't -- okay. If we need to pick that trail, we can. That's incorrect. Okay? So you are right that cannot be the final version of the letter. If anything, that's referring to minutes of meeting on 7th.
A. 7 January?
THE CHAIRMAN: That's right.
MS ANYADIKE-DANES: I accept that, Mr Chairman. I think that's probably the minutes. I apologise for that. If we need to find out exactly what happened, we will look for it.
THE CHAIRMAN: But I don't think we need recall Dr Steen on it.
MS ANYADIKE-DANES: Not on that point, certainly not.
A. Can I just say something?

THE CHAIRMAN: Of course, doctor.
A. Firstly, thank you for your consideration, because I have tried to help the inquiry, but I know my personal circumstances has made it difficult.
Secondly, I am so sorry to the Roberts. I think the death of a child is tragic and I think living with it and with grief is really, really difficult. I apologise for any part I had in it. It was never deliberate, but I understand your grief and your heartache and your pain. I'm not -- I don't -- I haven't experienced personally -- I am sure lots of people in the room know what it is like -- but I apologise to you.
Finally, it is the inquiry, Mr O'Hara. This is labelled hyponatraemia and I know, because I was on the ground when fifth-normal was banned from the wards, there was sort of "oh, fifth-normal is gone, the problem has gone". I think Claire's condition has started to make people understand that fluid mismanagement -- and I thank you for that term -- is really, really important. We need to get our fluid management right, which is not just the salt content, but it is monitoring, it is what we put in, it is looking at what we get out. I am just very keen that people realise fifth-normal was not the sole problem and getting rid of it have has not got rid of fluid mismanagement as a risk

for any patient.
THE CHAIRMAN: I don't know if you read Professor Gross' evidence in Adam's case. He says hyponatraemia is still misunderstood, so there is a lot more to it than one solution.
A. Yes, thank you.
(The witness withdrew)
THE CHAIRMAN: Ladies and gentlemen, we need to take a break. We will start at 2.30 with Dr Sands; okay?
(1.40 pm)
(The short adjournment)
(2.30 pm)
(Delay in proceedings)
(2.46 pm)
THE CHAIRMAN: Just before Dr Sands returns to the witness box, let me say something about his return to the witness box: I entirely understand, as best anyone can or any of us can, the depth of frustration which must be felt by Mr and Mrs Roberts, in particular as they have listened to the evidence from October onwards about Claire. That evidence has revealed a series of mistakes, missed opportunities, especially on 22 October, which might well have avoided Claire's death had they not been committed.
I also recognise that this frustration may well turn

to anger and incredulity at what they have uncovered and what they have had revealed to them as the last number of weeks have progressed.
I also accept entirely that they have previously raised a concern about the specific entry made by way of addition in Dr Sands' handwriting in the medical records. That is the entry which added "encephalitis/encephalopathy" as a possible or differential diagnosis.
Dr Sands was questioned about this on 19 October. He was questioned about when and why he made the entry and why he didn't time it and sign it. Mr and Mrs Roberts then gave evidence on Wednesday, 31 October, in the course of which they had the chance to and they did raise these issues.
It was not until 13 December that Mr Roberts alleged that this entry was fabricated in that it was made in 2004 or 2005, but only after Claire's case had been raised again by the family on foot of the Ulster Television programme.
It is this allegation that I am recalling Dr Sands to respond to.
Dr Sands, please.
DR ANDREW SANDS (recalled)

Questions from MISS ANYADIKE-DANES
MS ANYADIKE-DANES: Goo afternoon, Dr Sands.
A. Good afternoon.
Q. I wonder if you could first pull up the transcript of Mr and Mrs Roberts' evidence on 13 December. If we go to page 127. If we can pull up page 128 alongside of that, please. Thank you. So if we go to line 7, this is the chairman summarising points -- in fact, I think this is Mr Roberts:
"I think that raises another issue around -- and I don't want to go back to it too much, but when the actual note, the 'encephalitis/encephalopathy', was added because I do feel that when we did go back in 2004 and we were heading -- we had our meeting and we were heading for a coroner's inquest, that Dr Steen was asked by Dr McBride in the first instance to review the medical notes."
It goes on:
"I find that very difficult to accept, that a doctor who potentially is going to be asked a question about the treatment of a child is given in the first instance the opportunity to look at the medical notes."
Mr Roberts addresses that. Then we go over the page, 128. The chairman says:
"If I understand it rightly, in effect what you're

querying is whether, when Dr Steen saw the notes, and the issue 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?

Mr Roberts:

"That's my belief."

Part of what goes on thereafter is something you have seen already, which is along the lines of a letter from Mr and Mrs Roberts' solicitors dated, I believe, 17 December, where they are really setting out why it is that they think that including that reference to "encephalitis/encephalopathy" by way of an amendment or addition, if I can put it that way, to the ward round notes, why that doesn't fit with what actually happened thereafter and what is recorded thereafter.

I understand that you would, in the course of addressing that point that is quite crisply put by the chairman and where Mr Roberts says "I believe", like not only to deal with that but also to address these matters that are being said as supportive of why it is they have that belief; would I be right in putting it that way?

A. That's correct.

Q. Thank you. If we can go to that then.

MR QUINN: Mr Chairman, there is one fundamental piece of

this jigsaw missing. We wrote Salmon letters on 13 December. In the first and second Salmon letters, these issues were raised. There may be an issue as to whether or not the Salmon letters were received.

MR GREEN: Forgive me. They were not received by those representing Andrew Sands. That may have been due to an understandable misunderstanding by Miss Danes as to what the inquiry protocol mandated, because until moments before you came in, sir, it was her understanding that the inquiry protocol mandated that those third party Salmon letters were not sent to the parties whom they affected. Mr Quinn and I looked at the protocol and took her hands from the wrong end of the stick.

MS ANYADIKE-DANES: Sorry. Can I just interrupt there? My learned friend is quite right. We had a meeting and I had expressed that view, but I did not at any earlier time misunderstand the way the protocols worked. It is a long time since I had looked at those particular protocols. We had been over them in detail as to how these matters should be addressed and I am quite sure that people in the inquiry knew the process of Salmon letters going out. In fact, the letters from the third parties are not Salmon letters; they are third party letters which, if they indicate a potential criticism,

then the form is that those are then re-directed by the inquiry, who is the body that receives them, to the target of the criticism.

There was -- excuse me -- no misunderstanding in relation to the inquiry that that is the procedure. I incorrectly informed you when you came to speak to me, because it is some time since I looked at the protocols.

MR GREEN: Sorry. I didn't mean to sound as if I was falling out with Ms Danes about it.

THE CHAIRMAN: Sorry. I don't accept these are Salmon letters. That is why they were not set out by the inquiry. There is a letter about Dr Sands which raises 31 questions and it ends:

"We would be grateful if you would put these questions to Dr Sands and revert to us at your earliest convenience."

That's not a Salmon letter, Mr Quinn. I am sorry, it is just not a Salmon letter. Even if we are supposed to interpret that as a Salmon letter, that letter does not contain an allegation that Dr Sands fabricated a note eight years later.

MR QUINN: Well, you will see why we were somewhat confused by that response, because on 27 September 2012 we got a letter with a postscript at the back stating:

"We note the Roberts' concern as outlined in this

letter and the matters raised will be put to Dr Sands during the course of the oral hearings."

THE CHAIRMAN: That's right. Sorry. That's because -- those were understood to be you raising questions, factual questions to ask Dr Sands at the hearing, and in essence they were asked of him at the hearing. When he gave evidence in October, in essence those questions were put to him.

MR QUINN: Yes.

THE CHAIRMAN: Not one of those letters includes the allegation -- sorry. Let me put it this way -- it's what I said a few minutes ago. I see a fundamental distinction between querying Dr Sands as to when and why he made an entry in the notes in 1996 on the one hand and, on the other hand, making an allegation that he only made that entry in the note eight years later after the UTV documentary. Am I right in saying that the letter which you've referred to does not raise an allegation that the entry was made eight years later?

MR QUINN: You are correct.

THE CHAIRMAN: Am I not right in saying when Dr Sands gave evidence in October and he was questioned, as Ms Danes did, with input from you and others, that it was not requested that that allegation about fabrication be put to him?

MR QUINN: I accept that.
THE CHAIRMAN: Am I not right in saying that when Mr and Mrs Roberts gave their evidence late her October that that allegation was not made by them at that point?
MR QUINN: I accept that.
THE CHAIRMAN: So the first time that the allegation was made in the history of the inquiry was last week.
MR QUINN: Yes, I accept that also.
THE CHAIRMAN: If that is the case, why was it not made earlier?
MR QUINN: Can I ask: if these are not Salmon letters, then if we had written in the letter that there was an allegation that we suspect that something happened in 2004, it wouldn't have gone out either.
THE CHAIRMAN: No, but you would have alerted the inquiry to the allegation, and that would then have been followed up in whatever way we thought was appropriates, but the issues which were raised in -- the issues which are raised in this letter, in effect, found their way into the questioning of Dr Sands when he gave his evidence in October.
MR QUINN: Yes.
THE CHAIRMAN: So they were raised in October. So when he was giving his evidence in October, the allegation -- if it was accepted by the inquiry as an appropriate

question -- would have been raised with him.
MR QUINN: Yes, Mr Chairman. Let me put this in the context of the Roberts. They fully accept they didn't raise these issues, but they sit here as parents and they listened to the evidence and they put together what they feel is their opinion in this case and, at your own invitation, Mr Chairman, Mr Roberts tells the room, the chamber what he thinks. I have no control over that. Mr Chairman, you have probably no control over it. You are trying to get at the truth. You are trying to get at what the Roberts think. What they think is the truth they should say and put it in proper context.
Mr Chairman, you have the difficult task of balancing between those two opinions, those two sets of evidence and coming to a conclusion.
THE CHAIRMAN: Yes.
MR QUINN: One thing I respectfully submit is certain, and that is, between questions 12 and 20, we raise a number of issues in relation to the medical notes, and not only do we raise issues as to when the entry was made, we raise issues in relation to the reasoning behind why the entries were made. When one looks at our second, shorter letter of 1 September --
THE CHAIRMAN: I have no difficulty with that at all. I understand why the queries are raised and I understand

why the questions are phrased as they are because I understand that Mr and Mrs Roberts are concerned about the way that Claire 's treatment was provided and the way that there were exchanges between various doctors on the Tuesday.
MR QUINN: Yes.
THE CHAIRMAN: I have got no difficulty with that. I think you were going on then to say -- in essence, does it then come to this: that having heard all of this evidence unfold, they have moved from thinking, "This is hard to explain, it doesn't make much sense to us", to form a view that the only coherent explanation is that it was fabricated eight years later?
MR QUINN: I took specific instructions at lunchtime and that's what the parents will say.
THE CHAIRMAN: I think they have said what they have to say. Is the point that, having listened to the evidence over October, November and into December --
MR QUINN: Yes.
THE CHAIRMAN: -- having had these concerns before, they think the only conclusion anybody could draw is not just that there were question marks about the notes, but that the notes were fabricated eight years later.
MR QUINN: May I add to that: I think it was the day before I opened the governance issues on behalf of the family,

we were served file 139 and, in file 139, there were numerous e-mails, letters, et cetera, that were purporting to change statements, that were undermining the independence of Professor Young, that clearly showed Professor Young was in contact with various clinicians. If one looks at that as an outside observer and one opens file 139, which we have also written a lengthy letter about, and one looks at that as a neutral observer, one has to say, "Well, what's happening?". So on the basis of the evidence that is being served during the course of this tribunal, this inquiry, the Roberts formed an opinion and when we are invited to say what that opinion was, Mr Roberts did so.
THE CHAIRMAN: Okay. Then I understand the position more clearly. It is not that this was a view -- while they had concerns about the notes before the hearing started --
MR QUINN: Yes.
THE CHAIRMAN: -- those notes are now hardened into a view that the only credible explanation for the entry that we are going to come to on 22 October is that it was added eight years later.
MR QUINN: Yes. And may I just say, just to clarify things, this was not done out of any malic whatsoever. The other issue that they want to raise also is that other

documents were then identified. For example, the patient journey by Dr Steen. We didn't know who had made that, but on any neutral reading of that document, it is clear Dr Steen and Dr Sands consulted about it or wrote it together. It is clear that it is a joint document, because the timings -- we have written about this and I am not going to go on about it any longer -- the timings in the side columns where the timings are is not the same timings as in the medical records.

Therefore there has been some conversation between the clinicians, including Dr Webb, because he comes in at a different timing altogether at 12.35. It therefore seems apparent to the parents there has been discussion between the doctors, discussion with Professor Young, discussion with Professor Rooney -- who we think is not in any way involved in anything underhand whatsoever, may I add. When one looks at this as a neutral observer and one sees the weight of the documentation that is being served and the implications of those documents without the proper explanation that has been given in evidence now, one can see how the Roberts have arrived at that conclusion.

THE CHAIRMAN: Okay. I think what we have reached is some clarification that this is a -- so in the circumstances I am not critical of the fact that this issue was not

raised in the September/October period --

MR QUINN: I am obliged, sir.

THE CHAIRMAN: -- because at that stage they were not your instructions.

MR QUINN: Exactly.

THE CHAIRMAN: Your instructions were concerns rather than a belief.

MR QUINN: Yes.

THE CHAIRMAN: Right. In that case, I will take what Mr and Mrs Roberts have said as maybe an indication that their frustration is turning into even more, even deeper scepticism and possibly anger than it was before.

We will let Dr Sands respond to what is, in effect, a belief which Mr and Mrs Roberts have formed on the back of the evidence that they have heard to date; okay?

MR QUINN: My junior just wants ...

THE CHAIRMAN: Just one second. (Pause).

MR QUINN: Finally, we did submit a letter of 17 December, which clearly was not prompted by Mr Green's very ably managed submission.

THE CHAIRMAN: Yes.

MR QUINN: The two crossed in correspondence. The purpose of the 17 December letter was, in fact, to alert the inquiry to the problems that the Roberts have with the records and the evidence as it now stands.

THE CHAIRMAN: Yes. In essence, it's almost in the form of a submission.

MR QUINN: Yes.

THE CHAIRMAN: That because of these gaps, errors, failings, however they are described in the record, the conclusion which I should reach is that this entry was not made at the time.

MR QUINN: You actually asked me that, Mr Chairman, when this letter was presented. I made a concession this may be better argued in submissions.

MR GREEN: Sir, the allegation goes slightly further than you have quite pithily encapsulated it because what Mr Roberts said at page 127 of the transcript for --

THE CHAIRMAN: It is on the screen at the moment, I think.

MR GREEN: You are absolutely right. Sorry, sir.

That it was "as we were heading for a coroner's inquest". So the allegation seems to be that it was not just a forged entry as a back-covering exercise in a general sense, but it was a deliberate conspiracy intended to send the coroner down the wrong track. So in other words an act intending and intended to pervert the course of justice.

THE CHAIRMAN: Or knowing that the medical records would be referred to at the coroner's inquest, the records from 1996 needed to have something extra in them.

MR GREEN: Absolutely. I just want to make it absolutely plain why this is being taken so seriously: it is an allegation which involves several criminal offences, if true, that one could think of immediately.

THE CHAIRMAN: Thank you very much.

Mr Fortune?

MR FORTUNE: Sir, I rise at this stage, because, of course, Dr Steen is caught by this allegation of conspiracy.

THE CHAIRMAN: That's why she was asked about it yesterday.

MR FORTUNE: Yes. I have remained concerned about the timing of this allegation.

THE CHAIRMAN: I have explored the timing as best I can. I understand the that timing of it is -- I will try to summarise it beyond what Mr Quinn has said -- exasperation and disbelief on the part of Mr and Mrs Roberts about what they have heard. I am not sure if we can take it any further than that.

Is that fair, Mr Quinn?

MR FORTUNE: But, sir, even now --

THE CHAIRMAN: Is that fair, exasperation and disbelief?

MR QUINN: I think that's very fair.

MR FORTUNE: Even now, I now hear that Dr Sands was involved in the compilation of what's called the patient journey or the chronology. That wasn't actually asked of Dr Steen over the last two days; Dr Steen accepted that

it was her document.
THE CHAIRMAN: Yes.
MR FORTUNE: I do find it very difficult to understand how that matter wasn't put through senior counsel to the inquiry.
THE CHAIRMAN: Okay. I will take that point.
I think we have clarified things as best we can and I'd like to get on, Dr Sands, with your response to this; okay? Miss Danes.
MS ANYADIKE-DANES: Yes. Well, you have got the concern in a nutshell, what is the belief that's expressed.
Firstly, can you deal with that as to whether that is something that happened, whether either Dr Steen of her own volition came to you or in some way the two of you met, the result of that being at some time considerably after events, in 2004, when it was understood that the case was going to be or had been referred to the coroner and therefore the medical notes and records were likely to be looked at, that an opportunity was taken to add to those medical records to make them, if I can put it that way, consistent with what had been described as the viral cause of Claire's presentation or the trigger of her condition, if I can put it that way?
A. Well, I am grateful for the opportunity to give evidence

again on this point. This has affected me very deeply, because it goes to who I am as a person. It goes to my faith as well. I was surprised and shocked to read these allegations, to hear of them. I didn't understand, perhaps until very recently, why I was being viewed as being under suspicion or why my conduct was being questioned until the documents in front of me came to light and Mr Roberts made it clear what his concern was. So I was really surprised by that. I hadn't anticipated that.
I want to say very clearly that I made no entry to Claire Roberts' notes after her death. I want to say equally clearly that I didn't take part in any cover-up in terms of -- well, for the benefit of the coroner's inquest or any other matter. I don't think I can put it more clearly than that.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Yes. Just for the benefit of the record, you were asked last time about the timing of when you made that entry into Claire's medical notes and records. Your evidence on that was on 19 October 2012. It starts at page 164 and goes on to page 165 and on into 170. If we go to 170, because that's where you deal with it concretely. Up until then, you are explaining about why you went to see Dr Webb, what you

wanted to discuss with him and so on and so forth. Then the question comes to you at 170, really starting at line 10:
"Question: If we look at the notes, which we've had up a number of times, 090-022-053, so that's the note of that ward round which shows that addition, just halfway down, the addition to 'non-fitting status' of 'encephalopathy/encephalitis'. That's your handwriting, is it?
"Answer: It is.
"Question: Do you know when you actually added that?
"Answer: After speaking to Dr Webb, I came back to Allen Ward and I put that down in the notes. I appreciate it is not signed and dated and timed.
"Question: Should is have been?
"Answer: Yes.
Then it goes on to deal with what you might have explained to Dr Stevenson and Dr Stewart. You explain the fact you believe you had raised the issue of encephalitis at the ward round -- not encephalopathy, but encephalitis. You recognised it had not been included in the ward round note and, when you came back from having spoken to Dr Webb, you made that addition. That was your evidence really on 19 October. What you weren't asked about was this issue that you are now

being asked to address and you know the reason why, because Mr Quinn has just said about the timing point.
If you could help us now, having made that denial about the sort of thing that the Roberts have expressed their belief happened, if we can now deal with the letter itself, because that's part of an accumulation of factors that I understand have led the Roberts to believe that that is what happened.
This is paginated (indicating). I believe everybody in the chamber should have it from yesterday, but the pagination for it is 311-047-001. If we can just put these things up two pages at a time. So if you could bring up the 002, and I think, in fact, that's all we really need, because the last page deals with issues to do with Dr Steen and she's already been asked about those.
So, the ward round note is at 090-022-053. If you see there, it says:
"Dr Sands spoke to Mr and Mrs Roberts for a short period of time."
This is their view about what happened and I think they have already expressed a view about the length of time you spent speaking to them:
"Possibly 10 minutes or so, during which time Dr Sands examined Claire and explained to the parents

that it was his belief that Claire may be experiencing some type of internal fitting. There was no discussions by Dr Sands with Mr and Mrs Roberts about any other diagnosis."

And:

"The parents had no further discussions with Dr Sands that day or at any time thereafter (until after her death)."

Would you accept that that was the only discussion you had with them?

A. In terms Claire's illness, I believe that was the case.

Q. So if there was going to be any discussion between you and them about encephalitis, encephalopathy, matters of that type, that's when it may happen?

A. If I may add that any talk of encephalitis with Claire's parents, I wouldn't have used that word. They have mentioned a viral infection. If I was talking in those terms, I would talk about a viral infection that may have an effect on Claire's brain or something of that type. I don't remember what exact form of words were used.

Q. I wonder if you could help us with this -- the parents have sort of responded to that point. Their evidence is on 13 December 2012 and I am not going to go through it all, but in essence what they say to that is: if you

were discussing doctor to doctor, so you to Dr Stevenson, and the term encephalitis was raised with, which it might be doctor to doctor, although they accept it might not be the way you would describe things to them, and your evidence is you did raise that with Dr Stevenson, they say they were there throughout that time. If they had heard encephalitis, effectively they would have pricked their ears up and they would have asked: what is that about? So that's their sort of starting point, that you didn't mention it to them and they did not hear it, because they were listening for anything that could help them as to a doctor's analysis of what was wrong with their daughter, who seemed worse when they came in at 9.30. Can you help with that?

A. I think on a ward round discussion -- parents don't always hear everything that goes on between doctors and nurses on a ward round and indeed there are some things that one might not want parents to overhear --

Q. I understand that.

A. -- in terms of sensitive things, maybe worrying things. So one might not discuss it quite as openly as that in front of parents or as loudly, if you like.

Q. Is it possible you did discuss it with Dr Stevenson, but not literally there at Claire's bedside?

A. It is possible. As we were moving away at that point or

if I was moving away or drew somebody aside to talk to them.

THE CHAIRMAN: I think, in fact, you did say in October:

"We did think of viral infection. Specifically, encephalitis, I think, was discussed on the ward round."

MS ANYADIKE-DANES: That's my starting point, but I think you are saying a reason why the parents might not hear that is because you might be wanting to shield them from that and so you might either discuss that a little bit away from where the parents were or maybe as you go further up, moving on to another child, you might mention it then, which would all be included within the expression "ward round".

A. Yes, I think that's possible, yes.

Q. But in any event your evidence is that that expression would have been used, not to them, but to Dr Stevenson.

A. Yes, and the reason I believe that is because I have a clear recollection of discussion around a CT scan. I also recall that one of the things that I thought might show up on a CT scan might be early signs of encephalitis. Now encephalitis was not the working diagnosis, was not the number one diagnosis. It was a possibility only. Other doctors had raised that possibility. Dr Puthucheary in the A&E department has his primary diagnosis as encephalitis with a query

beside it. I know Dr O'Hare mentions encephalitis and then scores it out, but I think it was part of my thinking at that time of the ward round that a CT scan might show some evidence of encephalitis and I honestly think I would have shared that with at least the doctors on the ward round as a possibility, no more than that.

Q. I think you raised, maybe in fairness to you, the issue of CT scan was one of your contributions to the meeting on 7 December with Claire's parents. I am trying to see the actual place where you say that's something that might have happened. It is at -- 089-002-004 is one of your references to it. Second paragraph:

"Dr Steen advised that it is not always the case that children with low sodium levels will result in swelling of the brain [and so on]".

You add:

"A new CT scanner is in place today, which may have helped Claire had it been available in ICU eight years ago."

Does that reinforce the fact that you have some thinking that you were linking the CT scan and the possibility that that might have assist if she had encephalitis?

A. Only as one possibility. I also -- my recollection is that we would have -- that we did discuss what a CT scan

might show. You see, I couldn't have gone to Dr Webb and said, "Why don't we do a CT scan?", without giving a reason or reasons. I felt it might rule out other possibilities such as intracranial bleeding, for example, but a CT scan mentioned at that point, I suppose it -- the minute may not be quite correct to say "had it been available in intensive care". The CT scanner is down in the A&E department in the Children's Hospital now, but I did say that I felt a CT scan probably would have been carried out earlier. It may have been helpful.

Q. So sort of by way of a concession that that might have been something we could have done?

A. Yes.

Q. I understand. I think you have already said you had noted a CT scan in the ward round. That was a note made even before you had gone to see Dr Webb.

A. Well, we had discussed it. I know we'd mentioned it.

Q. Yes. So that was their first concern, that you didn't mention it to them. Your explanation of that seems to be you wouldn't have used the expression "encephalitis". They didn't hear it. You have an explanation for why they might not have heard it. If you were trying to convey encephalitis without using that medical term, what is the layperson's expression that you can use?

A. Well, I may have put it as loosely as an infection that may be having an adverse effect or having an effect on Claire's brain, but that leaves open the possibility that that had simply triggered seizure activity or, in fact, had infected Claire's brain and I may not have been any more specific than.

Q. You see, from the -- in fairness to the Roberts, from their point of view, if you had mentioned anything at all to do with her brain, that would have registered and I think Mrs Roberts' clear evidence was if anything had been mentioned about her brain, she certainly wouldn't have been going off and having her lunch; she would have been staying with her daughter.

A. I think it is in Mr and Mrs Roberts' evidence that they were aware of internal fitting being discussed.

Q. Yes, but I think the difference that we come to is that Dr Steen talks about some sort of viral infection and this gets linked with tummy bug and so forth and Dr O'Hare distinguishes between an infection of that sort and encephalitis, which is in the brain area, if I can put it that way.

When you are adding "encephalitis/encephalopathy", what you are putting squarely there is an issue to do with Claire's brain. We are not talking just about a tummy bug; we are talking about something -- whether

it started as a tummy bug or not -- we are talking about something now that is affecting her brain. That's the bit, as I understand it, that the Roberts did not appreciate.

If anybody had told them about tummy bugs, viral things of that sort, that's something they would understand, but their clear recollection is that nobody mentioned anything about her brain.

A. I must say it's my feeling that non-fitting status epilepticus, encephalitis and encephalopathy are all very much brain conditions.

Q. Then is it coming down to a matter of communication that, if that is what you intended to convey to Claire's parents, then you didn't do it?

A. I think there was a problem with communication and I think I've said that in evidence as well --

Q. Yes, I think you did.

A. -- and I fully accept that.

THE CHAIRMAN: I have a concern that we seem to be largely going over old ground again. I don't think that's particularly helpful. I know why you are doing this, Ms Danes, but a lot of this ground has already been covered with Dr Sands -- actually partly at your own instigation and partly at the specific request of the Roberts' representatives.

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: We could spend the rest of today going back over that. I am not sure that advances things.

MS ANYADIKE-DANES: I understand that and I certainly don't want to do that but my understanding is because this letter has gone out, it is out there, and Dr Sands wants the opportunity to allay, in so far as he can, the concerns that the family have that all these things amount to anything that suggests that he, together with Dr Steen, altered or added to the notes.

I am prepared to go through it faster or pick up the salient points, but that's what Dr Sands wants to address.

THE CHAIRMAN: Let me do it this way -- Mr Green, you will tell me if it is acceptable or otherwise.

As you will expect, I will re-read the evidence Dr Sands gave and re-read the statements and the records. I have read again what Mr and Mrs Roberts said in their statements and orally. I have now clarified, since I came out this afternoon, how it is that this allegation has come about. It is not on the basis of new evidence. It is the stage that Mr and Mrs Roberts have reached considering the evidence as it has developed over the last number of weeks. I have heard Dr Sands, like Dr Steen before him, deny absolutely that

there was any fabrication or addition to the note in 2004/2005 for the coroner or for any retrospective review or internal investigation.

If Dr Sands wants to go on to make some particular point in answer to any specific issue raised in this letter, I will not stop him from doing so, but I do not believe that it is helpful to me for him to go through all of these lettered points one after another.

MR GREEN: Sir, his position is he is able to deal with these points, if you wish him to. You have told him, through me, that that will not assist. I am content and -- I am sure he is -- in those circumstances if we move on.

MS ANYADIKE-DANES: I am very grateful for that, but I wonder if I may deal with a couple of them quite quickly?

A. Excuse me. If I may, I would be happy to quite quickly go through these.

THE CHAIRMAN: If that's what you want to do, doctor -- I don't think I have stopped anybody so far -- but on the basis that it is quick.

A. Yes.

MS ANYADIKE-DANES: So let's go to (b). If we do move quickly like that. The (b) is if that if you and Dr Webb had had that discussion, he had formed that view

and he makes no mention his own note of encephalitis.

A. Dr Webb doesn't make any note of encephalitis, nor does he mention non-fitting status epilepticus in his note.

If I might also say just again from file 150 -- I may be wrong in this, but I think I am right. Dr Mulholland, who came to see a patient who was thought to have a cardiological condition, who the ward round thought might have a PDA or patent ductus arteriosus. When he does the ward round, he makes no mention of patent ductus arteriosus. He gives his own view, his diagnosis.

Point (c), if I may. I believe Dr Stevenson will have followed Dr Webb's lead.

Q. If we just alight at that, there other point is that he doesn't address it in terms of making a note or prescribing anything for it, but neither do you.

A. That's correct. I have asked Dr Webb to come to see Claire. I have not been prescriptive at all about what he should or should not say. We have had a discussion about Claire, about what may or may not be going on. My impression was Dr Webb thought encephalitis was less likely. A CT scan, he thought, probably wasn't necessary right there and then. I think he said that as well in oral evidence, and I don't think my view of encephalitis was reinforced at all by talking to

Dr Webb. If anything, it was a bit reduced.

Q. Thank you. So (c) then.

A. Yes. I think Dr Stevenson will have followed Dr Webb's lead completely in this matter, when the issue is raised that Claire is still in status but doesn't mention encephalitis or encephalopathy. Dr Webb has given his presumptive diagnosis or working diagnosis, because usually there is only one working diagnosis and sometimes other differentials. He has made that statement, as Dr Mulholland did, regarding the other patient that appears in file 150.

Q. If we go to D, which is when Dr Webb sees Claire at 5.00. Just if one is trying to keep up with the references, it is 090-022-055, not to be pulled up, but that's the reference for it. It doesn't mention the diagnosis of encephalitis. It does discount meningoencephalitis. And his plan is a 48 hour plan and that plan is not consistent with a working diagnosis of encephalitis.

A. That's correct. I don't think encephalitis was Dr Webb's working diagnosis, nor was it mine. I would have deferred to Dr Webb, who was the consultant neurologist, who had made what he thought was the best diagnosis, the most clear diagnosis obvious to him and was managing things accordingly.

Q. So the fact that the records after, let's put it that way, when you say you made that entry, the fact they don't address the encephalitis point is because, in the interim, Dr Webb has come and he is actually not so persuaded about the encephalitis point. He has not supported that.

A. He has not particularly supported that.

Q. So then it says -- and I think we have already addressed this:

"If you had that view at the time of the ward round thought there was a brain infection [if one uses the layperson's expression], then why didn't you provide ..."

I think you have dwelt why you didn't provide any treatment for it. Then I suppose there might be an issue: why didn't you mention it at all to them if you thought that? At that time he wouldn't have come, so you would have a view that whatever you have described to Dr Webb, he thinks that encephalitis/encephalopathy is a possibility. So you have come back to the ward to write that into the note so that's clear. I suppose their point is: could you not have actually come to tell them that you've seen the specialist and he's coming to see the child and there's a bit of a concern, but don't worry, she is in good

hands, that sort of communication?
A. Yes. That's a fair point. I think it probably was influenced by the fact that Dr Webb didn't feel encephalitis was a pressing concern and I felt that he was coming to see Claire, I hoped quite soon, and so we wouldn't have to perhaps wait long for a more definitive, if you like, assessment.
Q. So if you had thought he was going to come, when he actually did come, which is what you are impliedly saying, you might have had a word with the parents?
A. It is possible.
Q. Okay. Then if we go then quickly to (f), well that's a Dr Steen point. I am not sure you can address that. Maybe you can just help us with the nursing notes very quickly. Those appear at (i). There is a nurse, if I can put it that way, that accompanies you round the ward round. We think we know who it is, but quite often the nursing notes are a little bit more expansive, if you will forgive me for putting it that way, as to what's happening. There seems to be no reference in the nursing notes to anything to do with encephalitis, which was something that was discussed at the ward round. They presumably would be trailing around with the junior doctor, with you. Can you explain why that would be the case?

A. Well, I don't think encephalitis was ever a number one or working diagnosis, certainly not at that point. It was listed as a possible differential but only a possibility, no stronger than that. I think the nursing notes span quite a period of time, and the nursing notes, I don't think either, make mention of meningoencephalitis, which Dr Webb, the consultant, who carries more weight than I, mentions at 5 o'clock. I don't think the nursing notes make mention of encephalopathy either, which again Dr Webb has listed as his acute encephalopathy as his diagnosis at 2 o'clock. I think the nursing care plan doesn't mention non--
Q. I was going to go on to the nursing care plan. It is absent from there as well.
A. I don't think it mentions non-fitting status, encephalitis nor encephalopathy.
Q. So your point is one can't necessarily take so much from the notes and records, because unfortunately the notes and records may not have been as full or as accurate as they might have been?
A. I think they run with a working diagnosis, which was non-fitting or non-convulsive status epilepticus as the number one working diagnosis with anything else below that. Dr Webb moves, when he sees Claire at 2 pm, to mention acute encephalopathy, but he qualifies that by

saying "most likely postictal".
Q. Although they run with the working or the differential diagnosis, it was sufficiently significant for you to you to feel you wanted to add it to the medical notes and records. We can't minimise it too greatly because otherwise you wouldn't have bothered writing it in. So you have raised it, checked it and then you are writing it in. So one might think, if it had that kind of standing, that the nurses would be asked to feature that in some way.
A. I think that maybe it was more of a discussion that took place between the doctors. I think Dr Stewart mentions in his evidence that he is aware of a discussion around encephalitis. So perhaps that was a failure of communication adequately to nursing staff to raise that maybe a little higher on the radar.
Q. Can I ask you just quickly, without wanting to go into it extensively or into clinical issues, if you are working with that, that it is non-fitting status epilepticus, encephalitis, encephalopathy, and that in due course Dr Webb will come and give a definitive view as to what he thinks is going on neurologically. If you are working with that and you had had a discussion with the nurses, what would the nurses have been doing if they now recognise there is a potential -- let's call it

a brain infection -- going on? What would you be expecting them to do or to reflect in their care?
A. I suppose -- closer observations and CNS observations had, I think, already been started or were started at 1 o'clock.
Q. No, they started at 1 o'clock, so they wouldn't have started necessarily at that time.
A. Perhaps at that point they were started, in fact, you know, for 1 o'clock, because I think they are stopped -- the routine observations stop at 12 and then the CNS observations start at 1. So some time between that, between 12 and 1, there is a decision made either by the ward round or perhaps in conjunction with Dr Webb, who I think -- I think he believes it was after my discussion with him that he suggested starting CNS observations.
Q. Yes. I think the point from the Roberts' perspective was: if you came back and you had that initial view of yours sort of confirmed pending by Dr Webb, if I can put it that way, then it was significant, one, because you wrote it in, and two, because it might actually have affected the observations or something that the nurses did. That might have been relevant. So if that is what was going on, then at the very least it's a failure to communicate these matters to the nursing staff.
A. I think there is that potential there.

Q. Thank you. Just give me one moment. Yes. There is one other aspect that I know that you want to address, which is the extent to which you regarded, at the time, Claire's condition as being serious. I know it's very difficult with hindsight because after you've trawled through any number of expert reports that tell you it is serious, it might be quite difficult to divorce yourself from that and go back and think of what you actually thought at the time, but you have heard what the parents say.

They have a real concern that one of the reasons why Claire's treatment proceeded the way that it did was that nobody really grasped how ill she was. She gradually deteriorated until she was beyond assistance really, so that's their concern. Can you help us with anything that indicates your belief of how seriously ill she actually was?

A. When I first met Claire on the ward round, it was my belief that Claire was -- there was something badly wrong neurologically and that prompted me to go, leave the ward round and try to get hold of Dr Webb as soon as I could. Now that's not something that I would usually have done. That's not something I believe people would commonly do unless they were really worried about a child and I believe I have been consistent in saying

that I was very concerned about Claire's well being and her neurological status in particular right from the very beginning, from when we first -- when I first met Claire's parents in 2004 at the meeting with Dr Rooney, at that stage, I did say at that point and in my evidence to the coroner.

It is my view as well, I have to say, that I am not sure that Dr Webb was as concerned as I was.

THE CHAIRMAN: He wasn't. He thought she was going to recover.

A. Yes.

THE CHAIRMAN: Can I ask you this in a different way, doctor? How quickly did you find out that Claire had died? That must have been a real shock.

A. Yes.

THE CHAIRMAN: If there was a mortality review of Claire's death, is that not something in which you would have been particularly interested because she was a young girl whom you had treated, about whom you had concerns, which you have expressed, but who had then died?

A. Yes, I would. Yes, I would, and I remember being shocked to hear that Claire had died, and there was a sense of I knew she was sick and I wasn't sure what was wrong with her and I --

THE CHAIRMAN: Well, do you remember a mortality review?

A. No, I don't.

MS ANYADIKE-DANES: I think in fairness to you, Dr Sands, your evidence earlier was that if you had been told there was one, you would have wanted to be there.

A. That's true.

THE CHAIRMAN: And it would have been arranged, as I understand it -- the mortality reviews are arranged, as far as can be done, to make sure that the doctors who have been involved in treating the children are there.

A. That is usually so, but the only problem with that is that it is usually geared, if you like, for consultant staff rather than junior staff.

THE CHAIRMAN: Dr Steen can't remember it perhaps because her illness has affected her memory. Dr Webb doesn't recall one. Dr Herron doesn't recall one. Dr Mirakhur doesn't recall one. I am driven to the conclusion that there wasn't one and Professor Harding said, by video link to this inquiry, that if ever there was a child's death and something to learn from that and that would benefit from a mortality review, it was Claire's. So if there was one, not only can nobody remember it, but nobody can recall anything that came out of it. It is pretty hard to avoid the conclusion that there wasn't one.

A. I think that's a reasonable conclusion. I certainly

don't remember one.

THE CHAIRMAN: It would have been one that you would particularly regretted missing and you might have followed up by saying, "Well, what was discussed?"

A. Yes.

MS ANYADIKE-DANES: Just one last point on that.

When the meeting with the family is arranged, Dr Steen asks you to accompany her and I think her explanation for that is because you knew the family and you had -- I don't mean knew the family as knew them socially. You had met them. You had done the ward round, discussed Claire with them and you had been, in part, involved in Claire's treatment.

A. Well, if you like, I can tell you, you know.

Q. I am going to ask you a bit about that. Where I am going with that point, though, is: do you think that, in those circumstances, Dr Steen could actually have presented at a mortality meeting without some discussion or assistance from you?

A. I think it would just have had to come directly from the notes or perhaps aided by Dr Webb or some of the junior staff, but I think my role would have been important.

Q. The likelihood is she would have had to discuss with you?

A. Yes.

Q. Then I did want to go to the place where you thought I was going, which is to ask you about how you got to know there was a meeting that you were being invited to attend?
A. It was in the board room in the Children's Hospital. There may have been an audit meeting or something of that kind on and Dr Steen passed me Claire's chart and asked me to look at it and asked me if I knew or remembered this patient, because her recollection of it was minimal, of this chart, and her recollection of Claire was minimal.
Q. This was 2004?
A. Yes. 2004, and I looked through the chart and said, "Actually, yes, I do remember at least parts of Claire's case and parts of what happened". So Dr Steen simply asked me, "Would you like to come along and meet with the parents? This meeting has been arranged. Would you be interested in coming along, meeting with them and perhaps providing any detail you can of the events of October 1996?"
Q. Did you know at that stage what had brought Claire's case to the attention of the hospital?
A. Actually the first time she mentioned it to me I didn't, but then when she subsequently told me where meeting was to be and it was to be chaired by Professor Rooney and

Professor Young was coming along, she did then say it was prompted by the television programme that had been aired.
Q. Had you seen that programme yourself?
A. No.
Q. Did you know anything about it?
A. Other people had seen it and asked me the same question just as you have, if I had seen it.
Q. I am going to ask you one quick question following that. After that meeting, Dr Rooney put together the minutes of that meeting or a note of that meeting. Did you have any part to play in looking at that minute or correcting it or advising on it?
A. No. I first saw it on the inquiry's website.
Q. And thereafter, in fact the next day, the Roberts wrote a letter with further queries that they had. Did you ever see those queries?
A. I did see that, yes.
Q. Did you have any part to play in the answer that was ultimately provide in January?
A. No.
Q. You never saw the letter that went out?
A. No.
Q. Or drafts of it?
A. No.

MS ANYADIKE-DANES: Thank you very much indeed.
THE CHAIRMAN: Okay. Mr Green, is there anything further?
MR GREEN: Sir, there is not, but I am conscious that Mr Quinn raised another issue with me and Ms Danes yesterday in relation to the reference in the note to Claire's parents having gone home that evening. I don't want a situation to arise where Dr Sands has to be recalled once again.
MS ANYADIKE-DANES: I quite understand. If you just give me one moment, I will find where that is. It is in the minute, I think.
MR GREEN: It is in the minute. I am sorry. I don't have the reference at my fingertips.
MS ANYADIKE-DANES: If you could just give me one moment.
A. I interjected one point to say it would have been preferable if somebody had spoken to Mr and Mrs Roberts before they went home at 9.15 on the evening of 22 October 1996. I have no reason to doubt that that portion of the minute is correct.
MS ANYADIKE-DANES: It is at 089-002-085. This is literally the final page of the minute. You see fourth paragraph up from the bottom or third from the top, whichever:
"Dr Sands stated that it would have helped if medical staff had spoken to Mr and Mrs Roberts before

they left at 9.30."
Can you say what you meant by that?
A. As I understand it, Mr and Mrs Roberts spoke to a nurse or nurses before leaving the hospital at that stage, and I thought then -- and I think now -- that it would have been helpful if preferably the most senior person on the medical side had been able to talk to them before they left and to go over things with them, to tell them how Claire was or how it was understood she was. I don't think anybody expected what happened to Claire to happen. I didn't, but I think it would certainly have been appropriate for a member of medical staff, preferably a senior doctor, preferably a consultant, to talk to Claire's parents again before they left to go home, because that's a significant step, leaving the hospital, going home, and I know -- I can only guess that that has been terribly difficult to reconcile for Claire's mum and dad. Whether a senior doctor would have said, "Please don't go home", or, "Please stay", I don't think that always happens and that's a step further maybe than what I was suggesting in 2004.
MS ANYADIKE-DANES: Thank you.
THE CHAIRMAN: Thank you very much.
Doctor, thank you very much for coming back; okay?
(The witness withdrew)

THE CHAIRMAN: Mr Quinn, can I say I want the Roberts -- I don't want there to be misunderstanding. I don't want the Roberts to think I am hostile to them or critical of them for the way in which this issue has emerged. I can't imagine how I would have reacted in their shoes to this story emerging over the last few years had Claire been my daughter. The fact that their views have hardened to the extent they have is understandable, even if I am inclined to think, at this stage, that it's a bit regrettable; okay?

MR QUINN: I am obliged.

THE CHAIRMAN: Can we move on to Professor Lucas?

PROFESSOR SEBASTIAN LUCAS (called)

Questions from MS ANYADIKE-DANES

THE CHAIRMAN: Have a seat, please, Professor. Thank you for waiting.

MS ANYADIKE-DANES: Professor, do you have your CV there with you?

A. No, but you have it. Oh, sorry. I do, yes.

Q. The reference to it is 306-069-001. For those who were involved in Adam's case, it was presented then, although you didn't ultimately have to give evidence in that case.

A. Correct.

Q. So from it we see, since August 1995, you have been

a Professor of histopathology.

A. Yes.

Q. What was now Guy's and St Thomas', is now Guy's, King's and St Thomas's.

A. Yes.

Q. Can you help with what histopathology is?

A. Histopathology is the study of disease by looking at tissues down microscopes ultimately. That's what histopathology means. It is slightly broader than that. Essentially it is tissue pathology seen at autopsy, tissue pathology seen from samples of patients taken during operations, inside hospitals or GPs' surgeries and also looking at what we call cytology, which is spreads of cells sampled in many ways, including gynae cervical smears. All that can be put into histopathology.

Q. Does that mean, in the course of that work, you would be looking at brain cells as well?

A. Yes, you could.

Q. The reason I asked you that was, when I was putting some of the matters that you have raised in your report to the pathologists who carried out the autopsy on Claire -- in particular, I think, Dr Mirakhur -- some of those differences she explained by the fact they were neuropathologists and you were not.

A. Oh, that's nonsense. If one does a lot of standard pathology, including brain pathology, you cover a lot of those things and I would regard myself as pretty good at things like encephalitis or not.

Q. Right. Another issue that has been raised is the extent to which -- maybe it's a difference that you can explain -- the distinction between what you do as a pathologist and what a forensic pathologist does.

A. Yes. That's a reasonable question. Forensic pathologists are employed primarily to look at deaths where there is suspected homicide.

Q. Yes.

A. In a sense, that's what they do, whether it's traumatic, whatever the cause is and so on. They may do other things as well, but that's primarily why they are qualified to do that.

Q. But the method they apply to analysing what they are looking at down the microscope, is there any difference between them and you about that?

A. Yes. In general, forensic pathologists are much less good at looking down microscopes than all the other pathologists and I am sure everyone in this court knows that.

THE CHAIRMAN: We do now.

MS ANYADIKE-DANES: Right.

A. The evidence for that is borne out in many recent cases. We need not adumbrate.

Q. There are a number of protocols and guidance, perhaps not as many as you would like, that bear on the issue of autopsy and post-mortem reports and indeed the audit of autopsy. They were all put to the pathologists and I don't think any of them deny they existed. If I just run through them very quickly: the 1991 joint working party on the autopsy and audit.

A. Uh-huh (positive).

Q. The reason I put that to them was really to do with the consultation that should happen or at least in certain circumstances it ought to.

Then the 1993 Royal College of Pathologists guidelines of post-mortem reports. And the reason I was putting that to them was:

"[Their] responsibility to be satisfied that a full account has been obtained and to list the major pathological lesions present and a commentary to be written in the light of all the information available and to reconcile, as far as possible, the major clinical problems with the pathological findings and then also the issue of audit."

If I just pause there, that clearly is a guidance that you recognise.

A. Uh-huh.
Q. In terms of their responsibility to be satisfied that a full account has been obtained, can you help us with that, because that's a matter that was specifically raised with the pathologists?
A. Well, it's actually put into at least one of these two documents and also reiterated in the later ones which I had a hand in. I didn't have a hand in any of those. The purpose of the autopsy is quite simple: to answer questions raised by a death, period, by whatever means is appropriate. There are lots of ways of doing, but the crucial thing is to establish what the questions are and to -- once the process has been done, to consult, if required, with other people like other doctors who have been involved in the death, to see that all the answers add up, or whether they don't.
Q. Yes. In terms of finding out what the questions are --
A. Yes.
Q. -- is that something, in this case, that the pathologist would be informed about from the autopsy request form?
A. This being a consented case, that came from the doctors --
Q. Yes --
A. -- that information because there is information in the notes which one may or may not read in any detail before

starting the autopsy.
Q. Does that mean that what the questions are is not something that is necessarily confined to just those questions that are put to you from the clinicians? It is what the circumstances dictate --
A. Yes.
Q. -- as the questions?
A. Indeed. That and also other things that may arise from observation of the autopsy that may raise questions that hadn't been raised before at all.
Q. So although your autopsy request form might be your starting point, it is not necessarily your end point.
A. Certainly not.
Q. The responsibility for that, for making sure you have looked at all the relevant factors, which could generate questions that you should be addressing, that's ultimately the pathologist's responsibility?
A. I think that's right, yes, but in collaboration with the doctors -- remember this is not a medico-legal autopsy. It is a consented one. In other words, doctors have had questions that they wanted investigated further. So it is only right they are involved in, in a sense, the final outcome process in writing.
THE CHAIRMAN: This is your single biggest criticism in this case, isn't it?

A. Well, I have been sitting here all this morning. I am not the first person to say it today.
THE CHAIRMAN: Yes, yes.
A. Quite. I mean to, summarise that, I believe, from the information that came from the autopsy, when viewed appropriately with the right people, the radiologist, the doctors who looked after the -- the answer would have dropped out of the sky as being fairly obvious as to what was going on.
MS ANYADIKE-DANES: Which was?
A. Hyponatraemia causing cerebral oedema causing death. Period. Because all the other possibilities have been excluded. That's what autopsy is about: excluding things as well as proving others.
Q. Now you have come to this so nicely, can I ask you about the extent to which you regard encephalitis or anything of that sort as having been excluded?
A. There's a lot of documents here and I should also say that I have not seen the histology slides, but I have seen everyone else's accounts of it.
Q. Yes.
A. I can also say at this point that whatever people were anything 1976 --
Q. 1996.
A. Sorry. I beg your pardon. 1996. And I just noticed it

again this morning, it is interesting that in 2006 the coroner writes "meningoencephalitis" down as his cause of death after the inquest. So something obviously rumbled on into that stage as well despite everything one has heard this morning. It wasn't quashed at that point, unless Mr Leckey was making it up. I don't know.
Q. Well, in your view, when you looked at the papers that you had --
A. Yes.
Q. -- what allowed you to exclude the encephalitis?
A. Well, there was quite evidently very little of it for a start, even by the most generous interpretation of some of the words there. Then I looked at Wendy Squier's comments. I looked at Dr Harding's comments. There were some pictures as well which I was given as black and white prints. I found them deeply unimpressive as encephalitis. I have seen a lot of encephalitis. This is not a new disease to me. I am not a neuropathologist, but actually infectious diseases, that's my trade, and I have seen quite a lot.
THE CHAIRMAN: Are you in Professor Harding's school that it is either there or not; it is not there in grades?
A. Virtually, yes. I noted that this morning, thinking I was going to get asked that. I think what he and I would mean is that encephalitis sufficient to cause

clinical brain damage and kill is either there or it's not.

THE CHAIRMAN: Right.

A. There will be many circumstances when there is a very mild. I am talking about a morphologically mild degree of encephalitis, which has no bearing on a case. It appears to me from the descriptions here even that doesn't pertain either.

Q. Well, the view of both Professor Harding and Dr Squier is that they simply didn't see inflammation in the way that was described by Doctors Herron and Mirakhur, that they were looking for some form of infiltration or something more than they saw on their slides.

A. Yes.

Q. And they didn't see it. Dr Squier's view is not only didn't she see it with the normal range of stains that had been applied by the pathologist, she went and applied further stains to try and see if that would highlight anything, and even with those further stains, she didn't see any evidence of it.

A. She phrased it slightly differently from that, but I think that's what she meant, yes.

Q. You actually had a comment on the staining.

A. Yes. Because that was actually put back to me to rewrite my report, which I was very happy to do. Where

is my corrected bit? I do beg your pardon, sorry. I will start again. Where are we? That's the final version.

Q. For everybody else, it is at 239-002-011.

A. Sorry.

Q. If you don't have a paginated copy, it is your paragraph 0?

MR LAVERY: If I heard Professor Lucas correctly, this was put back to him in order to allow him to rewrite his report. Does that mean there was a previous report we have not seen?

THE CHAIRMAN: I will get you whatever there was. There was an initial response which we asked the witness to develop.

A. Of which this bit is the only bit I changed. It is just a little section on how much encephalitis was there.

MR LAVERY: I think that's something certainly we would like to see, Mr Chairman, if that could be made available.

THE CHAIRMAN: I understand.

A. I can tell you what it said. The first version said there is no encephalitis, period. I was then invited to review in detail Dr Squier's second or third commentary and I then made my paragraph a little longer, which was -- I have actually quoted her here, so I can just read her out:

"Dr Squier's report of 16 June discusses some IHC [immunohistochemistry] special stains for looking at inflammatory cells in the brain, looking for [it is written down here] CD68+ positive [that's macrophages] and they are increased in some locations [but that is a fairly non-specific thing]."

I was much more interested in the T cells, that's capital T cells, which is the main inflammatory cells in encephalitis. It was done on two blocks, a bit of pons, bit of mid-brain, using pan T-marker C3, but only one slide is commented on. She says and I quote:

"Shows a uniform background colour and little specific activity. The preparation may have faded."

Now I take it to mean that she didn't re-do the slides herself; she was looking at someone else's.

Q. Sorry. I am not quite sure where you are --

A. Sorry. I am looking at my -- it is paragraph 0 in my comment in italics. Next page. Next page. No, no, no. That's not the one I am reading out. The one I am reading out from is the one I then sent.

THE CHAIRMAN: The one we have on the screen here, professor, pages 11 and 12, are you saying that's an original one which you then added to in this section?

A. Yes, I added about five lines to it, which I know you have received, because I was thanked for it.

THE CHAIRMAN: I tell you what. Can we go on with the rest of the professor's evidence and we will then track this one change and, before the professor finishes, we will give you a chance to see it and ask any questions you want.

A. It is there.

MS ANYADIKE-DANES: Can we look at the final version as it is now up on the screen?

A. Okay.

Q. Just for clarity it starts:

"I tread carefully here. I have not seen the brain histology slides, but am aware of the differing opinions of the Northern Ireland pathologists and the external referees, Doctors Squier and Harding. In brief, from the histology descriptions and the photographs supplied, it does not look like meningoencephalitis to me. I am a little surprised that no-one, even in retrospect, has performed specific immunohistochemical slides on the tissue slides to determine for sure the presence or absence of inflammatory T-cells or reactive astrocytes and microglia. In my book, infiltrating CD8+ T cells are necessary to diagnose encephalitis in most cases. They are there in the brain, or they are not. If they are not, then it is not encephalitis."

A. Essentially, the only difference is that I have put

a bit in between that saying: Wendy Squier did refer to that and it doesn't make a convincing case for encephalitis, which she said. All I am doing there is reinforcing that rather more scientifically.

Q. In other words, you are agreeing with her and Professor Harding on that issue?

A. Oh, yes, absolutely.

THE CHAIRMAN: This came about because, at the end of the page on screen, the end of the left page, it says:

"I am a little surprised that no-one had performed stains."

In fact, those had then been --

A. But only a limited amount, actually. I then make the point that if you were going to do it properly, you could have done a bit more.

THE CHAIRMAN: Okay.

A. But in the end, the end result would be the same: there is no encephalitis.

MS ANYADIKE-DANES: I think Professor Harding's point was he was not going to apply any more stains because there wasn't anything on what he saw. There we are. There are the three degrees of it: there is Professor Harding at one end of the extreme, Dr Squier in the middle, and you at the other. You were of the view there was no credible evidence of encephalitis.

A. From what I am able to read, yes. As I say, I haven't seen the slides myself.

Q. And from the photographs of the slides?

A. And the slides, correct.

Q. Thank you. If we just expand on that, though, if you are being asked to address a query as the pathologists were, there were four clinical problems that had been identified in the autopsy request form: the first was cerebral oedema, the second was status epilepticus, the third was SIADH, essentially, and the fourth was a query of viral encephalitis.

A. Yes.

Q. So the pathologists responded to that by saying, in relation to the second, status epilepticus, there was nothing they could really do unless things had got to such a stage that you saw the footprint of this in some way on pathology. The third one, on a metabolic cause, there was nothing they were going to be able to do to assist with that and I think they refer to that in the commentary of their autopsy report. The fourth was something they could assist with. That was a query as to whether it was there and they could certainly assist with that. Am I understanding you correctly that if you were receiving a query of that sort, then you do more extensive staining?

A. I would have done it. I would have done the whole thing slightly differently. What happened in this autopsy is the brain is removed and externally described. It is then fixed for a period of time and then subsequently is sliced. Samples are taken and looked at down the microscope, and that was all. That's fine except that if -- I would have thought, even in 1996, as a personal view, that if there was a query of a viral encephalitis going on, one would actually keep a sample of fresh tissue, not in the bucket of formalin, the fixative, but sent it to virology saying, "Look for it".

Q. I think they did take a sample and a query was raised as to -- at least I asked that very question, whether having taken it, they could have done -- sent that off and seen whether they grew anything, using the layperson's expression. The answer to that from both, I believe, Dr Herron and Dr Mirakhur is that there actually was some brain tissue in the cerebral spinal fluid and that didn't produce anything.

A. That's right. They looked at the fluid, which is another way -- it is a surrogate marker of the brain. It surrounds the brain. It is produced by the brain and that apparently, using the tests available in 1996, which is very different from what it is 16 years later --

Q. Yes?

A. -- found nothing. I saw that, but they didn't take any brain tissue.

Q. Sorry to correct you there. His answer was there was inadvertently some brain tissue in the cerebral spinal fluid and therefore he was content that they had addressed the question --

A. Okay.

Q. -- of whether that could have cultured anything or produced anything.

A. And the answer was the whole thing was negative --

Q. Yes.

A. -- because there was no viral encephalitis.

Q. Yes. So in terms of what else you think they might have done if they were faced as they were, with this query over a viral encephalitis. So they could have taken a fresh sample. Well that, hasn't achieved anything. What else do you say -- you say you would have done it slightly differently.

A. That's what I meant. I would have kept a bigger chunk of tissue as a routine procedure, put it in the freezer -- what one actually does is put it in the freezer and await the histology to tell you what to do next. It comes as a sequential process, otherwise you are bombarding laboratories with vast amounts of tests

which are unnecessary.
Q. Can I ask you then about the stains? Are you saying that they should have applied different stains?
A. Well, in Belfast in 1996, they could most certainly have done the immunohistochemistry stains for T cells and other cells themselves on the spot.
Q. Yes. Their view, if I put it to you, is they didn't do that because they found the low-grade sub-acute encephalitis. So once they had got that, there was not any need to find anything more. They had found enough.
A. Yes.
Q. Sorry. I am summarising.
A. You are summarising very well indeed. The problem is "low-grade". When you get to a low grade, you are then hitting against the buffers: is it there at all? In pathology terminology, "low grade" is often used for "mild" and "I am not quite sure if it is really there or not". If you mean -- if you say "severe", there is no misunderstanding that you mean something is certainly there.
Q. So then if you were being particular about it, because you are now dealing with probably the one thing that you could make some contribution to the clinical problems, if I can put it that way --
A. Yes.

Q. -- if you have got it on your standard stains to be low grade, then is it worthwhile then applying some further stains to see what you've got or is that sufficient?
A. In my personal view --
Q. Yes.
A. -- it would be advisable to pursue this further to take confirmatory tests and you might -- I can see the audience thinking, "Come on, this can't be that difficult, you can see inflammatory cells". It's not so easy because lymphocytes look almost the same, nearly, as oligodendrocytes, which the brain is full off. How do you tell the difference? I think that is what the neuropathologists were looking at. They weren't looking at inflammatory cells, they were looking at some of the background normal tissue of the brain.
The point about doing special stains is that it sorts that out instantly. One looks down the microscope and you know exactly what's there and is not there and it is cheap.
Q. Once you got to a sort of not terribly conclusive answer that you have got a low-grade presentation, if I can put it that way, then it doesn't cost very much or take very long to see whether you can confirm?
A. No, it costs about ú20 and takes one day.
Q. That's the staining point and, in your view, would have

clarified matters for them?
A. Yes, it would have eliminated encephalitis completely at that point.
Q. It doesn't go towards the cause of death at all, but the other thing they picked up from the autopsy report and, certainly, it is what Dr Steen was hoping that they would, which is if there was any explanation, on pathology, at all as to Claire's learning difficulties.
A. Yes.
Q. And they looked at their slides and came to the conclusion that she had a neuronal migration disorder, which is not something --
A. This is not an area I want to be questioned about at all. I don't do that. It's very subtle stuff, but I do know that Dr Squier, who has probably spent about 40 years looking at that sort of thing, thinks it is not there. I am stopping.
Q. Thank you very much. Then perhaps if I can cover with you just a few other areas in your report. The chairman has made the point that that is one of your main criticisms, if criticisms is the right expression, and that is this failure, at whichever stage it happened, for the pathologist to either perform some reconciliation themselves, to try to see what they had seen in pathological terms of the clinical information

that they had been given or, better yet, to do that in combination with the clinicians themselves, to see if, combining their expertise, they could come out with some better explanation for what actually had happened to Claire and why. How serious do you regard that as a deficiency? Is it that there seems to be no evidence of that having happened?
A. Well, as I've heard today, and as I know from the papers, there doesn't seem to be evidence that there had been a meeting about this and yet we know they regularly had them. This case seemed to have slipped through the net. It just fell between the stools, whatever metaphor you want to use, for reasons I imagine are entirely accidental, because these things happen. Had it come up for a meeting and, progressively, all the possible causes are crossed out, you are left with that.
Why didn't -- I mean, you are going to ask me why didn't the pathologists say outright, "It might be hyponatraemia causing brain oedema, causing death", and the answer -- and I don't know whether you have asked them this -- is they may never have heard of it before You don't think of things you had never heard of.
Q. I think they thought they had addressed that possibility by reference to their comment about metabolic causes.
A. That's a bit mealy-mouthed. I have done hyponatraemia

deaths myself. I have been very lucky in the sense that I was alerted as to what it might well be. So I had that as background. So my role in those autopsies is to confirm there is absolutely no other possible cause to explain why the person died as they died. And you are therefore left with that as the explanation. You are given it on a plate, but you still have to do the rest of the job by pointing out it is not something else. So if you know about it, it is easier.

Q. I think Dr Steen's view -- and she is the person who drafted the autopsy request form -- her view is that she had done enough to alert the pathologists to the fact that that's a possibility and, in any event, she had provided them with the medical notes and records, which weren't extensive, which certainly included information from which they could conclude that. If I am looking at the autopsy request form where she gets that from, if we just pull up 090-054-183, and it's under the "History of present illness", it is the line that starts:

"Serum sodium dropped to 121 at 23.30 hours on 22 October. Query inappropriate ADH secretion."

And underneath that:

"Fluids restricted."

Then:

"Respiratory arrest."

So she felt that a combination of that and maybe the reference on the following page, 184 -- yes? Sorry.

MR FORTUNE: There is the reference to seizures and also "See chart".

MS ANYADIKE-DANES: Yes.

MR FORTUNE: Bottom left-hand corner.

MS ANYADIKE-DANES: Yes. Probably it's the "See chart". The "See chart" is to indicate that this is being accompanied by Claire's medical notes and records. So in her view she's highlighted what her serum sodium level was, the fact it has dropped to that, when it did in relation to her timings, if I can put it that way, and that they are already querying "Inappropriate ADH secretion". So her view is that that's -- the question of hyponatraemia is something that was sufficient for the pathologist to glean from that and the medical notes and records, and if they had looked at the medical notes and records, which, as I say, aren't particularly extensive, then what they would have seen is -- I'm not going to take everybody through it, because we've been through it so many times, but just for the reference it's 090-022-056 -- that is the 11.30 reference that is -- that correlates with what's put there on the chart, and that has:

"Hyponatraemia, query fluid overload and low sodium

fluids",

and then on the second line:

"Query SIADH."

Let's have it there just so that you see. So that's 11.30, and it's at that time that you see the sodium level of 121 is recorded, and that's the suggestion that we need to increase --

STENOGRAPHER: We have lost the LiveNote feed.

MS ANYADIKE-DANES: Oh!

THE CHAIRMAN: Sorry?

STENOGRAPHER: The LiveNote has crashed.

THE CHAIRMAN: That means the transcript isn't coming up on anybody's screen. Is that right?

STENOGRAPHER: Yes.

THE CHAIRMAN: Could we pause for a moment or two?

MS ANYADIKE-DANES: Sorry.

THE CHAIRMAN: Professor, give us five minutes to see if we can sort this out. Okay?

MS ANYADIKE-DANES: Thank you.

(4.20 pm)

(Short break)

(4.24 pm)

THE CHAIRMAN: Thank you, Professor.

MS ANYADIKE-DANES: So what I had been showing to you -- let's pull it up again -- 090-022-056. Thank you. So

what I was putting to you is that Dr Steen was saying that she had indicated sufficiently on the form enough for the pathologist to have seen that hyponatraemia was an issue and that if you matched the fall in the serum sodium to 121 at 2330 hours on the 22nd and you went to look in the medical notes and records, this is what you would have seen: you would have seen that there is an identification of hyponatraemia, irrespective of the two ways in which it could have resulted. And then if you had gone over the page -- can we go over the page the page to 057? Okay.

Then you would see, if you work your way down to the entry by the paediatric neuropathologist, Dr Webb at 4.40, you can see:

"SIADH, hyponatraemia, hypoosmolality, cerebral oedema, coning following prolonged epileptic seizures."

So hyponatraemia was there as well. It is also in other places, which it is unclear would have necessarily been in the medical notes and records at that time, like the discharge sheet, but in any event looking just at the medical notes and records, it is there. So the point that I was putting to you is that, according to her, she would say she has identified hyponatraemia for the pathologist. Is that sufficiently clear as far as you are concerned?

A. Absolutely.
Q. So then if that is identified there and it is something that they could and should have picked up, then when they carry out the autopsy and they reach the view that they do about the low-grade meningoencephalitis -- and you say low-grade means "hardly there" --
A. Borderline.
Q. Borderline, certainly not having very much effect, if I can put it that way.
A. Yes.
Q. Does that mean that you are of the view that the pathologists should have been raising the issue of hyponatraemia more explicitly than is covered by "metabolic causes"?
A. Well, they certainly could have. Should, could. I mean --
Q. They could have?
A. They could have. That's right.
Q. Would it have been proper for them to have done that in your view?
A. Yes, but -- sorry, yes, but they also write in the comment, which I have in front of me:
"... possibility, though a metabolic cause cannot be excluded."
Obviously, in the back of their mind there is

something there. That's when you go back to your clinical colleagues and say: right, this is where we are so far, let's talk about it.
Q. Yes. A point I am asked to raise is: in your view, could they have got -- to the exclusion of other relevant factors, and therefore what we are really talking about is hyponatraemia before they went to talk to their clinical colleagues?
A. I think they could have, just by applying pure pathology, they could in my view -- probably should -- have excluded encephalitis because it isn't there.
Q. Yes.
A. There is no pathological indicator of recent death from status epilepticus, fitting or otherwise. So you can't really say anything about that. The business about SIADH, of which there are great long lists of causes as we know, but the one most people were thinking about is encephalitis, which isn't there, so that is cut out. So you really left actually with thinking about: it is something to do with the biochemistry in life.
Q. Yes. So they could have actually spelt out hyponatraemia?
A. Yes.
Q. But in any event, even if they didn't spell it out, they could have got into the territory of it?

A. Yes, and then they could have tried to work out why it happens. Trying to work out why it happens gets more complicated because one thing pathologists are not good at is looking at fluid charts and doing the counting. We are hopeless at that. All of the things I have been involved in where fluid balance and salt and water and potassium and sodium balance have been critical, we have relied on other people to actually go through that and establish it.
Q. So if you wanted to advance things further, apart from getting in some specialist yourself, which starts to take you out of your territory of a pathologist --
A. Yes.
Q. -- your next step is to say, as you said, "Let's talk about it".
A. That's right.
Q. Now you have --
A. Which is what apparently, in all other cases where a child dies and they have meetings, they do. The interesting thing is: why didn't it happen in this case.
Q. Well, in fairness the -- what the pathologists would say is although they can't specifically remember it happening, it is what they believe did happen and the source of that belief is because, firstly, if one sees on the daybook, if I can put it that way, there is

an entry which specifically identifies the fact that two further blocks were being prepared for Dr Mirakhur and she wanted those because that was going to be part and parcel, as I understand it, of her presentation.
A. Okay.
Q. She also prepared 35 mm slides. You have seen the photographs of those. Those are the photographs from her slides. She was preparing those for a presentation. So that's the evidence.
A. Yes.
Q. And then the assumption comes from: because that's we would do.
A. Just one tiny caveat: you can prepare for a meeting and it still might not happen. I mean, that's happened for me many sometimes. You get ready for what we call a CPC, clinicopathological conference and for some reason it is pulled. You say, "Let's do it next week or next month or whatever", and it doesn't always quite happen.
Q. So far as you are concerned, given the stage at which they had reached, how important was it to have one?
A. Well, important, because from the autopsy report they tend to be favouring meningoencephalitis, but it is very mild and then they raise other issues. The case is simply not resolved and that's why it matters, because

this comment ends with a big question mark.
Q. Yes. So I think --
A. When you stand back and look at it, it is just a big question mark there, is it not? In further evidence, Dr Herron, in one of his later submissions, says:
"We don't make diagnoses in consented autopsy cases."
That's a slightly contentious point, but I can see what he is getting at: we make comments and we make observations so that we can discuss them with the colleagues who asked for the autopsy in the first place.
Q. So in your view, that is exactly what should have happened, not just because it is good practice to do it, but because in this case matters were left hanging.
A. Precisely. The autopsy only got going because doctors asked for it. You don't close the circle until you go back to the doctors to close it, to discuss it.
Q. Yes. I think I have put that as that's perhaps your greatest concern in terms of what happened --
A. Yes.
Q. -- that process.
A. Just personally, just from the observation of what I have seen, had there been a sensible -- a conversation between the relevant parties who knew about the case with the notes in front of them and all the information,

the answer would have fallen out as being pretty obvious, because other things have been excluded.
Q. And if what was dependent on all of that is not just so that you understand what happened to this child and how and why this child died. Because it's consent, one of the things you're doing is so that you can then communicate to the child's parents as to what happened. So do I take it from what you say that you couldn't have been giving a satisfactory explanation to Claire's parents as to what had happened without having had some kind of meeting where the clinicians would have brought their understanding of what happened during her life, if you like, and the pathologist brought their findings on autopsy?
A. Yes. That is correct. In this case, where it's difficult -- some consent... -- I do quite a lot of consented autopsies, sometimes at the request of families who are not happy with what went on in a hospital or a GP's surgery. This is called a private autopsy. Answers are either startlingly different from what the death certificate said or exactly congruent with it. The amount of conversation you have afterwards, after the autopsy has happened, rather depends on where you are in terms of trying to work out the clinical scenarios. If it is all pretty cut and

dried, it may be that just posting a copy of the report is all that's required. But when there are questions left hanging in the air, as this case would prima facie seem to be, then you must have a conversation.
Q. So if you are going to write to the parents as they wanted to know, not surprisingly, what was the result from the autopsy, you are going to have to have the kind of meeting that you are that you talking about --
A. Yes.
Q. -- so you can pull it together and form a view that can then be communicated and explained to the parents?
A. Yes.
Q. Is that -- one of things that I had put to Dr Steen earlier this morning is a comment that you made when they did write. She wrote to the GP. Dr Webb wrote to the parents. I think the comment from your report is they had rather over-interpreted, if I can put it that way, the commentary section of the autopsy report. Is that what you are driving at, that you thought they had got too much out of that?
A. Yes.
Q. Or at least more than they should in the absence of having discussed matters with the pathologists?
A. I think so, yes. I think they made it more straightforward than the pathologists intended from

their comment at the end of the autopsy report.
Q. And if that -- if the view that the pathologists had reached was where you had got to, had you been conducting it -- and I understand you wouldn't have, because you would have discounted and eliminated even the low grade, but leaving that aside, say you had formed the view that it was that, then how do you think -- or at least what do you think ought to have been explained to the parents?
A. Well, the sensible thing is to have a conversation with the clinicians first.
Q. Yes.
A. I mean, this does come up quite often, "What are we going to tell the parents?", and I say, "Hang on. Let's sort this out, otherwise it is going to look silly". You arrange a meeting. It may be in a corridor or it may be a proper formal meeting with 35 mm slides or Powerpoints or whatever, but there needs to be some discussion so that the clear answer and correct answer -- as correct as one can make it -- is issued.
Q. Yes.
A. Because, after all, the autopsies only happened because the parents very kindly said yes when asked.
Q. So the view that the parents have been left with and were left with until 2004 was what was the trigger of

their daughter's demise, if I can put this that way, was something viral.

A. Yes. That is right. That persisted through for the next two years, didn't it, until the inquest, because that's what comes out from there too?

THE CHAIRMAN: Nine years, I am afraid, from 1997 until 2006 when the --

A. Sorry. I beg your pardon. Two years after 2004 is what I meant actually. Nine years.

MS ANYADIKE-DANES: And from what you have seen, that was incorrect -- or at least there was not sufficient evidence to justify that.

A. A lot this must have been gone over during the inquest. I don't know how long it went on for and I haven't seen the transcript. It would appear that Dr Herron did the talking from the witness box as pathologist. That's right, even though he then said, "Actually, it wasn't really my diagnosis in the first place". I know about that. That was what came out. So nine years after the event, he must have been reasonably happy with that to be able to say on oath from the witness box, "On balance of probability, this is what it is all about", otherwise the coroner would have picked him up.

Q. And are you saying from the pictures that you have seen of the slides and other material --

MR LAVERY: Dr Herron certainly, at the inquest, did not make a diagnosis because it wasn't for him to make a diagnosis.

A. It is possible then the coroner, faced with confusion all round, took the best he could.

MR LAVERY: Secondly, there was no issue on anything being decided on balance of probabilities at the coroner's inquest. I am not sure where Professor Lucas is getting --

THE CHAIRMAN: There is a multiple finding at the coroner's inquest, isn't there?

A. But it does put meningoencephalitis first.

THE CHAIRMAN: But in a sense, when you put down multiple findings in Claire's case, looking it now, professor, it seems that was because there hadn't been the necessary discussions to rule out the things that should have been ruled out.

A. That is one very reasonable interpretation, yes.

MS ANYADIKE-DANES: Can I just put one point, lest I omit it, which would be incorrect: you, to a certain extent, have agreed with the evidence of Professor Harding and Dr Squier about the absence of any real evidence that there was encephalitis.

A. Yes.

Q. Now Professor Cartwright, who was the inquiry's expert

in microbiology, he has a different view to that. In his view, he thinks it is quite possible she had an encephalitis and, for various reasons, that had not yet manifested itself in a way that could be identified at autopsy; can you assist with that?

A. Well, I was pointed to this, because he only gave evidence about a month ago. I was sent the transcript and I read through it and I know Keith Cartwright quite well as well, but I haven't spoken to him about this at all. I read through it and all I can say is I know why he is saying what he said because the numbers would appear that although, as he explained at great length, the numbers are very peculiar and we don't need to go into that again. I would simply discount all that CSF stuff because it does not fit with the brain morphology. In this sort of situation, the brain morphology trumps all other ways of investigating it.

Q. So if you are looking for the strongest evidence, that's the brain morphology?

A. Precisely. This may cause some dismay among laboratory clinicians, but I can assure you that this is by no means unique. All tests are unique, even morphology. Here we have something consistent that there is little or no encephalitis. The CFS indicates there is a lot of it. That's just wrong because there isn't. What happens

is one doesn't know why the numbers came out the way they did, but this happens all the time. We interpret tests in the knowledge of the total context of the case and, if something doesn't fit and everything else points in some other direction and is more consistent, then I am afraid the aberrant lab test goes out and you discount it as an error for some reason.

Q. Are there reasons in your experience for why the CSF sometimes doesn't fit?

A. Yes. I mean, there are lots of reasons. I mean, the specimens could be the wrong specimen; it could be someone else's. One hopes that's not the case, but it does happen. One in 10,000 specimens is going to be the wrong one by definition. That's why we do two HIV tests for everyone so the chance of that happening is essentially zero. There is a very good reason for that.

It may be the person who counted the lymphocytes was having a bad day. I am not going to speculate. I simply don't know. It is simply the CFS results were not matching the brain morphology and the brain morphology, in this case wins.

Q. In your experience, sometimes the CFS result cannot relied on?

A. Yes, and other things as well.

THE CHAIRMAN: You say all tests are fallible.

A. All tests.
THE CHAIRMAN: So if you have one test result which is out of context in the case and out of context with the other results, you can just discount it?
A. You should think about it very carefully before accepting that it means very much and not necessarily put very much weight on it.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: There were some other points that were raised with you really in relation to the report itself. There is an issue, as you know, about the report not being signed, leaving aside that, there is an issue as to attribution. The report shows on its face Dr Herron, which is, I suspect, one of the reasons why, all those years afterwards, he assumed it was his report. In your expert report to the inquiry, you put it slightly differently. You said that usually the consultant's name is there and you're trying to, if you are being fair to your registrar, who has actually done some of that work -- maybe even much of the work -- you would hope that the consultant would include the registrar's name. Could I take it that you are indicating the registrar's name should always be on the report?
A. Yes. That's right. They would normally write it in themselves, "as is done by them with Dr X", or something

like that.
Q. Then your other points that you make are -- well, the first which you have explained, the lack of clinicopathological correlation after the autopsy and histopathology. You have explained that and why you thought that was significant. Then you say that if one is looking purely from the point of view of what would be necessary to comply with the guidelines, you have a point in terms of timeliness.
A. Yes.
Q. Can you explain that?
A. This is right at the end, isn't it?
Q. Yes, it is. In fact, I can give you the reference. If you are looking at a paginated version, it is 239-002-014.
A. Yes. Gotit. This relates to the guidelines of autopsy reports published by the college in 1993. I didn't go through it block by block, but obviously this is a long delay after the event, partly relating to fixing the brain for three months rather than just three for four weeks, which was meant to be standard at that time.
Q. Well, Dr Herron gave evidence on that. It wasn't that the brain was being fixed for that length of time. What he said was that there is a four weeks-or-so period of time for fixing the brain --

A. Right.
Q. -- and then he had produced a pie diagram --
A. Oh, yes. I did see that, yes.
Q. -- which I don't have quite at my fingertips at the moment. In any event he said quite a lot of that was the lab time taken with getting the blocks, producing the specimens and so on and so forth. Their time in actually looking at the slides and carrying out -- and writing up their report was in the scheme of things quite short. So he wasn't saying that it had taken them three months to fix the brain, but what he does say is they were, you know, a busy unit and the lab technicians take some time to doing this kind of work?
A. Yes. I mean, fair point, and it still actually pertains in many neuropath labs. They were traditionally and are still very slow.
Q. Your point, though, was to go on to say, and I think this was recognised by Dr Herron, that part of the difficulty about that is if you wait so long for whatever good reason before you can get into your clinicopathological correlation, then the clinicians may have moved on to other things and the precise details of it all may not be to the forefront of their mind --
A. Yes.
Q. -- and that rather hinders that correlation process that

you think is so important?
A. It does, and also some of the staff move on as well, you know. They are not there in the hospital any more. You may remember the case.
Q. But if you -- sorry.
A. I just say. That may not pertain here, but that is a risk of holding things over for so long, that the people with memory aren't there any more.
Q. Yes, but you've always got your medical notes and records?
A. You've got the records. That's right.
Q. So the timeliness point in fairness may not be a big one or at least there may be good reasons for why it happens. I think Dr Squier's evidence was --
THE CHAIRMAN: I understand why that happened. I understand things are slow. I think in Claire's case it may have had a detrimental effect.
A. Yes.
MS ANYADIKE-DANES: If then -- maybe then you should address that. Are you able to assist with if there is any kind of time within which you would be wanting to have your correlation, if I can call it that way, discussion with the clinicians?
A. Ideally just one says as soon as possible.
THE CHAIRMAN: The sooner, the better, isn't it?

A. The sooner, the better. There's no absolute limit to this at all.
MS ANYADIKE-DANES: Is there any reason why even before you issued your final report why you couldn't be having that discussion then and there?
A. Yes, that's right. If you just think in medicolegal cases, where, for example, you know there is going to be an inquest, and you also know the inquest actually is not until next July, because for some reason you know that, you may not be in a terrible push to finish the case, because there is no great need. No-one is going to look at it until May at the earliest, for example. So that's just an example of in a sense why one plans -- how one plans work. One plans it on a question of what matters, but for some reason this got sort of shifted three months, by which time it just seemed to have slightly dropped off the radar.
Q. Yes. Thank you. Then I think really those are your three points. The timeliness point. The lack of commentary, well, maybe that's a separate point. Your third point about the:
"No mention of a clinicopathological or audit meeting in a complex case",
that's the meeting with the other clinicians?
A. Yes.

Q. But do I understand your second bullet point to mean that there is supposed to be a reconciliation or an attempt at it in the autopsy report itself?
A. In a consented autopsy there should be.
Q. There should be?
A. Not necessarily in a coronial one, because that's slightly different again.
Q. Yes.
A. Yes, there should, because, as I say, the relatives have been asked. They have agreed to an autopsy. It has been done. The system expects that everything is reconciled, and if the case is -- if the case is soluble, and I have to say that not all cases are soluble, but I think this one was, then there is a final commentary saying, "This is how it is. This is how it adds up. This is what happened".
Q. Well, if we look at -- because the pathologists in this case believe that that's what they had done -- 090-003-005 -- insofar as they could.
A. Insofar as they could at that stage. That's right.
Q. Let's have a look at it.
A. Yes. I've got that in front of me as well.
Q. Now in terms of what they knew and had found out and what was in the medical notes to assist, is that a sufficient attempt to reconcile at that stage?

A. Not really, no, it isn't. It needs a bit more. The point is this is done on a word processor. So there is no great harm and problem going back after a meeting and adding another paragraph. "Case discussed on 12th January. This is what happened." That's what we'd do anyway.
THE CHAIRMAN: But from what you're saying the reason why it is unhelpful is that it is too vague. It is "low grade" this and "a possibility of a metabolic cause cannot be entirely excluded".
A. You can look at this paragraph in many ways. I would look at it as a plea from the pathologists saying, "Please, doctors, come and tell us what you think is happening so we can provide a satisfactory conclusion". This reads to me like a plea for further help.
MS ANYADIKE-DANES: So that kind of wording, just to pick up from the Chairman:
"The reaction in the meninges and cortex is suggestive of ...",
that sort of wording, which I think you might have referred to as rather mealy-mouthed earlier --
A. Yes.
Q. -- that's because -- is that -- is your interpretation of that because they actually can't be more definitive than that?

A. At that stage.
Q. At that stage, yes.
A. They need help. I mean, again just to reiterate the point that the concept of possibly hyponatraemia producing this pathology, it doesn't -- it hasn't struck them as being a serious runner, but it is there in the background. Again I just reiterate I suspect that's simply because they hadn't heard of it.it. Not all pathologists have. Most pathologists when they come across hyponatraemia learn it the hard way for the first time, as they did.
Q. Well, it's --
A. It's not part of medical student training. It's not something -- I mean, I do lots of autopsy lectures to trainees across England, across the breadth of the land. I don't think I've ever particularly mentioned it myself. It's not something that, "These are the ten things you have to know if you're going to be an autopsy pathologist. Make sure you know about hyponatraemia". It's not like that. It's actually fairly obscure. I know you won't think it, having been in an inquiry for many months, if not years, but I can tell you on the path... -- I spoke to a couple of friends who are pathologists the other day, saying, "Tell me about your experience of hyponatraemia. When

did you learn about it and when did you first see a case?" There was much scratching of heads as to quite when they'd heard of it, but they admitted they probably had seen one case in their professional lives over tens of thousands of autopsies. This is not a common condition. So it's not like big things at the front of your mind when you're looking at obscure cases.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Then just finally --

THE CHAIRMAN: Mr Fortune?

MR FORTUNE: Could we ask Professor Lucas to scratch his head a little bit more? Given the paragraph under the heading "Comment" --

A. Right in front?

Q. Yes. No. In fact, it is the end paragraph. Would he like to --

THE CHAIRMAN: It's on the screen, professor, in front of you. It's on the screen.

A. Oh, sorry. That one. Yes, yes.

MR FORTUNE: Would he like to assist you, sir, in how he would have interpreted the paragraph if he had been the clinician writing to the general practitioner? We know that Professor Lucas has said that Dr Steen has over-interpreted the contents of that paragraph, but it is not an easy paragraph, is it, to put into words for

a general practitioner?

A. I think that is very well put. It isn't.

THE CHAIRMAN: It is exactly why -- it is exactly why the clinician needs to speak to the pathologist.

A. Yes. I read this as an invitation to the clinicians who asked for the autopsy to have a general discussion about this case.

THE CHAIRMAN: And this also leads me away, Mr Fortune, from thinking there was ever an audit. The evidence of the audit -- the evidence of an audit is disappearing into -- even further.

MR FORTUNE: We know, sir, that there is no evidence of any telephone conversation or meeting between the pathologists and the clinicians.

THE CHAIRMAN: But I'm not even looking for a paper trail of discussions and so on. The things which people did and the things which people wrote in letters to the GP and the parents are all consistent with the clinicians and the pathologists not having sat down together and worked it out.

MR FORTUNE: Yes, and one of the difficulties --

THE CHAIRMAN: That's why you end up with an over-interpretation and why Dr Webb is praised up to a point for his letter being closer to the mark than Dr Steen's when they are both working from the same very

general and not very specific conclusion in the "Comment" section.

MR FORTUNE: And this leads into one of the difficulties that I suspect has appeared in the minds of those of us at the Bar and perhaps yourself as to whether these are matters that are still clinical but running into governance or governance running back into clinical, because the difficulty is there is such an overlap.

THE CHAIRMAN: Yes. Up to a point, but when you are offering -- when the parents agree, as Professor Lucas has emphasised this afternoon, when the parents are kind enough to agree to an autopsy in any form, what they are entitled to expect is that it will lead to the best possible and clearest possible explanation to them of what happened their daughter --

MR FORTUNE: Nobody is disputing that.

THE CHAIRMAN: -- and they didn't get it.

MR FORTUNE: Nobody is disputing that.

MS ANYADIKE-DANES: Just one final point from me to you, professor, and that is that at that same part of your report, 239-002-014, you say not only was there no mention of clinicopathological correlation. You also say "or audit". Now audit is one of the things that the guidelines say you should do. Can you help us with that? What exactly do you mean that there should been

in relation to an audit?

A. Audit to me in this context means having a meeting with clinicians and discussing the case.

Q. Ah! Okay.

A. That's all, and reflecting on what one learns from it, which might possibly change future practice.

Q. Yes. Not audit in the sense of how quickly they came back and their response time and all that sort of thing?

A. No, no, no, no, no. Audit is in terms of the answer, the diagnostic answer.

Q. I understand. You had raised with me an issue to do with quite how often clinicians get these things wrong or make errors in terms of the cause of death.

A. Yes.

Q. I don't know if you raised that with me because you want -- there was something in this case that you wanted to draw the Chairman's attention to.

A. Well, in the con... -- if I -- in the context of -- the question that has been raised many, many times is why this wasn't a coronial case.

Q. Yes.

A. Why it was a consented autopsy. Just to make sure we are all absolutely clear, I am pretty sure the law in Northern Ireland is no different then than it was in England. You do a consented autopsy or you ask for

a consented autopsy when there is a cause of death that is natural and accepted by the registrar of births and deaths. You can't do it otherwise. Otherwise I think you are breaking some law/guidelines, whatever. Ergo -- and the point I also made to you earlier is that, you know, when a death happens, there is only two things that can occur, assuming it is not a murder or something ghastly like that. Either doctors write a death certificate, which has to be a natural cause of death, or the case goes to a coroner. It's two sides of a coin. In 1996 about 35, 40% of all deaths were reported to the coroner, which meant that 65% weren't. We know from many audits and many studies on the variability of doctors writing death certificates that are accurate, and I am sure that has come up in this inquiry before, and you also know I assume about how variable are coroners in interpreting precisely the same sort of guidelines as to what is a natural and what is not a natural cause of death, and I produced as a reference a paper which you again saw this morning showing that all coroners completely differ among themselves. That's an interesting point.

Therefore -- I suppose what I'm really getting to say is although the natural cause of death that was written down here, status epilepticus, is a natural

cause of death -- it is not forensic or anything like that. It is not suspicious under normal circumstances. The fact that it's wrong is in a sense neither here nor there. It's what they thought at the time. Remember the stringency for writing a cause of death certificate is to the best of your knowledge and belief. That's what is said in the 1953 Act and that still pertains and it certainly pertained in 1996: to the best of your knowledge and belief.

THE CHAIRMAN: I think the question, professor, here is with what confidence that that cause of death could have been identified on the day that Claire died in order to decide not to refer Claire's case to the coroner?

A. Okay. Well, I hope I've got it right, but, I mean, as far as I can understand at the time she died they thought she died either of status epilepticus or possibly with an encephalitis. Both of these are natural causes.

Q. Yes.

A. They are not nec... -- they are not by definition referable. Had they said "Oh, gosh!" -- I mean, I'm putting it very crudely, but I don't intend to. Had they said, "Ah, I wonder if this possibly relates to dilution of the blood causing hyponatraemia", then if they had thought that for a moment, then this has to be

referred to the coroner, but I don't believe they did.

MS ANYADIKE-DANES: No. I think the Chairman's point in fairness was how confident could they be on the evidence that they had that it actually was status epilepticus, whether or not triggered by encephalitis.

A. They were confident enough, but just as a matter of recorded research and anecdotal observation, if you do a lot of consented autopsies, you will be contradicting the cause of death in at least 50% of cases and quite significantly so. That is how medicine is. This is not a surprise to me.

THE CHAIRMAN: Thank you very much.

MS ANYADIKE-DANES: Thank you.

Mr Chairman, I don't have anything further.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: I don't know whether --

THE CHAIRMAN: Any questions from the floor? Mr Lavery? No.

Professor, thank you very much indeed. Thank you for your time and your contribution. I think there is a car arriving for you in a few minutes. Okay?

A. Thank you.

(Witness withdrew)

DISCUSSION OF HOUSEKEEPING MATTERS.

THE CHAIRMAN: Ladies and gentlemen, just before we finish

and as Professor Lucas is leaving, Mr Sephton, have you any word from Dr Webb?

MR SEPHTON: I understand that a letter was sent this morning. Certainly I --

THE CHAIRMAN: To the Inquiry?

MR SEPHTON: To the Inquiry, yes.

THE CHAIRMAN: Oh, right. Well, if there is, I will be able to pick it up when we go back. I haven't heard about that.

MR SEPHTON: If not, I have an unsigned copy, which I can forward to my learned friend right now.

THE CHAIRMAN: Okay, and then we can pick it up tomorrow morning. That's fine. Thank you very much.

Rather curiously tomorrow morning I think the idea is we start at 9.30. We break at 11 o'clock for a coffee morning and a charity raiser in the foyer and then resume at 11.30. Okay? So we will start with Professor MacFaul tomorrow morning at 9.30. Thank you very much indeed. Sorry. Sorry. Mr Green?

MR GREEN: I am grateful for the careful and measured way in which you expressed yourself during Dr Sands' evidence. I know that he is also grateful. He is also grateful, as I am, for the fact that you interjected him, thereby causing Professor Lucas to have to start his evidence later.

I simply rise at this stage because I am still going to be inviting you, sir, at least to consider making some sort of determination on the issue I raised in the written submission. It is there on paper. I am not going to repeat it, but I simply flag it up so that you are not taken by surprise if I mention it at some point tomorrow.

THE CHAIRMAN: Yes. We will pick it up tomorrow. I should say to you I have a reticence about doing this, because while I entirely acknowledge how Dr Sands can recognise a serious difference between being accused of not having done his job properly, on the one hand, and having lied and fabricated evidence, on the other, there is in the history of this inquiry a number of other examples of similar allegations or issues having been raised. I am reticent, subject to anything that's said tomorrow, about starting to issue preliminary findings on specific issues.

Having said that, I am also conscious of the fact that because the inquiry is going to go on through into next summer, I will not be presenting a report to the Minister for Health until the end of next year and it's rather a long time for Dr Sands and others to wait.

MR GREEN: Sir, if you were to agree with the proposition that the allegation is evidentially -- I don't mean this

in any way disrespectfully to Mr Roberts -- evidentially when objectively analysed without a proper foundation and that it is scandalous in the proper sense of that word in the sense that it's a real slur on Dr Sands' reputation, and it has been published in the media with might I say an unfortunate and tendentious slant, then you may be able to draw a distinction between that sort of allegation and the sorts of issues which were raised particularly looking at the transcript from the Adam Strain portion of matters where on one view of the evidence certain individuals did try to slip a lie past you.

THE CHAIRMAN: Okay. I will come back to this tomorrow. Okay. I understand the point. Thank you very much. 9.30 tomorrow.

(5.08 pm)

(Hearing adjourned until 9.30 tomorrow morning)

--ooOoo--