Wednesday, 12 December 2012

(10.00 am)

(Delay in proceedings)

(10.10 am)

THE CHAIRMAN: Good morning. Mr Stewart?

MR STEWART: I call Dr Seamus McKaigue, please.

DR SEAMUS McKAIGUE (called)

Questions from MR STEWART

MR STEWART: Good morning.

A. Good morning.

Q. You've been kind enough to furnish the inquiry with four witness statements, one in Adam stain's case, WS129/1, and three in this case, WS156/1, 2 and 3 with attached items of medical literature. Are you content that they be adopted by the inquiry as your formal evidence?

A. Yes. On recently reading through, I think, 156/1, and question 3, I make reference to answers given in questions 5, and it should be "2" and not "3".

Q. Very well. I'm grateful for that clarification.

THE CHAIRMAN: Sorry, let's just bring it up, doctor. It was on the screen a moment ago.

A. Yes. It should be, "See (2) and (5)".

THE CHAIRMAN: Okay, thank you.

MR STEWART: Thank you. You also have furnished us with a copy of your CV. If I could ask that page 306-086-003

be shown, please. This is from your CV. This is a record of your employment, indeed to date. And you have been acting as a consultant paediatric anaesthetist at the Royal Belfast Hospital for Sick Children since 1995.

A. Yes.

Q. And you practice there still?

A. Yes.

Q. In relation to Claire Roberts, your involvement started early in the morning on 23 October 1996.

A. Yes.

Q. And you were, in fact, the on-call duty paediatric anaesthetist at that time.

A. Yes.

Q. Did you receive a telephone call at about 3.30 in the morning to return to the hospital?

A. Yes. That's right.

Q. Do you remember that?

A. I remember being called -- essentially being summoned into hospital because a child had a respiratory arrest.

Q. Yes. And when you got there, what did you do?

A. I am unsure whether I went directly to the ward in question, which was Allen Ward, or whether I went to the intensive care unit.

Q. Did you subsequently accompany Claire for a CT scan?

A. Yes.

Q. And where was the scan?

A. I believe I accompanied her for a CT scan.

THE CHAIRMAN: That would be the normal thing you would do?

A. That would be the normal thing.

MR STEWART: What would the normal routine have been in order to accomplish that?

A. Claire was transferred by ambulance for the CT scan after she had been stabilised in the intensive care unit.

Q. Yes.

A. So by that stage, I would have been familiar -- reasonably familiar -- with her condition and what the problem was. I had stabilised her and had made her safe for transport.

Q. Can you describe the routine of getting a patient from the Children's Hospital across to the Royal Victoria Hospital for a CT scan? What did that entail?

A. The routine would be that a CT scan would have to be booked, you'd have to have a time. You would then organise an ambulance and the nurses usually did the telephoning. The patient then had to be physically transferred -- in Claire's case, physically transferred on to a trolley, which the ambulance service provided. You had to move across all the monitoring, including

ventilation if there was a ventilator. Then you physically transferred her out of the hospital into the ambulance. The ambulance drove the quarter of a mile to the main Royal and then you transferred her along the corridors into the CT scanning room. You then had to transfer her off the trolley on to the board which moved in and out of the CT scanner. So you had to, if you like, reverse everything.

There was full monitoring throughout all of that, throughout the transfer process. The X-rays were taken and then the whole thing was reversed.

Q. And how long did this process take before she was returned to the intensive care unit?

A. I would say on a typical -- at that time of the day, a typical could be 40/50 minutes.

Q. In 1996, had any concerns been raised that there was no CT facility within the Children's Hospital itself?

A. I am myself not -- cannot recall any concerns, but it was obviously a talking point, I believe. I'm not aware of any particular burning concerns.

Q. Very well. You had had an involvement with the Adam Strain case in the sense that at the inquest you were involved in the drafting of a set of recommendations that were presented to the coroner; do you remember that?

A. Yes.
Q. That set of recommendations referenced the Arieff paper on hyponatraemia in healthy children; had you read that at that time?
A. Yes.
Q. When you returned to the intensive care unit, did you have a chance yourself to read the medical notes and records that accompanied Claire?
A. Yes.
Q. And did you subsequently enter into the medical notes and records your own synopsis of her condition as you could determine and as you could find yourself?
A. Yes, I did.
Q. And does that appear at page 090-022-058, starting down there at 7.10 in the morning?
A. Yes.
Q. And that goes on then over the page to 059, if that could be drawn up beside it. It appears from this that you had read through the medical notes and records and, at the top of the second page, the paragraph beginning:
"Initially admitted to hospital with decreased level of consciousness with the clinical picture of acute encephalopathy. Status epilepticus subsequently developed, requiring phenytoin, valproate and midazolam. Serum sodium also noted to be low, down to 121,

presumably on the basis of SIADH."
What was your understanding of the clinical picture at that time?
A. Well, I think that paragraph is a good summary of it.
Q. If we go down further, we can see it's entered in there:
"CT scan shows severe cerebral oedema."
Had you formed a view at that stage of what might be the cause of the oedema?
A. Yes. I had come to the view that based on the handover and the previous written notes that Claire had encephalitis, status epilepticus, and had subsequently developed SIADH.
Q. Was hyponatraemia a cause? Did it seem a likely cause of the hyponatraemia along with those other things?
A. Yes.
MR FORTUNE: Sir, forgive me. Before my learned friend continues, can we establish from Dr McKaigue whether, on his arrival at the hospital, and in particular in PICU, he met and had the opportunity to speak to either Dr Steen or Dr Webb, and in effect had a handover and what he learned then? Because that may affect how he has written his note.
THE CHAIRMAN: I understand. Can you help us, doctor?
A. Yes. I recall Dr Steen being there. I think it was at some stage later Dr Webb arrived. But Dr Steen was

there, and while I have no direct recall of the handover, there would have been a handover done.
THE CHAIRMAN: From Dr Steen to you?
A. Yes.
THE CHAIRMAN: Or from Dr Bartholome?
A. I believe it was Dr Steen.
THE CHAIRMAN: Thank you.
MR STEWART: Do you recall a conversation with Dr Steen or Dr Webb?
A. I recall -- after Claire arrived back from the CT scan, I recall a specific conversation.
Q. And what was that?
A. That was -- the CT scan had shown the presence of severe cerebral oedema and with the history of encephalitis, status epilepticus and development of SIADH and hyponatraemia, and the fact that she had fixed dilated pupils and was unresponsive, I believed that she was not expected to survive. On that basis, I initiated a discussion about: could a death certificate be issued for Claire, or would the case have to be referred to the coroner?
Q. Why did you initiate that conversation?
A. Because I believed she was going to die.
Q. Did you think yourself there might be a doubt as to whether or not a death certificate could be issued and

a question about whether or not she should be referred to the coroner?
A. Well, I wanted to satisfy myself. I had knowledge that she had encephalitis, she had status epilepticus, had developed SIADH and hyponatraemia, and the recent experience of hyponatraemia that I had was in the Adam Strain case. Adam Strain had received a large volume of No.18 Solution very quickly --
Q. Yes.
A. -- and Claire had received No.18 Solution. So the hyponatraemia, I believed, was on the basis of SIADH.
THE CHAIRMAN: Because there wasn't the same overload, same comparative overload, as Adam had received?
A. Yes.
THE CHAIRMAN: So if it was hyponatraemia, it has come about by a different route?
A. Yes. I personally was not -- not being a paediatrician, I wasn't aware that encephalitis or status epilepticus could cause SIADH, so I wanted to clarify with -- I believe, Dr Webb was present at that stage -- with the paediatricians. I recall it was Dr Steen who said ... I can't remember exactly, but it was either she had seen a case like this before or she was aware that this could happen in cases of encephalitis, meningoencephalitis, that SIADH and hyponatraemia could occur.

So this was, if you like, pathophysiology in action. And whenever the hyponatraemia was recognised, the No.18 Solution which was the normal intravenous fluid at that time, the rate was reduced to treat the hyponatraemia. So on that basis, I satisfied myself that personally, for me, there were no red flags for me to report the case to the coroner.

THE CHAIRMAN: When you said earlier that you had knowledge that Claire had encephalitis and status epilepticus, that's from the notes and records over the previous 24 hours, which showed that that's what she was being treated for?

A. That's what the paediatricians were saying.

THE CHAIRMAN: Right.

MR STEWART: You say you satisfied yourself that there were no red flags. Do you mean red flags in the sense of: this is a case which ought to be referred to the coroner?

A. Yes.

Q. At that stage did you understand hyponatraemia to be a treatable condition?

A. Yes.

Q. Did you wonder whether or not it had been treated?

A. Well, I accepted what Dr Steen told me, that the fluids had been reduced to two-thirds maintenance rates, which

was the treatment for hyponatraemia occurring with SIADH.

Q. When you said subsequently and in a witness statement to the inquiry:

"With hindsight I would have preferred any discussions I had with Dr Steen and Dr Webb to have been documented."

What did you mean by that?

A. Well, that conversation was a very important conversation for me. It influenced my decision personally not to report the case to the coroner and, therefore, it should have been documented.

THE CHAIRMAN: Did you know, doctor, when you were having this conversation that Dr Steen had not seen Claire from her admission until Dr Steen received a similar call to the one which you did in the early hours of Wednesday morning?

A. I don't think I was aware of that.

THE CHAIRMAN: You were taking Dr Steen as the responsible paediatrician, which she was on the documentation?

A. Yes.

THE CHAIRMAN: But in any normal course of events, when you're in the disaster scenario that you were in in PICU that morning, the named paediatrician will almost invariably know the child and have treated the child

over the previous days.

A. Yes.

THE CHAIRMAN: Let me ask you: would it be very, very unusual for you to be in a discussion with the named paediatrician who'd never seen the child?

A. It could happen in a ... Well, I'm trying to think ... It can sometimes happen in a resuscitation/A&E scenario, but if a child's in hospital, then that would be unusual.

THE CHAIRMAN: When I am saying this, I'm not pointing the finger at Dr Steen. Whatever Dr Steen was doing the previous day -- I'm working on the assumption that she was working -- she hadn't just disappeared for some reason, she was doing some duties for the Trust, but whatever those duties were on the Tuesday morning, she had not seen Claire; right? In that scenario, what is happening is there are three of you talking about Claire's condition and what has brought this about. You are inevitably entirely new to it because you've been called in in the early hours of Wednesday morning. Dr Steen is new to it because she has been called in in the early hours of Wednesday morning. And Dr Webb isn't new to it, he has been treating Claire since around lunchtime on Tuesday, but treating her on the basis that she was likely to recover because that was

the view which he held when he left the hospital at about, say, 5-ish/6-ish, on Tuesday evening. So the fact that Claire has ended up in intensive care in this terminal state is completely unexpected for Dr Webb, who was the only one of the three of you who'd been treating her over the previous 24 or 36 hours.

What that takes me to is wondering about the degree of confidence which the three of you could have had in order to conclude that you were so sufficiently clear about Claire's cause of death that she did not need to be referred to the coroner. Do you understand where I'm going to?

A. Yes. I accepted the diagnoses which I was told and which were written in the chart.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: Do you think in hindsight that perhaps you could have been more proactive?

MR FORTUNE: In what way?

MR STEWART: Satisfying yourself that the matter was indeed one that it was safe not to refer to the coroner.

A. Well, I had to form a view and I did that as best I could on the information I had at the time. I did actually initiate that conversation, so I was actively thinking about how this child was not going to survive, and I initiated that conversation.

Q. You gave an account of that conversation in your first witness statement and it's perfectly consistent with what you say, but there's one additional comment that you make. I wonder if WS156/1, page 8 might be shown. This, in the middle of the paragraph, is where you describe this discussion:

"I discussed Claire's condition with Dr Steen. I believe Dr Webb was also present, but I cannot be certain. I do not recall who else was present. I do not recall what time this conversation took place, but I believe it was most likely after Claire had returned to PICU following her CT scan. By this stage, it was clear to me that Claire's prognosis was extremely grave and she would most likely die. I was then endeavouring to find out would Claire's cause of death fit the criteria for a death certificate to be issued or would the coroner have to be informed. Dr Steen gave a summary of Claire's current clinical condition. I cannot recall exactly, but I believe that Dr Steen was aware that hyponatraemia could accompany meningoencephalitis and that she further commented that the treatment of hyponatraemia in such circumstances was managed by fluid restriction. The other comment I remember her making, I don't have the exact words, but it was to the effect that Claire's parents had gone

through enough and she wanted to be able to get Claire home to them. At some point I brought up the issue of Claire being a potential organ donor."

In relation to that comment about Claire's parents having gone through enough and getting Claire back to them, is that a relevant consideration when it comes to determining whether or not the coroner should be informed?

A. No.

Q. What do you think the import, the purpose, of that statement might have been?

A. Well, I think I'm ... My interpretation of what Dr Steen was saying there was that she clearly believed that Claire was -- there was no chance of her recovering. What had happened had happened and I think, just on compassionate terms, not to draw this out unnecessarily.

THE CHAIRMAN: I don't want to seem cold, but you could say that in virtually every child's case, couldn't you? You could say in the case of virtually every child that the parents have been through enough.

A. Yes.

THE CHAIRMAN: There isn't a parent whose child has died in the Children's Hospital who haven't been through the mill and you could say in every case the parents have

been through enough and we want to get the child home to them.

A. Yes.

THE CHAIRMAN: So it's a perfectly reasonable, legitimate, human concern, but it is of no relevance whatever to whether a child's death is referred to the coroner.

A. No.

MR STEWART: Indeed, you say four lines down:

"I was then endeavouring to find out would Claire's cause of death fit the criteria for a death certificate to be issued."

What did you understand the criteria to be in 1996?

A. Well, a doctor could write a death certificate if the cause of death was due to natural causes and they had been treated in the last 28 days, seen and treated by a doctor in the last 28 days. A doctor couldn't issue a death certificate if the cause of death wasn't known and if the death was due to trauma, violence, neglect and misadventure -- and I think, as well, negligence. Those are the criteria that I used to decide whether or not a case should be reported to the coroner.

THE CHAIRMAN: So the death certificate can't be issued if the cause of death is unknown?

A. Absolutely.

THE CHAIRMAN: So in order to issue the death certificate,

the doctor has to be confident as to the cause of death?

A. Yes.

THE CHAIRMAN: Right. You have said, "I wasn't aware that encephalitis or status epilepticus could cause SIADH", and that Dr Steen said that she had seen such a case before or was aware that this could arise.

A. I can't remember which version it was.

THE CHAIRMAN: Whichever it was, the fact that such a case had been seen before or Dr Steen was aware of such a case, that means that it can happen, but the question surely in Claire's case was: is that what happened? So how do you move from saying, "This can happen in a case", to saying confidently, "This is what has happened in Claire's case. I therefore know why she died. I can issue a death certificate"?

A. What I ... I wasn't actually making any of the diagnoses --

THE CHAIRMAN: Yes.

A. -- in Claire's case. Therefore, I was accepting the diagnoses which had been made. And I was satisfying myself that the diagnoses were in keeping with the history I had received and also the fact that the hyponatraemia was not caused by maladministration of No.18 Solution because that's what happened in Adam Strain's case.

THE CHAIRMAN: I don't know the extent to which you've been able to follow the hearings here in Banbridge, doctor, but you will have heard some of the inquiry experts say that they fundamentally disagree that Claire's case should not have been referred to the coroner. I'll put it more clearly. They say that Claire's case should have been referred to the coroner. Maybe they have had the advantage of more time to look through the notes and records and consider things than you had in the early hours of that Wednesday morning, but would you disagree with what they have advised the inquiry?
A. What I was doing then was forming a view and then making a judgment. I didn't have the time and I didn't go through the charts in all that great detail. I was forming a view and making a judgment on what information I had then, just flicking back a few pages in the notes to look at what was written. A judgment -- I accept that I can make a wrong judgment. And again, it is quite hard because, as a person, I have developed and got a lot more experience and knowledge over the last 16 years. So I was there as an anaesthetist, I wasn't a paediatrician, I'd never looked after children like Claire before. So I was very much accepting what the two paediatricians were saying.
THE CHAIRMAN: Do I take it that sometimes there is a real

debate between the doctors about whether a child should be referred to the coroner? If we take you and two others -- it doesn't matter if it's Dr Webb and Dr Steen, but there are other scenarios, I'm sure, where there are three of you discussing what should happen.
A. I don't think there ever ends up a debate. I think if somebody expresses a view that a case should be referred to the coroner, then that's it.
THE CHAIRMAN: And things have changed since 1996. As I understand it, the bar has been lowered so more cases are referred to the coroner than was the position 16 years ago.
A. Yes.
MR FORTUNE: Sir, could we find out from Dr McKaigue whether he has been in that situation prior to Claire's death, that this wasn't his first time when confronted with the information that Claire was likely to die? Because presumably, he's drawing on his experience as well as his judgment.
THE CHAIRMAN: Sorry, you mean in the sense that this wasn't the first child whose death he'd been involved with in PICU?
MR FORTUNE: Yes. He has told us he has been a consultant for some time before this. Presumably he's been confronted with this situation before and it may be of

some assistance to you, sir, to find out just how many times, if he can remember, at that time he'd met that situation.
THE CHAIRMAN: Can you help us, doctor?
A. I was a consultant by that stage for about 15 months. I believe I would have been involved in making decisions about whether or not to refer previous deaths in the intensive care unit to the coroner. I can't remember specific cases, but I would --
THE CHAIRMAN: Probably only a few by that stage?
A. Well, if there were, say, 24 or 30 deaths a year, I would have in the previous year ... So I would have, on that grounds, been involved in that decision-making process.
THE CHAIRMAN: Thank you.
MR STEWART: Can you recall any contributions Dr Webb made to the discussion about referral to the coroner?
A. No.
Q. At that time did anyone ever say, "Why don't we ring up the coroner's office and see if they can give a steer?"; was that ever done?
A. No.
THE CHAIRMAN: I understand that there's a system now for doing that. Was there a system at that time for doing it? Sorry, there's a system that's changed or developed

to the extent that there is a doctor who works as a link between the hospital --
A. Yes, the medical examiner. If you expect a patient to die, some doctors may in actual fact in the past have contacted the coroner's office on a hypothetical basis. And then, after a patient has died, the coroner's office can be contacted directly and advice sought.
THE CHAIRMAN: Right. The other thing I just want to clarify with you: this conversation about whether Claire's death would be referred to the coroner or not, was this taking place in the early hours of Wednesday morning after you had taken her for the CT scan and taken her back?
A. Yes.
THE CHAIRMAN: Was that decision taken before any brainstem testing?
A. I believe so.
THE CHAIRMAN: Is that regular?
A. Yes, that would be regular enough. You can anticipate death.
THE CHAIRMAN: Yes. I got a bit confused yesterday when Dr Taylor was giving his evidence. He was saying that that decision isn't normally taken in his practice until after the second brainstem test and I was suggesting to him then that in Claire's case it was taken before the

brainstem testing. He thought that would be unusual and then later on in the day I was corrected and I indicated that, in fact, in Claire's case, the decision was taken after the brainstem test, but in fact it was taken before either brainstem test?

A. No, this was a discussion -- this was a discussion that I initiated.

THE CHAIRMAN: Right.

A. There was not a decision at that point taken whether or not to refer the death to the coroner.

THE CHAIRMAN: When was that decision taken? Were you involved in that later decision?

A. I wasn't involved in that. I believe ... I mean, I have been following the inquiry transcripts to my best ability, but I believe that was taken at some point later. This was just a discussion that I was having. I didn't actually think I would see Claire again. I was going to be going off duty.

THE CHAIRMAN: Right. So this was a discussion, not a decision at that point? Right.

MR STEWART: Dr Steen has given a statement in which she says she thinks the decision not to refer to the coroner was made by her in conjunction with the consultants in PICU; is that how you recall it?

A. No.

THE CHAIRMAN: In saying "no", you are distinguishing between this discussion which you have told us about for the last few minutes and a decision?

A. Yes.

THE CHAIRMAN: But if that's right, if this was a discussion, but not a decision, to what extent is it important that it isn't recorded in the medical records? Because it's not a decision -- sorry, I got the impression when you were saying you wish this conversation had been recorded and that would be consistent with it being decisive ...

A. It influenced my decision not to refer Claire to the coroner.

THE CHAIRMAN: Right.

MR FORTUNE: Sir, in fairness to Dr McKaigue, he did say that he had to satisfy himself personally as to whether he should inform the coroner. And he said that at the beginning of that part of his evidence about initiating this discussion.

THE CHAIRMAN: Yes. Thank you.

MR STEWART: Yes. I think you said you wanted to satisfy yourself about the medical certificate of cause of death. Was there a discussion about what would be entered on the medical certificate of cause of death?

A. It didn't involve me and it wasn't part of that

discussion there.

Q. Was there a discussion that you heard?

A. No, I wasn't aware of any discussion.

Q. Thank you. Were you aware of any discussion about the restriction of a post-mortem examination to the brain only?

A. No.

Q. I wonder if we go --

THE CHAIRMAN: Sorry, how common is that?

A. Again, I was a consultant in the Children's Hospital for 15/16 months, so I wouldn't have had a lot of experience to draw on. I think that would be best asked of somebody else. Prior to that, I was working mainly in adult practice.

THE CHAIRMAN: Thank you.

MR STEWART: 090-022-061. If we have that page alone, if we may. This is later on, on 23 October. The first brainstem death protocol test was conducted, I think at 6.00 in the morning, and the second one at 6.25 in the evening. The top entry is Dr Taylor's entry, then Dr Steen has entered:

"Diagnosis of brainstem protocol completed ... Discussed with the parents. Agree that ventilation should be withdrawn. Consent for limited post-mortem given."

Then you have entered in at 18.45:

"Ventilation discontinued at 18.45."

When you made that entry, you could see that Dr Steen had, in fact -- by indicating that consent had been given for a limited post-mortem, you could see that she had decided that she herself could issue a certificate of cause of death and she was not going to be referring it to the coroner?

A. Yes.

Q. Did you interest yourself at that stage in what she had entered on the medical certificate of cause of death?

A. Yes, I did.

Q. And did you ask?

A. No, I didn't discuss that with her.

Q. Did you try to find out, did you go and find the book and look at the stub?

A. Could you ...

Q. Did you ask Dr Steen what she had put?

A. I read what she had written there.

Q. Oh, you read that after?

A. Well, I ... I remember reading that very shortly after Claire's death.

Q. Given that you believed that meningoencephalitis was part of the clinical picture, that SIADH and hyponatraemia were part of the picture, were you

surprised that she had not put those on the death certificate?
A. I was surprised that encephalitis wasn't on the death certificate, but, on the other hand, Dr Webb had again, I think in his written note, talked about SIADH being related to status epilepticus.
Q. Given that you were surprised that the medical certificate issued didn't accord with your understanding, what did you do in consequence?
A. It was difficult to write all those things on the death certificate.
Q. The death certificate does give enough room to write a few words more, doesn't it?
A. The way that I understood death certificates had to be written was that there was a single cause of death attributed to each line.
THE CHAIRMAN: Just to clear up this point, Dr McKaigue, when you were saying earlier that you had 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?
A. No.
MR QUINN: Mr Chairman, may I come in here for a moment,

just to put the family's position? Maybe through you, Mr Chairman, could I ask the question: would it be fair to say that this witness was persuaded by the paediatricians that it should not be referred to the coroner? Perhaps that would encapsulate what we have heard in the last ten minutes.
THE CHAIRMAN: Would that be an unfair summary that you were persuaded by your discussion with doctors?
A. No, I formed a view. I very definitely formed a view and made a judgment.
THE CHAIRMAN: In reaching that judgment, and forming that view, was that because you were accepting what you'd heard, in particular what Dr Steen had said, not necessarily in these terms, that while you weren't aware that encephalitis or status epilepticus could cause SIADH, Dr Steen had said that she'd seen such a case or was aware of such a case --
A. Yes.
THE CHAIRMAN: -- and that led to you being satisfied that Claire's death did not need to be referred to the coroner because Dr Steen knew of such a situation in the past?
A. Because SIADH, which causes hyponatraemia, can occur as a complication of meningoencephalitis and status epilepticus. I believe that Dr Webb linked SIADH

to status epilepticus.
THE CHAIRMAN: And on that basis then you were satisfied that the cause of death was known rather than unknown?
A. Known and naturally occurring.
THE CHAIRMAN: Right.
MR FORTUNE: I only rose because I was concerned that the verb "persuaded" might have a loading to it.
MR QUINN: If I could just come in? "Persuaded by the expertise and knowledge of the paediatricians" perhaps would be a better way to put it.
MR FORTUNE: Well, I'm grateful for that clarification because what you obviously want to hear, sir, from Dr McKaigue is how he reached his judgment, independently or otherwise.
THE CHAIRMAN: Okay, thank you. Just before we go on, I don't know if you were able to pick up on Dr Taylor's evidence from yesterday. There was some discussion yesterday about deaths arising from encephalitis and he thought there had been a number of them in the mid-1990s, which is why, if Claire died as a result of complications from encephalitis or directly from encephalitis, that in itself was not unknown in the Royal in the Children's Hospital at that time. We then looked through the primary diagnosis of death for 1995 and 1996, which had been given to us by DLS from the

hospital, and it wasn't very clear at all that there was such a run of deaths. Were you aware or can you recall being aware of a number of deaths around the mid-1990s of children from encephalitis?
A. No. I have to say that in the mid-1990s I was in adult practice then. I had one -- approximately 15/16 months in the intensive care unit, in Children's.
THE CHAIRMAN: You were in Children's in 1995/1996.
A. As a consultant, yes.
THE CHAIRMAN: Let me just tidy that up a little bit with you: when you joined the Children's in 1995, can you remember what month in 1995?
A. August.
THE CHAIRMAN: How long did you stay there?
A. How long did I stay there?
THE CHAIRMAN: Sorry, you are still there?
A. I'm still there, yes.
THE CHAIRMAN: At the time Claire died in October 1996, you'd been in the Children's Hospital from August 1995. Thank you.
MR STEWART: Just to pick up where we were: about that time, you'd seen in the medical notes and records Dr Steen's entry that she had issued the death certificate and cited on it as a cause of death, "cerebral oedema secondary to status epilepticus". Did you then,

subsequently on the same day, fill out the PICU coding form? And that's available at 090-055-203. That's your signature, I think.

A. Yes, that's my signature, and the date corresponds.

Q. You filled this out for a very specific purpose, and that's clinical coding.

A. Yes.

Q. Can you describe a little bit about why you make the entry you do and in the way that you did?

A. The coding form was -- the term that remains in my memory was "depth of coding". There must have been a move within the Trust to better code or improve the depth of coding for patient episodes. That's what prompted this relatively new development. I recall, I believe, that this was a new development, this was an ad hoc, unofficial sort of Trust form. It was something we made ourselves in the intensive care unit.

Q. The system, which was the PAS, Patient Administration System, clinical coding, this was the formal hospital coding system?

A. I don't know what exactly PAS did or what the code -- I don't know really know anything about coding, I was just asked to improve the depth of coding, and I think we all agreed to do that. This free text allowed the coders to improve the depth of coding.

Q. There was also, running at the same time, I believe, an internal PICU coding database --

A. Yes.

Q. -- that's been described in various ways, used at that time on an ad hoc basis. Did you choose to use it for Claire's case as well?

A. Yes. It would have been used as well, yes, because there was a separate pro forma whereby codes were -- a separate pro forma was used to generate codes for the PICU in-house database and we had our own home-made coding schedule.

Q. We may ask to see if we can see a copy of the in-house PICU coding, but can we just read through this? The initial part is, I suppose, the history:

"Admitted from ward following respiratory arrest."

The next section is, I suppose what was done when she arrived at PICU:

"Intubated, ventilated, arterial line, central line, CT scan, IV infusion, brainstem tests x2."

Then we come back to what I suppose might be coded as her conditions:

"Hyponatraemia, hypernatraemia, hypokalaemia. Concentrated potassium infusion. Died."

There's no mention there of status epilepticus or indeed encephalitis. Why would that be?

A. I suppose the diagnosis which prompted her admission to ICU was the respiratory arrest.

Q. Yes. But moving on down, it seems that the first of the diagnoses that you have entered is hyponatraemia.

A. Yes.

Q. That seems to be at variance with what you understood Dr Steen to have entered on the medical certificate of cause of death.

A. Whenever a medical certificate of cause of death is being formulated, there is a sequence and there is a set of rules to be followed.

Q. Yes.

A. Those rules were clearly different from the rules I was employing to generate that document.

Q. Why did you choose not to enter status epilepticus on this document?

A. I can't really think of an answer for that at the moment because I'm a bit unsure about the rules. This document, again, was -- there are other documents, there are two other documents which have been generated in relation to her admission to ICU.

Q. Yes.

A. I have seen those.

Q. All right. Well then, we may return to this, but can I then go to what's called the "Discharge/transfer

advice note" from the PICU, which is at 112-030-045? Perhaps we could put it side by side. This is the discharge note and it's signed by an SHO called Dr Mannam, I think, on 29 October. Do you see the discharge, which is:

"Transferred: died 23 October 1996. Principal diagnosis: cerebral oedema. Other diagnoses: status epilepticus, hyponatraemia."

How come one person in PICU is able to discharge with a diagnosis of status epilepticus and hyponatraemia, but you're coding it in a different way?

A. The only explanation I can offer is that by the time Claire arrived in the intensive care unit, the diagnosis which had superseded the others was respiratory arrest.

Q. Okay. Let's have a look at WS156/1, page 14. This is where you're asked what would be the causes of the cerebral oedema:

"I cannot recall. There may have been more than one cause. It is likely that some or all of the following would have been mentioned: hyponatraemia, meningoencephalitis and seizures."

You can see the import of this question. If these are the considerations that were mentioned at the time and if the discharge note has another set of diagnoses, why didn't you code that yourself? Why did you only

code hyponatraemia? Why did you not make sure that that was the same as the medical certificate of cause of death?

A. I can't explain that. It ... And the only explanation I can come up with now is that it was related to the rules that we used on the coding sheet, to put on the coding sheet. I know it sounds -- it's very obvious, you know, the differences between the documents, but different documents for a different purpose.

Q. Okay. You mentioned the rules. Were these rules reduced to writing?

A. I don't think so.

Q. Who would have told you of these rules?

A. I think that if anybody -- well, I think it would have been part of the process of introducing this new coding sheet, which was new, it was ... We weren't ... I don't think we were told on high to introduce it, I think it was something that we took upon ourselves to introduce.

Q. And you don't remember what those rules were?

A. No, I don't. I'm trying to work backwards from what I recorded on the document.

MR McALINDEN: Mr Chairman, perhaps the witness could be asked what the purpose of the coding was, the depth of coding. Perhaps that might help to explain the

situation.

THE CHAIRMAN: Okay. That's the coding form at 090-055-203?

MR McALINDEN: Yes.

A. I think it was in some way to provide evidence for how sick patients were and the intensity of treatment that we were providing to our patients. That's what I think was the depth of coding. Ultimately, I think there was, from a point of view of obtaining more money for the Children's Hospital -- it was important to be able to demonstrate that we were looking after very, very sick children, who required all these extra procedures needing to be done to them.

MR STEWART: Weren't these procedures in order to allow the diseases and conditions to be notified to the Department of Health so that statistical and epidemiological analysis could ensue?

A. Well, I am not an expert on how the hospital coded everything. I have read Mr McWilliams' statement and I understand from it that the coders used a number of sources for their information.

Q. Yes. And indeed, in this case, you can see at the bottom of the page on the right-hand side it says:

"This form is to be retained in the unit for coding clerk (Margaret)."

And you can see below your signature is the

signature of "M Newell" and we believe that to be Margaret Newell, the coder, and she has coded it on 28 October.

If we can to page 302-153-003, this is the document we saw yesterday, and this is the result of Margaret's work. You can see she has taken in quite a number of the conditions mentioned, and it seems apparent that she has actually taken time to go through the medical notes and records in order to produce this coded encapsulation of the case.

Did you see this when it came back, the actual coding, or would that not have been returned to you?

A. No.

Q. Can I ask, would Dr Steen have seen that discharge note from PICU we looked at a moment ago, which was 112-030-045? Would she have seen that?

A. She might have seen it. I think that was a document that, at least, was in duplicate.

Q. It was, because we can go and find the duplicate part. That's the top copy.

MR FORTUNE: I was just about to ask the basis on which this witness can answer this question.

MR STEWART: This was in duplicate and we find the other half of it, the lower half, at 090-009-011. Can we put it alongside it? Although it's given a different

heading, which is "Case note/discharge summary" as opposed to "Discharge/transfer advice note", the actual content and the writing is the same. Would the purpose of this have been to be attached to the medical notes and records? Would one copy have actually gone to the notes and records, the 090 copy, and the other part sent elsewhere?

A. That's a carbon copy of the top copy --

Q. Yes.

A. -- isn't it?

Q. Yes. We've looked at it and think that it is. Although you'll see on the right-hand copy, it's "Case note/discharge summary" -- it's not the same as the "Discharge/transfer advice note" -- but the actual handwriting is correctly --

A. Yes. So one would assume then that that was included in the chart.

Q. Yes. And that would have been available then to Dr Steen if she had access to the chart?

A. That would be the normal process.

Q. Thank you. Can I just ask one further question. Do you see on the left hand copy here, which is the clearer of the two, we have "cerebral oedema", "status epilepticus", and then down below, "hyponatraemia". It does seem to have been written in

slightly different handwriting, and it certainly is out of line. Can you help, could that have been written in later? Could that section be enlarged?

MR FORTUNE: Sir, before this witness answers --

THE CHAIRMAN: If it's added in later, it's not added in much later because it appears in the duplicate, doesn't it?

MR STEWART: Oh yes, and furthermore it's quite clear that it has been sent to the general practitioner. There's no intention in any sense to doctor the document, if I use that phrase, but it does seem to have been written in a separate hand.

MR FORTUNE: Well, before Mr Stewart invites us all to become handwriting experts, I would invite you, sir, to look very carefully. Can we have it blown up again, please? The A of "oedema" and the A of "hyponatraemia", there is a similarity that might draw the inference of the same hand.

MR STEWART: I merely asked the doctor to comment on it and he's unable to do that.

THE CHAIRMAN: Okay. Have you finished with this point?

MR STEWART: Yes.

THE CHAIRMAN: I just wanted to go back for a moment to 090-055-203. At the instigation of Trust counsel Mr McAlinden, you were asked what the purpose of this

form was. The gist of your response, doctor, was that it's to provide evidence of how sick the patients were and what treatment you were providing. That's the coding form on the left side of the screen.

A. These would have been surrogate markers.

THE CHAIRMAN: Right. A lot of the treatment that Claire got through Tuesday afternoon and the evening was in the form of anticonvulsants.

A. Yes.

THE CHAIRMAN: Are they referred to in this coding form?

A. No. This coding form was the treatment that was provided in the intensive care unit.

THE CHAIRMAN: Sorry? Only in PICU, right, thank you.

MR STEWART: 090-006-008. This is the last of the PICU documents and it's the ICU discharge summary. You were asked about the initials at the top right-hand corner in your witness statement request, and it says:

"File per S McK."

And it's dated 27 November. Could those initials refer to you?

A. As I said in my witness statement, they could.

Q. And the diagnosis is given there as "respiratory arrest", and that's again a different diagnosis to the discharge summary itself; could you explain that?

A. Yes, could we put up the top copy?

Q. Yes, 112-030-045. You can see the body of the text is taken from the text at the bottom left.

A. Yes. I have said in one of my witness statements that the typed document was produced by -- this is, I believe, the secretary in the intensive care unit, compiled from the written commentary on the discharge note. The diagnosis of respiratory arrest was the diagnosis which prompted her admission into ICU and I have said that this document was -- the purpose of this document was to allow us to look back and profile her admissions. In other words, with a diagnosis of respiratory arrest, that was clearly an emergency admission, as opposed to an elective admission. By looking at these documents, we could glean, in a very crude sort of way, surgical admissions, medical admissions, cardiology admissions, and so on.

Q. So what happens to this document, where is it placed?

A. It would have been filed in the intensive care unit.

Q. And a copy --

A. And there may have been a copy sent for the notes.

Q. Thank you. May I ask you now about audit and the paediatric audit committee meeting and whether or not Claire's case was in fact reviewed at a mortality meeting. You have given us your recollection that you believe that you were present at a meeting where

Claire's case was discussed. I wanted to ask the basis upon which you have that belief. First of all, can I ask you what you do remember?

A. Well, I remember that Dr Steen presented Claire's case at one of the mortality presentations.

Q. Do you remember when that was?

A. No.

Q. Do you remember who else was there?

A. No.

Q. Did you take any notes of it?

A. No.

Q. Do you have any documentation relating to it?

A. No.

Q. Were there any lessons learned from it?

A. Not that I remember.

Q. How do you know it was Claire's case?

A. Because I remembered Claire's case, so therefore I remembered Dr Steen presenting it.

Q. Was the autopsy report available?

A. I have no recollection of the presentation of the autopsy report, but I -- on the basis of normal practice of the mortality meeting, the presentation would not have been arranged until the neuropathology reports were available.

Q. And in this case, that was in February of 1997.

A. Yes.
Q. In your witness statement given at 156/1, page 35, towards the bottom, these are questions relating to the mortality meeting, you say at (a):
"I believe that I was present at the audit meeting when Claire's case was presented. I believe that Dr Steen presented the case. I cannot recall the date of the meeting. I have no documents to provide."
And the question is asked of you:
"In particular, state whether you attended the mortality/morbidity meetings on or about 8 November 1996 in relation to Claire, and if so, state was discussed and furnish minutes thereof."
And you have advised:
"I attended an audit meeting on 8 November 1996. I believe I presented a case. I do not have any details in this case. I have no recollection of what was discussed."
Did you believe then that Claire's case might have been discussed on 8 November and, because you were there, you therefore conclude that you must have actually heard Claire's case being presented?
A. No, I actually have a document which was the flyer for that meeting, and I have handwritten on it that I presented a case. That's how I know for sure I was at

an audit meeting on 8 November 1996.
Q. We don't think Claire's case was presented at that meeting and that date came about because the DLS advised the inquiry that the only event where Claire's death would have been discussed was the paediatric directorate audit meeting where deaths during the previous month were discussed, ie November, and they further advised the inquiry at 302-024-001, when enclosing a copy of the RBHSC paediatric audit meeting minutes for 8 November 1996, and that:
"The attendance register has not been retained ... it is therefore not possible to know whether Claire Roberts' death was discussed at any particular meeting."
The implication of that correspondence was that it may have been discussed on 8 November and that's why I think you were asked, "Were you there on 8 November?", and you were.
A. I was definitely at an audit meeting on 8 November and I presented a case. I remember Dr Steen presenting Claire's case at an audit meeting. I would not have been presenting Claire's case at a mortality meeting.
THE CHAIRMAN: Maybe the way through this is that since you do remember Claire's case being presented and you were at a meeting in November, they're almost certainly not the same meeting because Claire's care could not

properly have been presented at a meeting until February, maybe March?
A. Yes.
MR STEWART: Do you remember what Dr Steen said about Claire's care at that meeting?
A. I cannot recall the detail. There was a presentation. Despite what was said yesterday about audit meetings being heated --
THE CHAIRMAN: Sometimes.
A. -- the norm was that they weren't. So if there was particular issues, then I -- that's when you would tend to remember.
MR STEWART: Did Dr Webb say anything at that meeting?
A. I don't know if Dr Webb was at that meeting. I can't recall.
Q. Can you remember any single thing about the meeting?
A. No. Other than Dr Steen presenting the case.
THE CHAIRMAN: Doctor, can I ask you one point about that? You say you don't remember whether any lessons were learned. Can I suggest a lesson? The lesson is that if you don't do regular electrolyte testing on a child with encephalitis, you run the risk of SIADH developing and causing the child's death. If encephalitis is the correct diagnosis or, for that matter, if status epilepticus is the correct diagnosis, then the

lesson to be learned from Claire's death is that you need to do regular electrolyte testing, isn't it?
A. Yes.
THE CHAIRMAN: I don't understand if the view held in October 1996 was that either encephalitis or status epilepticus was the foundation for the development of SIADH, which in turn leads to hyponatraemia, which in turn leads to cerebral oedema, which in turn leads to Claire's death; is that not a lesson to be learned?
A. Yes, that is a lesson to be learned, but would that not have come out at the meeting? Would that not have been presented at the meeting?
THE CHAIRMAN: Well, the reason I asked that was because you've no recollection of any lesson being learned from the meeting and there's just no -- nobody has any recollection.
A. I can't remember specific, "Here are the learning points", rather than, "This is what happened", and the audience are supposed to draw their own conclusions.
THE CHAIRMAN: The only way in which this would come out would be if it was identified at the meeting and picked up as a specific issue that Claire's electrolytes or bloods were not tested between Monday evening and Tuesday night. Mr Walby said here quite bluntly

yesterday that if the Roberts sued the Trust, the case would be settled because there was a failure to carry out a blood sample. So if we take that approach, then the lesson to be learned from the meeting is: we made a mistake in Claire's case, we did not repeat the blood test between Monday evening and Tuesday night, and had we done that, Claire's death might have been avoided or at the very least the SIADH element could have been identified and treated. That might still leave an unknown issue of some form of encephalopathy, but at least we can learn from Claire's death because we made a mistake there.

I don't get the impression from you that whatever was discussed at that meeting went along those lines. In fact, it involves Dr Steen -- not necessarily personally, but on behalf of the group -- putting up her hands and saying, "We got this wrong". And that is something which indisputably went wrong, isn't it?

A. Yes.

THE CHAIRMAN: I do not see in any of the masses of documentation any acknowledgment from 1996/1997, or in 2004, that this is what went wrong. If that had been discussed along the lines that I've outlined at that meeting, would you not have remembered it?

A. I think I would have remembered that.

THE CHAIRMAN: Thank you.

MR STEWART: Thank you, sir. I have just one more question. Did you have any discussions with Dr Taylor on 23 October 1996 in the intensive care unit?

A. Yes. I handed over my care of Claire to him some time between 8 and 9 o'clock and I would have outlined the history as I understood it, namely that Claire came in with encephalopathy on the basis of encephalitis, status epilepticus, developed SIADH, got hyponatraemia and has had a respiratory arrest.

MR STEWART: Thank you.

THE CHAIRMAN: Are there any questions for Dr McKaigue before he finishes? Mr Quinn? Before I come to you, Mr McAlinden? Nobody else? No questions?

Doctor, thank you very much for your time. It has been very helpful and you're now free to leave.

(The witness withdrew)

Ladies and gentlemen, we'll take a break. I think we're going to facilitate Dr Murnaghan next and we'll start in about 10 or 15 minutes. Thank you.

(11.30 am)

(A short break)

(11.49 am)

THE CHAIRMAN: Just before we start, have we any word from Professor Young and Dr Webb about the privilege?

MR McALINDEN: Professor Young was in London all day yesterday, so I managed to get him in Heathrow last night, where he looked at the documents online. He is very happy to waive privilege in relation to that issue.

We still haven't had any word from Tughans in relation to the position of Dr Webb. They were supposed to inform us at 10 o'clock this morning as to the position, but there has been no information provided.

THE CHAIRMAN: Okay.

MR McALINDEN: So there's one document which is a consultation note with Professor Young, taken prior to the inquest, which is 7 April. Dr Webb has no involvement in that, so that document can go to you at this stage. The other two documents -- one is a consultation with Dr Webb, obviously that matter is still to be resolved.

THE CHAIRMAN: That's a telephone --

MR McALINDEN: Yes. The third document is a consultation note which seemed to have occurred just before the inquest started, the morning of the 27th. Both Dr Webb and Professor Young were there. Obviously Professor Young is happy that the inquiry has that document, so the only reason for the hold-up is the lack of confirmation from Dr Webb's legal team in relation it his position.

THE CHAIRMAN: Okay. If they're not consenting, then I'm going to bring them back tomorrow morning to deal with this issue. I'm very anxious to avoid the scenario that we had at the end of June where the Brangam Bagnall consultation note came in and then we had to start recalling witnesses and disrupting the schedule.

We'll contact Tughans before lunch and say that if we don't have confirmation this afternoon, then we will deal with the privilege issue tomorrow morning. And, in effect, that would be representations by Dr Webb as to whether he can't claim privilege, if that's what's doing. We will need an answer one way or the other. It also might help with Mr Walby's evidence later today if we had that cleared in advance. I'm already inconveniencing him by bringing him back a second day and then asking him to wait. I want to avoid bringing him back for a third day if at all possible. Thank you.

DR GEORGE MURNAGHAN (called)

Questions from MR STEWART

MR STEWART: Dr Murnaghan, welcome back. Just to remind ourselves of where, in 1996, you stood: you were, at that time, director of medical administration in the Trust and, from early 1997, you were re-designated director of risk and litigation management.

A. No, sir. That re-designation did not apply to me. That

happened subsequent to my resignation.
Q. Are you saying that you were never director of risk and litigation management?
A. That's not what I'm saying. I said that the second title that you ascribed to me did not arise until after I left the Royal site.
Q. Are you saying you were not the director of risk and litigation management?
A. Correct.
THE CHAIRMAN: It's on your CV, doctor.
MR STEWART: In the Adam Strain case, we looked at a letter that you had signed as that person. In fact, I think it was one of the letters notifying consultants that the medical negligence case had in fact settled.
THE CHAIRMAN: Just while you're looking for that, on Dr Murnaghan's CV --
A. I accept that part, chairman. My memory going back -- what is it, 16 years now? -- is that at all times I was director of medical administration. I may be wrong, but --
MR STEWART: Can we please look at 060-010-015? This is a note of 9 May 1997. Do you see at the top left-hand corner it says:
"From Dr GA Murnaghan, director of risk and litigation management."

Does that jog your memory?
A. Honestly, it doesn't, and I have no memory of the title changing from one to the other. But if it's there, it's there --
Q. Thank you.
A. -- and I accept that.
Q. Is it correct that you in fact resigned your post the following year in February 1998?
A. Correct.
Q. Further, just to remind ourselves of the context, in June 1996, you had been involved with Adam Strain's inquest.
A. Is that a question?
Q. Yes.
A. The answer to that is "yes".
Q. And also at that time in 1996, at the time that Claire Roberts was admitted to the Royal Belfast Hospital for Sick Children, you were also handling the claim brought by Adam Strain's family, the medical negligence claim.
A. That's correct.
Q. You were also at that time charged with the coordination of medical audit within the hospital; is that correct?
A. That's correct.
Q. And you also reported to the medical director.

A. Correct.
Q. And you were accountable to the chief executive.
A. Correct.
Q. So you had very close links with the highest levels of clinical governance in the Trust.
A. Yes.
Q. Indeed you shared a floor, I think we remember from the evidence, in the same office as they did; is that right?
A. Could you repeat that for me? I just missed --
Q. Your office was on the same floor --
A. Correct, it was, yes.
Q. -- in the same building?
A. Yes.
Q. But at the same time, I think you told us you maintained pretty close --
A. I beg your pardon. I changed my location somewhere -- I don't know exactly, somewhere between 1994 and 1995 time to another building on the Royal complex.
Q. Did you continue in 1996 to --
A. Because you'll see on this 1997 letter that there is an address, third line from the top:
"1st floor, east wing."
Q. Yes.
A. I transferred from the place that you described was the same floor as the chief executive and medical director

to this other office, which gave us more office space in the east wing. Somewhere -- 1994/1995 time.
THE CHAIRMAN: Okay, thank you. But that didn't --
A. It didn't preclude me from having access.
THE CHAIRMAN: In fact, it was a necessary part of your job that you had direct contact with the medical director to whom you reported and the chief executive to whom you were accountable?
A. Yes.
THE CHAIRMAN: Thank you.
MR STEWART: And did you also continue your practice in 1996 of walking around the hospital and talking to people?
A. Certainly.
Q. I think you led us to understand that in fact you liked to keep tabs on what was going on on the ground.
A. Yes.
Q. The inquest, you described to us in your previous evidence, was something of a surprise to you because external criticism was received in relation to the care and the management of a patient and that you hadn't seen external criticism being levelled in that way before at a doctor in the hospital. That was what you told us; do you remember that?
A. Could you bring that up for me, Mr Stewart, please?
Q. Yes. It is the evidence that you gave to this inquiry

on 11 September 2012 at page 181. Perhaps I could read to you, if I may, at line 5, you said:

"But at that time, and in the context of what had happened, it was an extreme example."

We are talking about Adam Strain's case:

"I had never come across a situation where an external expert had criticised the clinical management of any colleague in any of the multiple specialties that we had at the Royal. I had never come across anything like that."

A. That is my correct interpretation of the situation then.

Q. So in other words, the Adam Strain inquest was something remarkable?

A. Correct.

Q. And accordingly, and because of that criticism, it was something from which lessons could be readily derived.

A. And were intended to be so done. I've already explained how that was my intention, but didn't happen.

Q. We'll return to that in a moment. The point I want to ask you about is medical audit. Witness statement WS015/2, page 22. You were asked about the purpose of medical audit. The actual question is posed on the previous page, page 21. If we could have the two up together:

"Please state whether there existed a formal

approach to assessing and developing the competence of the staff ..."

And it is (b) and (c) I'm interested in:

"A formal approach to: (b) disseminating outcomes and lessons learned internally, both before and after the inquest; (c) disseminating outcomes and lessons learned externally, both before and after the inquest."

And you have responded:

"This was the intended purpose of the medical audit process."

By that, did you intend to mean that any lessons deriving from an inquest could be in fact disseminated through the medical audit process?

A. Yes, and that is the purpose of my answer there.

Q. Did you ensure or take any steps to ensure that a medical audit of Adam's case did take place?

A. As I've just, in my penultimate answer -- I've explained that I intended so to do, but it didn't happen, and I remain sorry that that didn't happen.

Q. I think you're referring to a seminar --

A. Yes, which would have fed into the medical audit process.

Q. Which, with respect, is not the same as the medical audit --

A. I accept that. One is linked to the other, Mr Stewart.

Q. Very well. Can we take them step-by-step? There was no medical audit done to review the external criticism that the coroner had accepted and which you found so remarkable. And you've also referred to the seminar which you had intended to organise. Just so that we can remind ourselves, the notes appear at 059-001-001 and 002. If those two pages could be displayed side by side. This was the note you took at the end of the second day of Adam Strain's inquest. Do you want me to read this out in full:

"Attended Coroner's Court. Ms Strain was represented by a barrister who made a major 'meal' of most witnesses. Generally, the outcome was satisfactory with a fair write-up in Friday's Evening Telegraph. Other issues identified which relate to structure and process of paediatric renal transplant services. Agreed with [Dr Carson] that should deal with this as a risk management issue and arrange a seminar with Doctors Mulholland, Hicks, Gaston, Taylor, Savage, O'Connor, Keane and [yourself] present [underlined] ASAP."

And you ended up by saying:

"Additionally [you] telephoned the editor of the Belfast Telegraph to thank him for his correct and sensitive reporting of the inquest."

And then you told us in your evidence to the inquiry

that this was in fact intended to be a discussion of the totality of the Adam Strain case and you intended it to address the issues arising at the inquest.

A. That's correct. Chairman, if I may just put this in context --

THE CHAIRMAN: Sure.

A. -- because Mr Stewart is asking me about medical audit.

The list on the right-hand page there has names of at least five members of staff of the Royal Belfast Hospital for Sick Children, all of whom were involved in the inquest in one way or another. And all of whom would have been invited at least and expected to attend when Adam Strain's unfortunate death was discussed.

THE CHAIRMAN: Yes.

A. So while I didn't feed directly into it, I knew that the death would be discussed subsequently. This meeting was intended to reinforce that issue. And as I've previously explained in my evidence in the Adam Strain module, unfortunately it didn't happen, and regrettably it didn't happen.

THE CHAIRMAN: Yes, sorry, just to clarify, doctor: you say you knew it would be discussed subsequently; do you mean that you knew it would be discussed subsequently even without this seminar which you were planning?

A. Yes.

THE CHAIRMAN: Right. And it would be discussed subsequently, quite apart from the seminar, through the audit process?
A. Yes --
THE CHAIRMAN: Right.
A. -- or the mortality process.
THE CHAIRMAN: Yes.
A. Whichever. And at that time they were virtually coterminous. I hope that helps.
MR STEWART: But if your key responsibility was to coordinate medical audit, why did you not coordinate and ensure that Adam's case was the subject of a medical audit?
A. Mr Stewart, I can't answer that question because my coordination means that one ensures that medical audit is happening, but not the particular -- of any particular patient.
Q. Not even when it is one when an external expert does something you had never come across before?
A. But as I've explained, there were at least five colleagues from the Children's Hospital who would have been present and would have ensured that that did occur.
Q. It doesn't seem to have occurred. Can you explain how Dr Elaine Hicks was involved in the Adam Strain case?
A. I have problems with my memory in regard to the exact

detail of when she and Dr Mulholland shared responsibilities and one or other took over from one or the other. I don't know.
Q. I asked --
A. If I may finish. Her name is there because I believed at that time that she had a directorate responsibility --
Q. Can we go --
A. -- and that is what my memory makes me believe.
THE CHAIRMAN: Yes, it seems that she was going to be the incoming paediatric lead.
A. Yes.
THE CHAIRMAN: Right.
A. That's what my memory tells me.
MR STEWART: You told us last time that, sadly, the seminar didn't happen. Holidays intervened. On your part, you were off on sick leave and the matter wasn't taken forward.
A. That's correct.
Q. Your evidence, which appeared at page 208 of the 25 June 2012 transcript, indicated to us the process by which you set about organising the seminar. At line 3:
"My staff, who are very good at organising meetings of this kind and did always work on a matrix of availability, did their best to get colleagues together

and failed to do so in the period before summer holiday time, July and August. Next, I went on leave myself the second fortnight in July and, close to or during my holiday, the end of my holiday, I got sick."
Perhaps on to the next page, 210. It's mostly the chairman asking, but maybe 211. The point you're making there is that your staff took forward the process of inviting people.
A. If you would go back to the previous page, please.
Q. Yes. Did you spot it there? 210.
A. If you go to 21, the chairman paraphrases me:
"I'm the one to take all the blame for this."
I think that's what you --
Q. That wasn't what I was searching for because I do remember you saying that. What I was searching for was the fact that you were getting your staff to organise it, and we've heard evidence from all those other people who have all been asked, "Were you contacted about a seminar? Were you invited to a seminar? Were you asked about a seminar?", and not one of them has said they remember anything about that. The conclusion might be that they weren't contacted and no invitation was issued. Can you comment on that, please?
A. I can't. No, I cannot, because all I can do is depend on my written evidence.

Q. You can depend on your staff.
A. And I absolutely depend on my staff.
Q. Why did your staff not then remember about this seminar to ask people when the holiday season was over?
A. I can't answer for that.
Q. Why did they not then liaise with you when you returned from your sick leave to discuss this as a pending matter?
A. Unfortunately, I can't answer that either, other than to say that time had moved on and other issues had arisen. This is where the whole problem is, chairman.
THE CHAIRMAN: I'm afraid it is part of the problem, Dr Murnaghan.
A. It's a significant part of the problem for which I take responsibility.
THE CHAIRMAN: Let me go on at a tangent to Mr Stewart's point. You were saying that apart from the seminar, you knew that what had emerged about Adam's death and the external criticism from Dr Sumner, you knew that that would be discussed subsequently through the audit/mortality process. Well, do you know if anything ever emerged from the audit/mortality process as evidence that anything had been learned from Adam's death?
A. No, I don't. What I do know -- again at a tangent,

chairman, to use your term -- was that there was widespread discussion within the RBHSC of the issues that arose and particularly when Dr Sumner's report came in and then his evidence subsequently.

THE CHAIRMAN: You see, the widespread discussion seems to vary. Let me take as an example the lady who you referred a few minutes ago, Dr Hicks, who was the incoming paediatric lead. I think from her evidence the other day, which I'm paraphrasing, she had heard about Adam's death around the hospital, but she didn't have any specific learning or any lesson learned from it. If the incoming paediatric lead doesn't pick up anything, does this not bring us back to what we were talking to you about in June and September, which is to the extent that there was any learning from Adam's death, it was confined to paediatric anaesthetists?

A. We're talking now about something for which I have coordinating responsibility, but it was an internal issue within the Children's Hospital --

THE CHAIRMAN: Yes, but the --

A. -- and there is a remove between the two.

THE CHAIRMAN: I understand. I'm sure I'll be corrected from the floor if I'm wrong, but a criticism which was levelled during the Adam segment is, to the extent that anything was learned from Adam's death, it was confined

to paediatric anaesthetists and the issue which was debated in this chamber was whether that was far too narrow a group of people to confine the learning to.

For instance, let me take one group who were entirely excluded from everything: the nurses. There's no evidence whatsoever that a single nurse was spoken to about what happened in Adam's case at the time. I think, in fact, when you were here in June you assumed they had been and were rather taken aback to find they weren't. They weren't spoken to at the time of the inquest. They don't appear to have been spoken to after the inquest. There's a whole group of people who have the most hands on-contact with the patients. Isn't that right, the nurses do?

A. Well, there was another group, who were the renal physicians as well. They were as intimately involved as the anaesthetists.

THE CHAIRMAN: In terms of hands-on treatment of patients, it's nurses who have the most hands-on treatment of patients; right?

A. Of course.

THE CHAIRMAN: So there's a group of people who are -- I'm sure this is a rather crude way of putting it -- the first port of call because they're the ones who are with the children on the wards, and they're not spoken to,

they don't appear to learn anything. In fact, Miss Duffin, the director of nursing, wasn't even aware of Adam's death according to her evidence to the inquiry. So to the extent that there's widespread talk through the hospital about what happened in Adam's case, it entirely bypasses the nurses and entirely bypasses the director of nursing.

A. That worries me and concerns me both because --

THE CHAIRMAN: Sorry, let me just develop this. It also worries me because when we come to Claire's case, Miss Duffin knew nothing about that either.

A. Nor did I.

THE CHAIRMAN: I don't doubt, Dr Murnaghan -- I mean, as I said yesterday, and I don't want any misunderstanding about this, I don't doubt that an awful lot of good work is done for the protection of our children in the Children's Hospital. And maybe I don't get a typical snapshot of it at this inquiry. But what I apprehend or see at this inquiry is that at difficult times, as in Adam's case and as in Claire's case, the system didn't work very well, if it worked at all.

A. That appears to be a reasonable conclusion. Now, if I may go back. In the context of the clinical environment, a ward area such as Allen Ward, it's smaller than a village, and everybody talks about and

knows about what's going on, or else they've got their heads in the sand, or they're too busy to know. But essentially, in my clinical practice, in all the years that I was in the various hospitals I worked in, there was nothing that happened that a senior nurse and all the other nurses didn't know about. And as a matter of fact, I was subject, always, to the senior nurse in the ward at any time. And anything I did in that ward in regard to a patient was done with the consent of the senior nurse, who in turn filtered down, as she would, because they met on a regular basis at changeover time and everything was discussed. So much so that if I walked into a ward at handover time, I couldn't get hold of a nurse.

THE CHAIRMAN: I see. Thank you.

MR STEWART: So time moved on, as you said, Dr Murnaghan, the seminar was forgotten, the audit didn't happen. What about the medical negligence litigation, was any attempt made to extract any lessons from that?

A. I think I remember that I, either in June or September, referred to a memorandum that I sent to the clinicians involved saying that the matter had been settled.

Q. I think there was correspondence between yourself and Mr George Brangam, the solicitor, in which Mr Brangam advised that there was really no defence to these

proceedings and it was on that basis that settlement was then effected. On the basis that there was no defence to them, that might have seemed to you to be therefore a case where a simple lesson or two could be extracted. Did that occur to you?

A. I cannot explain what happened at that time, Mr Stewart, I honestly can't.

Q. Was there any --

A. My memory doesn't help me in that regard.

Q. Was there a system for the extraction of lessons from medical negligence claims at that time?

A. Yes, there was.

Q. What was that system?

A. That system would have been direct conversation between me and the clinicians involved.

Q. And would you then have disseminated what you had obtained from the clinicians to others?

A. No, because I didn't practice in each of the multiple 11 or 12 directorates.

Q. All right.

A. The job was too diffuse for me to do all of that. That was delegated to the clinical directors in the directorates.

THE CHAIRMAN: Okay. So if a patient was injured or a patient died as a result of an error by an anaesthetist,

when the case settled, you would speak to the anaesthetist, but also speak to the anaesthetic lead?

A. The clinical director. Yes, I would.

THE CHAIRMAN: And you would, on that basis, expect that that clinical director would ensure that, I suppose, number 1, that an eye would be kept on this particular doctor, but that more generally, if there was a lesson to be learned, that that lesson would be learned in that directorate?

A. Yes.

THE CHAIRMAN: Right.

A. Because all sorts of issues arose. Some were particular, some were --

THE CHAIRMAN: Yes. Some were serious and some were less so.

A. Yes, some were very serious.

MR STEWART: Was there any follow-up on that?

A. In this particular.

Q. Or in a general sense, any follow-up?

A. There wasn't the follow-up then that there is now.

Q. All right. In 1996, your manifold duties included serving on health and safety committees.

A. Yes.

Q. And we have now obtained a copy of the November 1993 health and safety policy of the Royal Group of Hospitals

Trust. That's at WS061/2, page 232; do you recognise that document?

A. I do.

Q. Can we then go to page 241, which details the responsibilities of the medical risk management group and outlined at the top it has those specific responsibilities. At the top, it just describes what it is describes what it is:

"Medical risk management group has responsibility for clinical risk management within the Trust and its undertakings. The group will report through the risk management steering group to Hospital Council on clinical risk management and related matters."

It carries on:

"The responsibilities of the risk medical management group involve and affect health and safety and non-clinical risk management. For this reason, there must be close liaison between the medical risk management group and the Trust health and safety group, and the director of medical administration will be the link between the two groups."

It goes on to say what, on behalf of the medical risk management group, you will do:

"Advise on all aspects of medical risk management, provide specialist advice, co-operate with the collation

and location of information."

And then it goes on to set forth the specific responsibilities of the group. Number 3:

"Untoward incident reporting (clinical)."

Do you remember having responsibilities as part of that group for untoward clinical incident reporting?

A. I do, on a daily basis.

Q. On a daily basis?

A. Yes, I would receive a bundle of forms on a daily basis.

Q. Can you take us through the system and procedure that was in place for untoward clinical incident reporting?

A. Essentially, untoward clinical incident reporting was performed by nurses, and they had a book, a ward book.

THE CHAIRMAN: Is that the statement book?

A. Statement book, exactly. Those statements were compiled by nurses in duplicate, a copy was kept in the book, and a copy was sent to my department. They arrived on my desk for review to determine whether any action needed to be taken or whether the appropriate action had already been taken.

For instance, I'll give you an easy and common one. I'll give you two different ones. One: granny fell out of bed in the middle of the night. Cot sides had not been put in place and, for granny, in future, cot sides were put in place as appropriate, day, 24 hours, or only

at night. And they would say on the report what had been done.

THE CHAIRMAN: Okay.

A. That's an easy one. The second easy one is that a syringe needle was found in the bed. The sister in the ward would have gone to war in relation to that matter in the ward area and most commonly it would have been a medical student or a junior doctor who had left the needle behind, but it might have been a nurse because she was giving an intramuscular injection.

MR STEWART: What training and guidance was given to nurses as to (a) the definition of an untoward clinical incident, and (b), the criteria for reporting it?

A. That, I don't know, but it was just custom and practice and I saw an awful lot of very minor issues coming to me, and the majority, the vast majority, 95/96 per cent of them, were of a very minor nature: slips, trips, falls and so forth.

Q. And that's valuable work and very useful information.

A. Yes.

Q. And it helps patient safety. But the big cases are also important. In fact, in a sense, because the consequences are so very grave, they're so very much more important. In other words, were you relying upon nurses who'd received no guidance to report on the

errors of clinicians?

A. I relied both on clinicians and nurses. There was the occasion when I would seek out a clinician and he would ask me, "How did you find out about this?", and I would say to him, "The nurses told me".

THE CHAIRMAN: The statement book, as it has been described, is most commonly filled with reports of something untoward happening involving a nurse. Does the statement book also apply to doctors?

A. The occasional statement came from a doctor. Occasional. Most commonly, the way the statement from a doctor came was a knock on my door.

THE CHAIRMAN: Right.

A. And there was the third evidence [sic] where a nurse told me and then I went to see the clinician.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: So nurses were better at reporting than doctors; is that right?

A. That, I think, is a reasonable conclusion to draw.

Q. And tell me this: when you got, for example, a medical negligence claim coming in --

A. Before you continue, I'd better add to my answer that the nurses were better, but they were better because they were reporting on a virtually daily/weekly basis about minor issues.

Q. Yes. Did you ever have cause to speak to the medical staff, to doctors, about reporting on themselves and on each other; was that ever an issue?

A. No. Certainly not about what would now be known as whistle-blowing.

Q. Was any guidance available to them at that time?

A. No, there wasn't. Not that I know of.

Q. When you got a medical negligence claim in, would you, as part of your process of responding to it and investigating it, would you have said, "Let's see if there's a statement book entry"?

A. I don't think I would.

Q. Why not?

A. Because I would have depended on the chart, the record, the clinical record.

Q. Why would --

A. And in the context of medical negligence, what we are talking about is medical negligence, that is something -- or clinical negligence, where something was done allegedly by a doctor or nurse or some other of the paramedical staff, that was alleged to have injured a patient. Now, in that context, the patient's chart is where I started. And that gave me (a) the clinician or clinicians involved, (b) the chronicle of what happened and how it was dealt with at that time and so forth, and

therefore who I was to approach.

Q. You have a system for the reporting of adverse clinical incidents. You're on the committee that is charged with this responsibility and you're also charged with investigating medical negligence claims. Why would you ignore a vital piece of internal evidence, if it existed?

A. Well, because I might not have had it.

Q. You'd call for it, wouldn't you? You're the director of medical administration. You'd say, "Let me have a look", "How is this case being coded?", or, "How have the nurses responded?", "Where's our internal evidence?"

A. Yes, but the internal evidence was not necessarily provided in that way, it was provided in the chart, and didn't -- and unfortunately, now, when we look at it, in the way you're seeking to find out, it didn't come to me in that form. It went into the chart.

Q. But you can have a situation --

A. I didn't get a statement made up.

Q. But you could then face a situation where a chart indicates one thing but a whistle-blower has made a statement in the statement book that says something quite different, and you don't bother to look? Is that really the way you ran the operation?

A. Chairman, I'm not too taken with the use of the word

"bother".
THE CHAIRMAN: Well --
A. I almost take offence at that.
THE CHAIRMAN: Are you saying that for these more serious incidents the statement book really was either entirely irrelevant or peripheral?
A. The statement book couldn't have given me detail, it could only have given me a one or two liner.
THE CHAIRMAN: But it gives you a starting point, doesn't it?
A. Yes.
THE CHAIRMAN: The fact is that when you get a statement book -- and accepting what you say about 90 or 95 per cent of the issues raised in the statement books are minor, which you don't need to follow up on, because you know they're followed up on on the ward --
A. And possibly if there was an accumulation of them over a short period of time, I would have gone walkabout.
THE CHAIRMAN: The more major ones, if I got you right, the ones involving doctors, say, you say normally it wasn't the statement book, normally you would get a knock on your door; right?
A. Commonly and usually.
THE CHAIRMAN: Yes. But I think what Mr Stewart is focusing on is that here we have, in Claire's case, a sequence of

events which don't appear to have featured in the statement book and haven't led to a knock on your door, with the result that you were entirely unaware of it.
A. I think I might be able to assist Mr Stewart insofar as, if it got into the statement book, because I would have seen it and done something about it. In that regard, we were along two parallel lines rather than addressing the issue in the way that he wanted to because of the way he put the question to me.
THE CHAIRMAN: However it came about, if Claire's case had been recorded in the statement book at all --
A. Absolutely.
THE CHAIRMAN: -- then that would have come to you because the statement book is in triplicate. One copy of the triplicate comes to you --
A. Yes. And one would have gone to the nurse manager's office.
THE CHAIRMAN: Right. But this brings us back to an issue which we raised earlier in the last couple of weeks with one of the nurse managers about how do you know, because we're not all very good at putting our hands up and saying we did something wrong, and her answer was: it's such a small community that I found out within a day or two anyway and that's when I really go after the nurse because not only has she done something wrong, but she's

left it out of the statement book, so it's almost aggravating the offence.
A. Yes.
THE CHAIRMAN: In Claire's case --
A. It didn't happen.
THE CHAIRMAN: And that's I think what Mr and Mrs Roberts are most worried about. They accept things go wrong, people make mistakes, children aren't treated as well as they should and, in this awful case, Claire dies. But the system broke down completely because not only was there no entry in the statement book, not only did nobody report anybody else, and we've just heard from, insofar as Dr McKaigue could remember from the mortality or audit meeting, there was a basic lesson that wasn't learned from it. And it wasn't quite the same in Adam. There was something different in Adam, Adam being a case where the problem, if I might put it bluntly, was that a very, very good paediatric anaesthetist, Dr Taylor, made a terrible mistake and it's almost more difficult to deal with when somebody is very, very good and the impression I've got from Adam's case is that everybody danced around or shied away from ensuring that Dr Taylor had learned a lesson from it because, until he came to this inquiry, just before he came to this inquiry, he appeared not to be facing up to things.

But if you go to Claire's case then, we have a scenario where, as Mr Walby said yesterday, there's a fundamental mistake made in Claire's case, which is not repeating a blood test. He says -- and I think it's quite clear in the evidence that he's right -- if that had been picked up, it would almost certainly have shown a falling sodium level into the potential danger zone, so that at least that aspect of Claire's condition could have been treated, whatever would have happened with the viral condition. And that would have at least increased Claire's chances of surviving and may indeed have saved her life entirely.
A. Indeed.
THE CHAIRMAN: But this isn't picked up in 1996/1997, nor is, for instance, the overdose of drugs picked up in 1996/1997. In fact, that's not even picked up in 2004/2006. And that does not -- and I know 2004/2006 is beyond your time, you're there in 1996/1997 -- but the parents in this inquiry are looking for reassurance that these mistakes, when they happen, are picked up and lessons are learned. We know that did not happen in Claire's case.
You can only take us up to the time when you left, Dr Murnaghan, but what reassurance can you give that this was a one-off or something close to a one-off?

A. Chairman, if we take Adam's case first, I was in the loop. I think I've explained my role in that loop --
THE CHAIRMAN: Yes.
A. -- both on the clinical side and on the negligence side.
THE CHAIRMAN: Yes.
A. In Claire's case -- and I know that the parents are here -- I wasn't in the loop at all. The first I knew about Claire was after the UTV documentary. I just ... One only can say that I wasn't in the loop at all. I never knew about Claire's unfortunate clinical episode and her absolutely regrettable death, with which I sympathise with everybody involved. But I didn't know anything about it and I'm only picking up now on what I read about it.
I can explain as best I can from my memory what systems were supposed to be in place, but the systems are only as good as the people that run them and drive them.
THE CHAIRMAN: Yes.
A. The systems were intended to be there, but they were part of an incremental process of introduction and getting it on the go, and they're driven much better now, I understand, than they were then.
THE CHAIRMAN: Okay, thank you, doctor.
MR STEWART: Back in the middle 1990s, Mr McKee has told us

that the occasional adverse clinical incident case was reported to the department; is that right?
A. That's correct. I reported about these matters to the Trust board and to the hospital council when a significant matter arose, like Adam's, for instance.
Q. What about reporting to the Department of Health?
A. I can't remember specifically about what the reporting line was to the Department of Health, but I know it happened.
Q. You know it happened?
A. Yes.
Q. I wonder if you can help us just understand how this particular circular was operated. It's at WS061/2, page 321. This is from 1991, circular ET5/90, and this is about untoward incidents and the reporting of these and the various times they may be reported and to whom. Do you recognise this document?
A. At this remove, I don't, no.
Q. This was in order that an untoward incident such as is defined over the page at 322 -- if we go to the bottom of the page.
A. Just one second, if I may. Could you go back to the first page, please?
Q. Yes. Side by side.
A. I wanted to look at -- I thought I saw up on the very

top right ... No, it's number (ix) there. I don't understand where (ix) comes from.
Q. It comes from Mr McKee's witness statement to this inquiry and it's the ninth exhibit to it.
A. Thank you. It's insofar as I thought I recognised the writing, but I don't now.
Q. You don't recall this document?
A. No. The reason I don't recall this document is because if that -- if this copy came from Mr McKee's files, so to speak, there's no circulation on it.
Q. All right. Well, this --
A. And there usually would be a circulation list written on it.
Q. The reason I ask you is that this may in fact have gone into events at the time the Trust came into being in 1993, but it's about a procedure and a system which should have been in place until 1993 for adverse clinical incidents to be identified and reported up.
A. Correct.
Q. Was there a system until 1993 for the identification of such incidents?
A. Formally, I don't remember, but informally there probably was because I would have been in regular communication with board officers in Linenhall Street, in the Eastern Board Health and Social Services.

Q. This brings us back to the work of the medical risk management group that you were on, along with the medical director, who chaired it, and then you were liaising between that group and the health and safety group. Surely things must have been more formalised, given the existence of these committees with such high level representation than just: informally there would have been a system?
A. I can't answer that question, Mr Stewart, I'm sorry.
Q. Is that because you can't remember?
A. Exactly.
Q. All right. I just want to ask you about your own description of yourself as a link or a facilitator between the Trust and the coroner's office. This is something you described in your initial statement to the police in Adam Strain's case. That's at 093-025-068. Halfway down:
"From my experience of other meetings with the coroner, it was common for myself to be present as a facilitator and as the link between the coroner and the Royal Hospitals Group and the Trust."
A lot of your work entailed making contact with and liaising with the coroner?
A. Yes, it did.
Q. And therefore the issue of whether or not a case be

referred to the coroner must have been something that you dealt with a regular basis?
A. Not on a regular basis because my colleagues would have decided themselves on the basis of the known circumstances in which -- as Dr McKaigue has explained earlier this morning.
Q. Was any guidance or assistance given to practising clinicians as to when they should go to the coroner or what they should do if they're undecided?
A. I don't know whether I should use the word "occasionally" or "rarely", but it's one or other of those. It might have been once or twice a year.
Q. What form did that guidance take?
A. I would get a telephone call: should I, on the basis of this or that clinical circumstance, ring the coroner's office and ask for guidance? My answer always in those circumstances was: when in doubt, ring.
Q. If in doubt, do it?
A. Yes.
Q. Was there anything written down, any criteria circulated for anyone to keep as an assistant?
A. Well, the coroner had issued guidance. Now, I don't know whether that guidance had been circulated by my staff or otherwise.
Q. Did you direct that it be circulated?

A. I can't remember because I have no document to rely on, but I do know that the coroner had a document where he set out in detail what types of case should be referred to him. I've referred to that in one or other of my witness statements, as did Dr McKaigue earlier today.
MR STEWART: Very well.
Thank you, sir. I have no further questions for Dr Murnaghan.
THE CHAIRMAN: Okay. Any more questions?
MR QUINN: No.
THE CHAIRMAN: Doctor, thank you very much for coming back. Thank you for your time, you're now free to leave.
(The witness withdrew)
I'm going to recall Mr Walby. It's 12.45. Do you want to break for lunch from 12.45 to 1.45 and start early? Does that make more sense?
MR McALINDEN: It might allow further enquiries to be made of Dr Webb's status.
THE CHAIRMAN: I've just got a note. Apparently, Tughans are complaining of the late notice of this, but anyway. Mr Conrad Dixon, who I think is the solicitor in Tughans who's been here before, he hasn't been able to contact Mr Alistair Wilson, who's in court this morning. There has been no contact with counsel either, and Mr Dixon will contact Mr Wilson at lunchtime to try and get this

issue resolved. We'll do well to have an answer for 2 o'clock, but can we start with Mr Walby at 1.45? Thank you very much.
(12.45 pm)
(The Short Adjournment)
(1.45 pm)
THE CHAIRMAN: Just to confirm publicly the position: over lunch, we received a message that, on behalf of Dr Webb, any claim for privilege is not being asserted. The result of that is that I think we now have the documents in file 140 for which privilege has been waived. Those are some correspondence which we had previously received, but of new relevance, potentially, are three consultation notes.
Mr McAlinden, I have to say this: I accept that the Trust is fully entitled to assert privilege. It's in the statutory framework under which I operate. What I am unhappy with is the Trust asserting privilege and then waiving privilege during the proceedings and after witnesses to whom the privilege relates have finished their evidence.
MR McALINDEN: I appreciate it's unsatisfactory.
THE CHAIRMAN: It does run the risk that we may have to recall -- I don't know yet because the notes are being looked at inside. I don't expect there will be anything

as dramatic as the consultation note in Adam's case, but it is disruptive.
MR McALINDEN: Yes.
THE CHAIRMAN: What I would ask the Trust to consider in future is, while you have the right to assert privilege, whether in each instance you need to do so, because there's nothing in these documents which you've disclosed which seems to me to be so confidential that, in the rather different circumstances of an inquiry such as this, mightn't have led to a reconsideration at the start of it, whether you claim privilege in the first place.
MR McALINDEN: Yes.
THE CHAIRMAN: If we do have to recall people, we'll fit them in as best we can -- hopefully next week, if they're available -- but this inquiry generally has been going on for too long and this particular segment of it must be trying everybody's patience, particularly the patience of Mr and Mrs Roberts. They want to know what happened, we want to get to the heart of what happened, but we have to try to do that in as effective and efficient a way as we can.
MR McALINDEN: I very much hope that there will be no need to recall anyone arising out of the disclosure of the documentation.

THE CHAIRMAN: Thank you very much.

Mr Walby, could you come back again? Thank you very much. You're still under oath from yesterday.

MR PETER WALBY (continued)

Questions from MR STEWART (continued)

MR STEWART: Good afternoon.

THE CHAIRMAN: Yesterday we had got to questions about ...

MR STEWART: I think, sir, yesterday afternoon I was trying to establish what had been done and what had not been done in the light of the information coming through to you in 2004 about Claire's case. I made a point to you that there was no report made to the department at that time, nor was there an attempt made to locate all the documentation that might relate to the case and secure it, nor was any formal investigation launched into the case.

THE CHAIRMAN: Thank you.

MR STEWART: Then I was going to take you to where you start to become formally involved in the process, whereby the coroner was informed and the case referred to him. We take up that trail at WS177/1, page 45. The upper e-mail is a communication to you from Dr McBride of 15 December:

"Peter, I have asked Nichola to copy you the minutes of the meeting with the Roberts family. At the meeting,

on my recommendation, we clearly indicated that, following our case note review and the expert opinion of Professor Young and others, we were significantly confident that their daughter's fluid management was a contributory factor to her death amongst the many others involved. In these circumstances, at the meeting with the family, we indicated we would be referring the matter to the coroner. At the meeting, we sought to determine their view on this action as we are aware that HRM Coroner would wish to be informed of their wishes in arriving at this determination. It is clear that our requirement to refer their daughter's case to the coroner has the full support of the family. I need you now to take responsibility of this matter. Nichola will take the lead in liaison with the family and I would ask that you now begin to coordinate notes of the meetings and a report to date so that you are in a position to share this information with the coroner for appropriate action. It will be for the coroner to determine whether he should have discussions with others at this stage."

So your instructions were pretty clear there: to get together what you had and to make the report to the coroner.

A. That's correct.

Q. Looking at that, it looks as though there is (a) a case

note review and, (b), an expert opinion from Professor Young and, (c), an expert opinion from others. We haven't been able to locate or identify any others who may have given an expert opinion at the time; would that be correct?

A. I was not aware of any.

Q. And was the case note review that of Professor Young or was there any additional case note review?

A. I'm not aware of any others than Professor Young's.

Q. All right. When you were coordinating notes and reporting to date, did you seek any of those additional items of information that may have existed?

A. The e-mail trail which you have in this file was all that I became aware of. I obtained the notes, the clinical notes, in order that I would report the case to the coroner.

Q. The e-mail trail continues then at 139-151-001. It's a letter we looked at yesterday. And you get back to him to say:

"Michael, I have reported Claire Roberts' death to the coroner yesterday as requested. Mr Leckey asks that the parents should now be invited to contact his office in order to express their concerns directly to him and he will take things from there. I think the letter to Mr and Mrs Roberts should come from your office rather

than mine, given its adversarial name. I attach a copy of the coroner's booklet for you to include with your letter."

Ultimately, the letter was in fact put onto the medical director's writing paper and sent --

A. Correct.

Q. -- and that appears at 140-061-001 and 002. This is very curious.

THE CHAIRMAN: It might be that we don't yet have it on the record for bringing up on screen this document. What date is on that letter, Mr Stewart?

MR STEWART: 16 December 2004, from Mr Walby to the coroner, and presumably it will appear also in the coroner's file. I apologise. (Pause).

THE CHAIRMAN: If we go to the coroner's file, it's from Dr McBride to Mr and Mrs ...

MR STEWART: In fact, it does come from the litigation management office now we look at it.

THE CHAIRMAN: Sorry, I know it takes you out of sequence. Can we try to come back to that?

MR STEWART: Yes, of course.

THE CHAIRMAN: The coroner's file has a letter dated 17 December from Dr McBride to Mr and Mrs Roberts.

MR STEWART: That's separate. This is a formal letter which makes the referral to the coroner on 16 December. It

also appears at 139-149-001. That's the first page, thank you, and 002.

THE CHAIRMAN: Okay.

MR STEWART: So this is your letter formally reporting the death to the coroner on the 16th, and indeed I see it finally does come from your office, the litigation management office. I know that you've already commented on this in one of your subsequent witness statements, but I want to draw your attention to your recital of the circumstances in the second paragraph.

A. Could I stop you just so that you're aware of what happened? As the previous item you put up showed, the e-mail to Dr McBride was saying I reported the death to the coroner yesterday, and it's dated the 16th. So I reported it by telephone to the coroner on the 15th.

Q. Thank you.

A. And we had a discussion, and as indeed on a number of occasions where -- it's rare for me to report a death to the coroner, you can understand. Normally, my awareness of a death that the coroner was investigating came from a clinician to the coroner and then the coroner would ask me to deal with matters. I think there have been ten occasions that I have reported a death to the coroner in my 12 years of doing this work, and on each of those occasions I telephoned the coroner because,

apart from officially reporting the death, there clearly was an issue as to whether the family were aware that there was an issue of a patient's death. Therefore, there was some choreography needed as to how the family were to be made aware, if they didn't know. Now, they did know in this case. So that's the reason why I always telephoned the coroner to tell him about a death that has been reported. He then asked me to put our conversation in writing in a letter, and I have no doubt that, although I haven't seen it as yet because I haven't seen the coroner's file, no doubt there will be a hand note by Mr Leckey of our telephone conversation. But the coroner's file has not been made available as yet.

Q. I know. Thank you for that, that's a useful addition. The second paragraph:

"The circumstances are as follows: Claire had a history of epileptic seizures since age 10 months and had learning disability."

The point is taken that Claire had had her last previous seizure some years before her admission to the Royal and that therefore, to give a history of "epileptic seizures since the age of 10 months", is incorrect.

A. Well, it's incorrect on two counts, we now know. The

10 months is an error --

Q. Yes.

A. -- and my reading of that was not to give any opinion as to whether -- any description as to whether the seizures had gone on continually or whether they had stopped. There was certainly evidence from the GP's letter that there seemed to have been a seizure which had led partially to the admission of Claire. Therefore, I did not appreciate that there had been a halting of the seizures and I apologise for that. The 10 months error, as you know, comes from the autopsy report. There has been some discussion as to whether the autopsy report was or wasn't in the clinical notes during the previous few days when the meeting was with the Roberts family.

All I can say is that when the notes came to my office for me to report the death to the coroner, what I considered was an original autopsy report, albeit unsigned, was in the notes.

Q. It was definitely in the notes then?

A. It was.

Q. And that's where you got this piece of information from?

A. Because it says it twice, at the top and at the bottom, and I didn't think to query it.

Q. And you didn't cross-reference it against the content of the medical notes and records?

A. It's not just so easy to see the 6 months. I agree it's there. I would then have had to make a decision as to which one I thought was correct. But I didn't make that choice, I went with what I saw.

THE CHAIRMAN: In fairness to you, Mr Walby, on the basis that you're reporting this to the coroner, you're not purporting to give him the complete definition of everything that happened and, when the notes and records are going to be scrutinised, as you expect them to be for the inquest, any inconsistencies or errors should be picked up as part of that process.

A. Yes. I really expected this letter to take no further part in affairs. It could have been a one-line letter to ... "Further to yesterday's conversation, I'm reporting Claire ..."

MR STEWART: It made no difference because, in any event, as you know, Mr and Mrs Roberts wrote to the coroner to correct what they took as an error and, indeed, Dr Steen also availed herself of the opportunity to correct what she saw as a mistake. So there was some, as it were, oversight of that.

Can I ask, on the issue of the autopsy report, were autopsies of that time generally unsigned or were they generally signed?

A. I would have thought they were signed. I'm just

thinking from my own clinical practice. I would have thought they were signed. The particular layout of this report and the paper, the heavily textured paper that it's on, made me know immediately that this was one that had emanated from the pathology department and wasn't a photocopy. It was very typical of the autopsy reports that come from the pathology department. So if it had been issued in error as a draft in some way, I would have thought that's most unlikely. And I've heard further discussion during Dr Herron's evidence that his explanation may well have been that he sent a covering letter, which was stapled to it -- and the top left-hand corner, I believe, has staple holes, which suggests that a covering letter might have been taken off before the autopsy report was filed in the notes and therefore a signature of Dr Herron or Dr Mirakhur could have been lost if the copy letter -- if the original letter enclosing the autopsy report wasn't filed in the notes.

Q. Do you remember seeing any other unsigned autopsy report turning up at about that time in medical notes and records?

A. No, I don't, but I wouldn't have gone looking for it.

Q. Subsequently, Mr and Mrs Roberts -- in fact, maybe a bit before -- after their meeting with Dr Rooney and Professor Young and Doctors Steen and Sands,

in December, wrote a letter setting out a series of questions or queries and issues that they wanted addressed. We find that at 089-006-012. It's a lengthy letter that runs to three pages. A number of people were involved in preparing and putting together a series of responses to this letter.

If you see at 139-139-001, that's part of an e-mail trail that has been copied to you because I've come to recognise your handwriting.

A. Yes.

Q. This is where Professor Young and then Dr Steen indicate they've made changes to the draft responses to be issued by the hospital to Mr and Mrs Roberts, and it's coming to Dr Rooney and it has reached a final, final, final draft, and then you have annotated this e-mail at the top right-hand:

"I have made some comments. They may not be appropriate. Please ensure I get a copy of the final letter. I will need to send it with the questions to HMC."

And you have initialled that and dated it 11 January. We have a copy of what we believe to be the draft on which you made comments. Can I ask you: what did you mean by the phrase "they may not be appropriate"?

A. Could I take you, first of all, to 139-152-010?

Q. Thank you, yes.

A. The bottom e-mail, it's from Nichola Rooney and she's saying:

"Michael would also like Dr Walby to get sight of any responses made."

That does not say "would like Mr Walby to get involved in the responses". But if you then go to 139-173-005, this draft letter is then forwarded to me for my consideration.

Q. Yes.

A. So Dr Rooney has decided that she would like me to make some comments on this letter.

Q. Does she say that or does she simply say it has been forwarded for your consideration? She's, with respect, asking that you become aware of it, consider it, but not necessarily comment on it or suggest alterations to it.

A. Well, therein lies the reason for my comment. That is a note where I have made some comments. They may not be appropriate. Then if you then go to -- and if you put it up beside it, the page that you have, 139-139-001. If you put beside it 139-173-001.

That shows the secretary's translation of my handwritten note. She's sending, by fax, my suggested amendments to the letter to Dr Rooney, and there was an

appreciation that this was wanted to be dealt with quite quickly. If you look at some of the other e-mails, you'll have seen that Dr Rooney was itching to get this letter out.

Q. Yes.

A. In fact, the letter that's dated 12 January, sending my comments, it enclosed my comments and asked them for a copy, but it is not put into it "these may not be appropriate". That indicates that I had a query about my part in this. But I took it that the medical director and Dr Rooney had wanted me to. They wouldn't have sent me a draft if they hadn't wanted me to; they would have sent me the final letter if it was just for my file.

Q. I suppose they might have wanted you to give your consent to it going out as opposed to your suggestions for its alteration.

A. I wouldn't have taken that decision, I wouldn't have consented or withheld consent.

Q. You see, there is a bit of a difference between a tentative "I have made some comments, they may not be appropriate", and:

"Find enclosed draft copy of your letter with my comments as requested. Grateful if you could let me have a final copy of the letter for my file."

There's a little bit of a disconnect between those two, isn't there?

A. I expect we're going to come on to looking at the comments that I've made --

Q. Yes.

A. -- and you'll realise they're really rather of a different nature than the comments that I make on witness statement drafts.

Q. All right.

A. They are really margin notes in that I read the Roberts' letter and, with each question, I looked at the answer and I thought there were some disconnects between the two. The purpose of my comments was not largely to amended the drafts, they were to draw the attention of the author, Dr Rooney, that to somebody who hadn't been involved in this before, this answer didn't quite match the question.

Q. This is not a major issue, but let's do just that. Let's go to the draft at WS177/1, page 89 and page 90 beside it.

A. Just to help everybody, you see my written comments and you see the crosses and the ticks. The crosses and the ticks are made much later. When the final letter that was sent was sent to me, I go through it and see which of the comments that I made were taken on board and were

not taken on board, were accepted and acted on and which ones weren't. So that gives you -- the first one there, there was a reference in the Roberts' letter to 133 sodium and the reply refers to 132. I just have made a note, "This disagrees with the Roberts' 133", yet no comment.

THE CHAIRMAN: So you're picking up that, in this instance, Mr and Mrs Roberts had made a small mistake about 133 and 132?

A. I really wasn't saying it was a mistake; it was just saying: they have asked about the 133 and we're talking about a 132.

MR STEWART: So you were highlighting an inconsistency --

A. Yes.

Q. It's really on the second of those two pages at paragraph 6(b), which says:

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

That is a response to a question which asked:

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

Why was she not admitted to intensive care?

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

Your annotated remark is:

"This suggests we ..."

A. I'll tell you what it says:

"This suggests we are critical of our failure to move her. Maybe we are?"

Q. Yes. So that indicates to you that there's self-criticism. In other words, an acceptance of something perhaps or self-criticism and, of course, having made that suggestion, that comment, of course that leads to that phrase being expunged, taken out of the letter.

A. Well, they amended it and they then amend it to the wording that I had written below.

Q. Yes.

A. Because they ... If they indeed were critical, then they could have said so. I thought that the problem with this was -- the person who would have given an answer to this was Dr Webb. Dr Webb was in Dublin and wasn't involved in dealing with this. Therefore, they have said it is difficult to give an opinion because none of the people who were authors to this letter were those who could give an opinion.

Q. You could have annotated it by saying, "Please refer this to Dr Webb for his opinion", as opposed to, "This looks like we're critical of what happened, let's take it out".

A. You can see exactly -- there's certainly no disguising what I do. I'm absolutely transparent about it and it's up to them to look at it and say -- I mean, they could have involved Dr Webb in it. I don't know whether there was a decision to not do so or what.

THE CHAIRMAN: Or if it's pressing to get the response out, going to Dr Webb might slow it down another day or two.

A. I'm sure that would have been an additional difficulty.

THE CHAIRMAN: Okay.

MR STEWART: I was merely going to suggest that because of your work defending the Trust against claims, you might have got into the habit of restricting information that might have revealed vulnerabilities and that is why you thought this was best taken out.

A. Absolutely not. I had two different hats, wearing my litigation hat or my coroner's hat. I had to deal with them in a completely different way.

Q. This letter is intended by you to go to the coroner as well, isn't it?

A. Well, I can tell you from my experience that when the coroner finds during an inquest that there has been some correspondence and that the Trust has been in possession of some information which he hasn't been made aware of, he's not best pleased. So I'm aware that under circumstances like this, the coroner would want to

receive copies of such correspondence.
Q. Would you want the coroner to be informed that the letter had received editorial rewriting from the litigation management office?
A. Um ... I don't know that that would be necessary because it would apply to all the inquest statements that are received by his office and I am sure that the coroner will have been aware that I was providing assistance to and support to those providing witness statements. So I would have thought that that would not become as any sort of surprise to the coroner.
Q. Why do you think the coroner might have been aware that you were involved in, in parts, the rewriting of statements for inquests?
A. Well, the first part, you said was?
Q. Why do you think the coroner would have been aware that you were involved in partial rewriting of statements?
A. He'd have been aware that staff who produce their own attempt at a witness statement frequently do it rather clumsily and in an inappropriate format. And he was used to obtaining witness statements from the Trust which followed the format that he required, in terms of being in the first person and starting off in a manner that the witness will be reading this in the witness box and therefore third person is not appropriate. So I've

no doubt that the coroner would have known that that was part of my function.
Q. You say he would have known and you have no doubt he did know, but did you ever tell him?
A. I can't think of telling him in those terms, no, I can't.
Q. Did you think that this letter going out to Mr and Mrs Roberts, in response to their questions about Claire, do you think it should have indicated to them that it also has received input from the litigation management office?
A. Well, this goes back to the comment that I have made about the appropriateness of it in that I was asked to do it and I did it. I could have drawn the line and gone to the medical director, Dr Rooney [sic], and said, "Send me the final version, but don't let me get involved in the drafting of it". And so I was alert to it at the time, as you can see from my comment, "they may not be appropriate".
Q. Yes.
A. "They may not be appropriate", unfortunately, did not get translated into the typed letter and it may well be that the secretarial and admin staff in my office thought that everything I did was appropriate and therefore they weren't going to put that in. I don't

know. But it means that that potential warning to Dr Rooney that -- was this right, was maybe not ... It was maybe not appropriate for me to comment, but the fact is, Dr Rooney did want my comments.
I think you'll find that there's at least another e-mail, which does refer to wanting comments from me. I think she's in no doubt that she wanted me to make comments.
Q. She's going to be with us tomorrow so I can ask her.
A. Indeed. And it may well be also that her conversations between Dr McBride and Dr Rooney may have had some implicit instruction that I should see the letter after a final draft. And I did say to you yesterday that there have been other occasions where I have been sent draft letters maybe that the complaints department have virtually got finalised for me to cast my eye over. I think I used the words "proofreading". That's really what this was intended to be.
Q. I see. Can we now just follow the trail of this to 140-062-001? I'm sorry. I have a completely different document with exactly the same pagination.
THE CHAIRMAN: What is it you're looking for?
MR STEWART: It's a letter of 25 January 2005. It will appear in the coroner's file from Mr Walby to Mr Leckey. (Pause).

Perhaps I could read it to you. It's of no great startling import. It simply says [inaudible]:
"I have now received the enclosed series of questions posed by Mr Alan Roberts in his letter of 8 December 2004 following his meeting at the hospital on 7 December 2004 and a comprehensive reply from Dr Nichola Rooney, on behalf of the hospital, dated 12 January 2005."
So you forward that to him and then you add:
"I will leave it to you whether you wish to forward them to Dr Bingham to assist in compilation of his report."
Dr Bingham was the independent expert that the coroner had --
MR McALINDEN: Mr Chairman, the reference I have for that letter is 139-135-001.
THE CHAIRMAN: Thank you.
MR STEWART: Yes. Dr Bingham was the independent expert retained by the coroner from Great Ormond Street Hospital; is that correct?
A. Yes.
Q. Why did you want these responses to go to the independent expert?
A. Well, I didn't, I just said to the coroner "you may send them to Dr Bingham".

Q. Why did you need to suggest that?
A. I think I wanted it to be clear that because I had previously written to Dr Bingham -- as you see the start of that letter, "further to my letter to Dr Bingham" -- and I had sent copies of the ... The coroner had asked me to send copies of the hospital notes to Dr Bingham. Therefore, I was just marking the coroner's card that I hadn't also forwarded this material on to Dr Bingham.
Q. The purpose of asking you these questions is to determine whether or not the information supplied to Mr and Mrs Roberts was substandard in quality and whether poor information was also provided to the coroner. That's the area we're interested in. Did you yourself read Dr Rooney's final letter with any sort of reference back to the medical notes and records or what you knew of the case?
A. No.
Q. Had you looked at the death certificate or the medical certificate of cause of death?
A. I did not do an analytical response to the Roberts' letter. I was a final viewer of it when a lot of other people who had been intimately involved in looking at the case notes -- and therefore it wouldn't have been appropriate for me to be doing that. So when the final letter came, as I've told you, I read it because I went

X and tick to see, but it then was the Trust's letter, which was a response to the Roberts', and if there were errors in it -- at that stage, it would not have been for me to be getting involved in that. This was what the Trust had said to the Roberts in response to their letter and I was sending it to the coroner for his information.
MR QUINN: Mr Chairman, if I can just come in. I don't want to come back on this point later on. I wonder, Mr Chairman, if we could look at the transcript of yesterday at page 165. It's day 67, page 165 of the transcript. Sir, we're on the live transcript. I will get back to this point when we find it in the live transcript and marry it up. It's a quote that the witness said yesterday. It's in relation to what he said about the blood test and that is that the claim would be settled on that point alone. It's in relation to litigation and it is in the transcript.
Before we move off this point, what we want to know is: when one looks at the letter, at the final draft of the letter, which is at 196-018-113, you can see that this point is referred to at paragraph 2 and paragraph 3 of the letter. Perhaps the letter could be brought up. The letter is 196-018-113. (Pause).
THE CHAIRMAN: We are clearly having referencing

difficulties this afternoon.
MR QUINN: This letter is in a different file and I'd be obliged if ... (Pause). I'll come back to the point.
THE CHAIRMAN: Sorry, let's stick with it because we are looking at the issue of how the draft letter to Mr and Mrs Roberts was knocked backwards and forwards a bit within the Trust.
MR QUINN: It was. The final draft is referred to in my opening, and when one looks at paragraphs 2(a) and 3(b) of the letter ...
MR FORTUNE: 177/1, page 39.
MR QUINN: Thank you. This is a final version. It's the second paragraph of 2(a):
"Practice now would involve approximately six-hourly checks and use of the CT scanner. However, in 1996, before there was such extensive knowledge about hyponatraemia, it would have been normal practice to monitor sodium level every 24 hours."
Then again it's mentioned at 3(b), the third sentence:
"As already explained, common practice in 1996 would have been to monitor sodium level approximately every 24 hours."
What the Roberts family want to know -- and this is the question specifically highlighted by Mr Roberts

yesterday after the evidence -- is if this witness was aware that there was a problem with monitoring the blood levels in 1996, that is that he would have advised settlement of the case on the basis of the failure to monitor the levels, then why weren't the parents simply told that? Why wasn't the Trust at this stage open and honest and told the parents that there was a problem and that they've recognised this problem?
The question is: why did the clinicians tell the parents through this letter that it was normal practice when the witness seems to be saying: well, if it was normal practice, I would still have settled the litigation on the basis of what I know about it.
THE CHAIRMAN: And the difference in Claire's case was that even if it was normal practice in 1996, the fact is that she had come in with a slightly low level.
MR QUINN: 132.
THE CHAIRMAN: And that is the issue which should have prompted a repeat of the blood test earlier?
MR QUINN: Yes.
THE CHAIRMAN: And your evidence yesterday, Mr Walby, was simply on the failure to repeat the blood test, that that would be enough for the Trust to be advised to settle a medical negligence claim.
A. Yes.

THE CHAIRMAN: You see, the contrast here is between the information given to the Roberts in 2005, I think this letter is, and what you said yesterday.
A. But what I said yesterday was with the benefit of all my knowledge at the end of an inquest. I mean, I fully accept that the doctors, the paediatricians, would have been monitoring electrolytes once a day in children where there wasn't any specific reason to do it more often. I think we've heard evidence that indeed there was reason to be doing it more often. And that will have been the basis of -- was the basis of my answer yesterday, that a claim would have been settled.
MR QUINN: I sort of used a bit of foresight and I expected that that would be your answer. But that then leads on to the question, Mr Chairman, and through you again: if Mr Walby, as I suspected he would say, left the inquest knowing that there were mistakes made by the Royal Victoria Hospital, why was no action taken? That is an even more pertinent point in relation to the governance issues that we have here know because he knew precisely then what he said yesterday to the inquiry, yet nothing seems to have been done.
THE CHAIRMAN: In terms of internal audit or lessons learned? I know we're jumping around a bit on this, but do you see that point?

A. Yes, and I did say that the normal sequence of events, which would occur following an inquest, didn't happen in her case because there was knowledge by most parts of the Trust about this issue. The medical director knew about it and therefore it wasn't taken further.
THE CHAIRMAN: I know we're continuing to jump around, but in Adam's case, as Dr Murnaghan has reminded us this morning, a view was taken that the only lesson to be learned in Adam's case was to be learned by paediatric anaesthetists. And the consequence of that is that nothing was learned from Adam's case beyond the paediatric anaesthetists because the note which was provided to the coroner in Adam's case towards the end of the inquest was effectively drafted collectively by the paediatric anaesthetists and circulated only to the paediatric anaesthetists. So nothing was learned. If it was a lesson at all, it was a minimal lesson. And apparently on the basis -- well, they're the only people who need to be concerned about this. In Claire's case, as I understand it, what you're saying is that given the outcome of the inquest, everybody who needed to know had heard about it.
I'm curious about that, Mr Walby, because I understand that, by 2006, governance had developed considerably from the position it was in ten years

earlier; right?
A. Yes.
THE CHAIRMAN: I've been told that repeatedly, that governance was more advanced by 2006 and from what I've been told, it's more advanced today.
A. Yes.
THE CHAIRMAN: By 2006, for instance, Dr Hicks, who gave evidence yesterday -- she wasn't asked directly. I didn't pick up any understanding from her that she had learned anything from Claire's case. So is it really safe -- let me ask you it in this general way -- to rely on: there has been an inquest, it has been quite high-profile, so everybody's heard about it?
A. Could I take you to my answer to question 8 of my first witness statement? I am asked the question:
"What did [I] think about learning from these cases."
My answer is that I felt the learning was on the basis that you needed to do electrolyte testing as often as required and you needed to look at the results and you needed to act on the results. I have a feeling that, if indeed Claire's case was discussed at an audit meeting, that the learning that may well have come out of it after a discussion with all the junior doctors who were there would be to say that that is the important

point. The failure is -- it's a failure to monitor blood levels at the right time and then act on the results. And it would be just the same if the patient had a drop in haemoglobin and it wasn't tested until the patient had a collapse with a haemoglobin of 4. It's exactly the same story that you need to get the doctors to be aware of, that you need to monitor results often and act -- monitor particular criteria often and act on the results.
THE CHAIRMAN: Sorry, when I asked Dr McKaigue about this this morning, about a lesson which might have been heard from any mortality or audit review of Claire's death, and I suggested to him a lesson that might be learned from it, he said that that wasn't any lesson which he remembered and he thinks he would have remembered it. I think you were here and you'll have heard that exchange.
A. Yes. As he was giving that answer, I thought to myself: you would not remember now, at an audit meeting in 1996, that the outcome of a case was that you need to do the blood tests very often. It's a generic --
THE CHAIRMAN: Sorry, this is a more specific point, which is what is, on the evidence, a possible but unusual side effect of encephalitis is that it leads to SIADH and that is the particular reason in that condition that you

don't need just to worry about treating the encephalitis, you also need to keep a particular eye on the sodium level because that can unexpectedly deteriorate very quickly. So this much more than doing blood tests every 24 hours, this is stepping up blood tests in a child who's suspected to have encephalitis because it may not be the encephalitis which really threatens her health or kills her, it might be the SIADH leading on to hyponatraemia, leading to cerebral oedema, leading to death; is that not the lesson?

A. I do accept that, but if you had just by rote done the blood test sooner, then you'd have been on the ball to be picking this up.

THE CHAIRMAN: Okay. Mr Fortune?

MR FORTUNE: Sir, we seem to have ranged far and wide.

THE CHAIRMAN: We do, a bit.

MR FORTUNE: It's very difficult when Mr Walby talks about "clinicians", "most parts of the Trust", as to who he is referring to. Perhaps we could --

THE CHAIRMAN: That's my concern about Mr Walby's suggestion that the lesson would have been picked up from knowledge of the inquest because that strikes me as being questionable, about whether that's really an adequate response in 2006 from a governance perspective.

MR FORTUNE: And also, sir, an expression that's been used,

I think for the first time, that this was a high-profile inquest. Well, even if it was a high-profile inquest, what does that actually mean in terms of people in the hospital getting to know what the facts were?

THE CHAIRMAN: Knowing that it's on as opposed to knowing the detail of it?

MR FORTUNE: Absolutely.

THE CHAIRMAN: Yes, I understand.

Mr Stewart, I'm not sure where I left you some time ago.

MR STEWART: Let's go back to the document I was at, which is the letter 140-062-001. I hope that was the one. No, it wasn't, it was 25 January 2005, 139-135-001.

When you forwarded to the coroner Nichola Rooney's comprehensive reply on behalf of the hospital, did you intend the information contained therein to be given to the coroner on behalf of the hospital?

A. Yes.

Q. This is a case that you knew at that time may have raised a care management problem.

A. Yes.

Q. And by channelling this information to the coroner, which included information from Dr Steen, who might have been one of the clinicians involved in the care management problem, without checking that information,

you were giving information to the coroner on behalf of the hospital as though it was officially the hospital's information.

A. Are you suggesting to me that the reply from Nichola Rooney's wasn't the hospital's ...

THE CHAIRMAN: The reply from Dr Rooney, she is not a medical director. I understand that her position is that she relied at least to some extent in the answers she gave to Mr and Mrs Roberts on information provided to her by Dr Steen and Professor Young, and we know she had some assistance from you. But let's focus for the moment on Dr Steen and Professor Young.

Professor Young had not previously been involved in Claire's case: he didn't know Claire at all, he had never been involved in treating her. Dr Steen was the named consultant and had been involved at least to the extent that she was there on the morning of 23 October when Claire was in intensive care. So if there is an issue about care management, then the fact that Dr Steen has contributed to the consideration of Mr and Mrs Roberts' letter and the response to that letter leaves open the possibility that a person who is making a contribution of substance to the letter sent on behalf of the Royal is a person who's also under some scrutiny herself for her role in Claire's care. And I think

you're being asked: is that satisfactory as a position?

A. I believe it is satisfactory in that the letter stands aside from the clinical notes. It is to be ... There is a disconnect between the medical records, which were created in 1996, and this letter, which is going to the coroner in 2005. I don't think I would have expected there to be any risk of merging of these two in some way.

MR STEWART: It's exactly because of, not just a disconnect but a series of disconnects. Inconsistencies and discrepancies between the medical notes and records and the content of this letter means there's a problem. That's a problem unless it's properly checked and properly investigated. And a version should not be given on behalf of the hospital unless it has been properly investigated.

A. Well, you'll recollect that I'm not the director of this letter to be going to the Roberts. That is a decision that has been made by the Trust to reply to the letter.

THE CHAIRMAN: I have got that point, thank you.

MR FORTUNE: Sir, can I raise one matter in the light of how this question-and-answer part of Mr Walby's evidence is developing?

One matter that seems to be beginning to emerge is whether at this stage, if there was, to use the

expression, something of a disconnect, whether somebody within the Trust -- and here is Mr Walby representing the Trust for these purposes -- should have been asking themselves whether the Trust could represent all the interests or whether there was the beginning of a conflict.

THE CHAIRMAN: It's an issue which you raised in Adam's case as well.

MR FORTUNE: Absolutely because in Adam's case it caused a problem leading up to the inquest and indeed at the inquest.

THE CHAIRMAN: Yes.

MR STEWART: It's something I raised briefly, the possibility, with Professor Young the other day.

Were you alive to that as a possibility?

A. Yes, and I presume we're going to be coming on to talking about the witness statements, all four, and in my letter to each of the four, which I can give you references as we go along for -- who would you like to start with?

THE CHAIRMAN: We'll pick that point up as we come to those letters.

A. Well, I can tell you, I did it to all four. In my first letter to each of the four, I referred to them obtaining their own legal advice.

MR STEWART: Will you permit me to take us through the chain of documents in a chronological fashion so we get there having touched all bases along the way?

The first of the documents is the coroner writing to you, 139-147-001. It's 21 December 2004:

"Dear Peter, please advise me if you would be able to obtain for me statements from Dr David Webb, Dr Heather Steen, Dr Sands and Professor Ian Young? If you are not, please let me know and I would write to each direct."

That gives you your basic instructions to go and chase these people down and obtain statements. And at that time, you had, as I understand it, a witness statement protocol that had been circulated in 2002, dealing with the issue of obtaining statements from witnesses. That's available at 133-003-003.

A. That's correct.

Q. Presumably that was what guided you in this operation.

A. Yes. If you look at that document and marry it up to any one of the four witness statement requests, you'll see the various features of that protocol being reflected in my letter.

Q. Yes. With one or two minor variations, yes. Some of them aren't dated and perhaps one could quibble about whether or not each witness decides on the content of

their witness statement themselves, but yes. Can we look at 129-007-001? It's from the coroner to Dr Michael McBride and it's about the investigation of hospital deaths:

"Last autumn, a senior detective expressed concern to me about the present limited role of the police in the investigation of hospital deaths. In particular, concern was expressed at the system that has been in operation for a number of years whereby the medical director or clinical director of the hospital will arrange to obtain statements from staff involved and forward them to me without the statement makers having been interviewed by a police officer. In many instances, the individual concerned had consulted their legal adviser prior to making a statement and the legal adviser had input into how it was drafted. It was put to me that this approach did not constitute 'best practice' as the police should interview those concerned as soon after the event as possible and, where necessary, seize medical notes, any relevant equipment and, if the circumstances of the death warranted it, treat an area of the hospital as a potential crime scene. I agreed that in future, I would agree to a police officer interviewing those involved. The present system would be discontinued."

I appreciate that that is a letter and not a formal protocol, but it seems to express a view as to what best practice might be.

A. I agree, and ... You extracted this correspondence from one of the Brangam Bagnall files?

Q. Yes.

A. When it was brought to my attention and there was concern that I had left things in the air because I hadn't taken it to its final conclusion with the Trust solicitors at the time ... But in actual fact, it came away from the legal aspect and was dealt with directly between the medical director and the coroner and the Department of Health. I produced a lot of other correspondence, which -- senior counsel for the Trust gave details of in an e-mail he provided to senior counsel to the inquiry, which gave the paper trail as to how indeed it wasn't that I did nothing. I followed things along and although I wasn't involved in it, I was disappointed to discover that the memorandum of understanding which was developed, which it seemed to have been thought at the outset was going to deal with how hospital deaths are investigated, really only dealt with the complex situation where the health and safety executive, the police, the coroner and the Trust need to form a system for these organisations all to interact.

It left out completely how a simple, straightforward death should be dealt with between the hospital and the coroner. And you have that correspondence.

Q. Yes, we have that correspondence. Did you at any time revert to the coroner, with whom you had very regular contact, to ask him what he would like you to do in relation to this communication of best practice?

A. Well, when I received this, I thought to myself: I'm not going to hear from the coroner any more. The consequential effect of him putting this letter into operation was that I would cease to get requests from the coroner's office to collect witness statements. When a death occurred that was reported to the coroner, the coroner would report it to the police, the police would get an investigating officer appointed, and this investigating officer would start dealing with the case, assuming it was a murder, and he would downgrade it in the various levels of police investigation as quickly as they could, and that would be the way it would be handled. And that would involve my office ceasing communication with the coroner.

THE CHAIRMAN: So that you would not again receive a letter from the coroner, asking you if you could help to get statements from Dr Webb, Dr Steen and so on?

A. That's right.

THE CHAIRMAN: That would be the logical follow up to this letter of 30 January 2004.

A. Yes. And actually, I thought there'll be a bit of a tail-off. There are some letters in the post -- it'll go on for a week or two, but it's going to stop. Nothing changed.

THE CHAIRMAN: Okay.

MR FORTUNE: Sir, that seems to be the effect of the letter at 129-004-001, when Gary Daly for Brangam Bagnall wrote to Mr Walby by a letter of 14 March 2005. That seems to be the last letter in that chain of correspondence. Certainly, it's the last letter I've seen.

MR STEWART: There is a further one at 129-003-001 where Mr Walby responds to Gary Daly to say:

"This matter remains in abeyance and, as you know, we still operate the old system."

MR FORTUNE: 003?

MR STEWART: 129-003-001.

MR FORTUNE: I've not got that copied in my file.

A. May I say, that is where the inquiry -- as I said in the start of my answer to this -- the Trust solicitors dropped out of this matter. It was taken up by the medical director with the coroner and the department, so the Trust solicitors weren't required. That's why the Brangam Bagnall file ends there. You say you do have

the correspondence. Do you have the e-mail from my secretary of 3 November to Dr McBride?

THE CHAIRMAN: 3 November?

A. 3 November 2005.

THE CHAIRMAN: If it's a short document, would you read it out for us?

A. The memorandum of understanding has been issued and it says:

"I would have no issue with this. The Health and Safety Executive (Northern Ireland) have clearly taken control of this and most of it is not relevant to us. The issue of how the police manage things once the coroner decides to get involved in a straightforward hospital death gets no mention and that was what started this off, you'll remember, from our perspective."

The medical director then e-mails the Chief Medical Officer in giving a comprehensive response to the memorandum of understanding, and that is a letter from the medical director to Dr Ian Carson on 4 November 2005. He makes a large number of points in the letter, but the penultimate paragraph says:

"On a final note, the memorandum makes no reference to the manner in which the police service will manage processes once the coroner becomes involved in a straightforward hospital death. I would suggest that

more specific guidance with regard to such processes would be helpful."

So my point gets taken to the medical director, gets taken to the deputy Chief Medical Officer.

MR STEWART: Yes, but the point remains that you took statements from the witnesses in this case before that memorandum came into existence and you received a note of the coroner's view of what might amount to best practice and you did not revert to him for advice as to how you should implement it.

A. That's correct.

Q. And that is notwithstanding your general duty to the coroner. It's also notwithstanding what is described as your main duty in your job description:

"Assisting the coroner in the preparation of statements."

A. Yes. So my method of assisting him --

Q. Was to ignore his letter.

A. -- would have been to stop co-operating with him --

MR McALINDEN: Just in relation to that, perhaps Mr Walby could be asked: the letter that has been referred to, if after that letter had been sent by the coroner to the Trust, did the coroner persist in sending written requests for statements?

THE CHAIRMAN: I agree. I think the problem here is that

there is some confusion and uncertainty caused by the fact that the coroner has written to say: I want to move away from the old system because the police have suggested to me that it is unsatisfactory, and he did not then move away from the old system, at least in some areas, and Claire's case is an example of one in which, if you relied on what the coroner had written to Dr McBride on 30 January 2004, he would not have been coming back to you a couple of years later, asking you if you can help to get witness statements from various people. That letter would have gone to the police, saying: please obtain witness statements from the following four doctors.

A. Yes.

THE CHAIRMAN: Okay. It's a bit unsatisfactory, it's not what the coroner said he wanted to do, it's not what the police said that they wanted the coroner to do, but it's what happened.

A. But attached to that letter was Mr Leckey's letter to the Chief Constable, dated 22 September 2003.

THE CHAIRMAN: Right.

A. And you'll remember that Mr Leckey is writing to Mr Orde, saying that what was being suggested -- there are a number of reasons:

"I think it is fair to say that investigating

a hospital death may well prove more difficult than the investigation of many other categories of deaths. There a number of reasons for this: identifying all the medical staff involved, locating them and taking their statements, a difficulty in comprehending medical procedures and medical language."

And then:

"In the past, a number of police officers have stated that they meet with obstruction when attempting to take statements from medical staff and some feel intimidated by having to approach medical consultants."

But I must say that I take number 4 -- I would hope the member of medical staff would be arrested if he obstructed a police officer. So I think that one is a bit light, but the others --

THE CHAIRMAN: It's a different -- it depends on what ... Obstruction can be active obstruction or a degree of lack of helpfulness. In any event, thank you, Mr Walby.

Let's move on from this point. I've got the point that the procedure which was followed for Claire's inquest isn't what the coroner had indicated two years earlier it would be.

MR STEWART: I know, Mr Walby, that you'd like to go through the process by which you did take the statements from the various witnesses. There's Dr Sands and

Professor Young, Dr Steen and Dr Webb.

A. Yes.

Q. Which order shall we deal with them? Do you want to deal with them all?

A. I think the best thing is to deal with them in chronological order, and that's Dr Steen.

THE CHAIRMAN: Mr Walby, I'm not going to stop you doing this at all. I already have a specific example which was raised with Dr Webb about his statement, and I think if we can take a few of them as examples and then decide whether I need to go through every single one. I'm not going to cut you off if you think it's important for you to go through every single one, but let's take a few as examples because I suspect that your examples will illustrate the point which you want to make to the inquiry.

A. I would like to go through enough of them that the inquiry is reassured that the process that I was undertaking, I could stand over it. Then and today.

THE CHAIRMAN: I'm not going to cut you off from doing that. Similarly, I'm not going to cut off the Trust representatives or the family representatives or anyone else from asking any further questions. You were going to suggest starting with Dr Steen.

MR STEWART: Could I, sir, suggest Dr Webb because we have

already covered some of this territory. You read the transcript and produced a separate witness statement request in relation to some of the evidence given.

A. Let's do that. Could I say one thing beforehand? I felt that it was very important that witnesses should have access to the original hospital notes when making their statements.

Q. Yes.

A. That's because, as a practising clinician, I was well aware that I would come into the ward, look at the notes, and find a circumstance like you had with Dr Volprecht, where there are blood results written in and you mightn't be sure who wrote it in. Therefore, the colour of the ink and the type of handwriting -- and you could often tell that they were two different people from looking at the originals. The trouble with photocopying the note is that you lose all this. Let's just take Dr Webb.

Dr Webb wrote in green ink. He was unique. He wrote in green ink, but unless he looked at the originals, you wouldn't realise that. He wrote in Adam Strain's notes in green ink. He writes in Claire Roberts' in green ink. But when you go to his first note that he makes when he sees Claire, he writes the note in green ink, but the "4 pm" is in blue ink.

That immediately begs the question as to was it written by the same person, did he change his pens? But when you only have a photocopy that you send to Dr Webb, which is of course what happens because you might ask me: why didn't I photocopy four sets of photocopies and send them to the four clinicians on the first day? The day I wrote to Dr Steen, why didn't I send copies? It's because I know that it takes each individual when they're making their own witness statement to look at -- focus in on their part and they will want to see ... I'm sure it would have been of interest to Dr Webb to realise that that time was written in a different coloured ink. He may have a good explanation for it, but unfortunately, I wasn't going to pick up the significance of this.

So although the other three got their notes to make their witness statement, Dr Webb had photocopies, which was sent to Dublin.

Q. And there was no such thing as a colour photocopier at that time in the Royal, was there?

A. There are colour photocopiers. I'm not aware of the inquiry having been using photocopies --

Q. I wish we had.

A. And so I must apologise because I was very much part of the process by which the inquiry obtained Adam Strain's

notes at the end of 2004/2005. Apart from the colour, different coloured inks, laboratory reports have got different colours: haematology uses pink, radiology uses green, and you would now know that text merged into the background when they were photocopied. Therefore, it caused the inquiry a lot of difficulty and I apologise for that. But it would have taken an expert to look at the tone that I set the photocopier on every page as they did it and --

THE CHAIRMAN: I understand. Don't worry.

A. So it's very difficult. Let's go on to Dr Webb.

MR STEWART: The trail starts at 139-124-004 when you write to Dr Webb asking him for the statement:

"I should be grateful if you would provide a draft statement outlining your part in the care of the late Claire Roberts."

And you say:

"Your statement should commence with 'I am a registered medical practitioner ..."

And you go on to give the formal warning, I think, that:

"This is a legally significant statement and you may wish to consult your professional body or legal adviser before submitting your draft to this office. A booklet explaining the function of the coroner is available.

Thank you."

You were still operating the old system whereby individuals were advised to go to their professional body or legal adviser.

Then Dr Webb returns to you on 16 May at 139-112-001:

"I received your letters 22 March and 30 April."

Presumably you sent a reminder on 30 April regarding Claire Roberts:

"I have produced my report and have sent this to the MDU --

Is that the Medical Defence Union?

A. Yes.

Q. "-- for their comments. As soon as I hear back from them, I will forward my report to yourself at the Royal Belfast Hospital."

And you have noted "noted".

Moving on to 139-098-001. David Webb writes again on 16 June to enclose his report for the coroner on Claire Roberts:

"I hope this is in order. I will be away until 10 July."

139-098-002 is in fact the statement, I think, that he forwarded to you; is that correct?

A. It is.

Q. It's quite a lengthy document for a statement. And you have gone through this, through the succeeding pages, correcting typographical errors, making very minor spelling suggestions and so forth. Until you come to the one with which we are principally interested, which is many pages further on at 139-098-021.

There, Dr Webb had written:

"I made the mistake of not seeking an intensive care placement for Claire before I left the hospital."

And you have put a line through that and written in: "Although I did not seek ..."

It seems as though Dr Webb was making an acceptance or an admission of error there and you thought that was inappropriate and decided to excise it. Can you explain why that was?

A. Well, "decided to excise it" is not the way I would put it. You've got my witness statement number 3.

Q. Yes.

A. And to save the inquiry's time, would you like me to amplify any parts of it rather than starting from scratch?

Q. Please?

THE CHAIRMAN: WS176/3, page 2. (Pause). Do you have it to hand yourself?

A. Yes.

THE CHAIRMAN: Okay.
A. My belief was and still is that a witness statement for the coroner should be a factual statement and should not contain opinion or comment.
MR STEWART: Can I ask where that derives from? On what basis do you understand that a witness statement should not contain comment or opinion?
A. I can't quote you chapter and verse, but I understand that that indeed is what's supposed to occur.
Q. Does that mean that an individual cannot accept error?
A. It doesn't mean that an individual cannot accept error, but in the position of an inquest I have listened to the opening of many inquests by Mr Brian Sherrard, one of the Belfast City coroners, and he always opens it with how the purpose of an inquest is to determine who the person was, where they died and how they died, it's not to apportion blame, and if that's what's being looked for, it's not going to be obtained in his court. I am conscious that witnesses who are being required to provide statements to the coroner are providing factual information to allow the coroner to make whatever decision he wishes to make.
Q. But you'll also be aware, having sat through many inquests, that in determining the cause of death, many separate opinions are advanced.

A. Yes, I accept that.
Q. Would you also accept that if opinion comment is excluded from a witness statement, it means, for example, that a whistle-blower would be precluded from making comment? That can hardly be the purpose of the system.
A. Well, if you take this example, if I was wanting this subject not to be raised, would I not have suggested expunging this sentence and saying, "We're not going to go there"? I wanted the subject to be live, to remain alive in Dr Webb's witness statement, but that it should -- I felt that he was being overly harsh with himself. And here, I have to admit that I was using my extensive clinical knowledge and I was able to appraise him of why I thought use of the word "mistake" was really quite inappropriate here. And you see my long explanation --
Q. Can I stop you there? There are a number of things you said there. First of all, you said you did not want to stifle the debate. I'm not quite sure how you phrased it. But if you actually exclude the reference to the mistake in not referring to intensive care, don't you remove from the agenda the very possibility of a debate or reduce the possibility of a debate that it might have been a mistake?

A. No.
Q. You think not?
A. No.
Q. Okay. Secondly, do you think it appropriate that you, as litigation management officer, try to use your general medical knowledge to sway clinicians who were involved in a particular case?
A. In this particular circumstance, I did feel that. I mean, as you'll have read, I had a position in which I ... Somewhat analogous, frequently -- whereas it had only happened to Dr Webb once in Allen Ward, comes along as a visiting clinician and has a child in the ward who ... There has to be an issue, could they have been in intensive care or not? I had that in my clinical -- I was a practising ENT surgeon, my on-call commitments were to the Children's Hospital and the regional service in Northern Ireland, to provide airway management for paediatric airway emergencies. Therefore, during the winter months, children with croup and epiglottitis would be admitted and they tended to go to Allen Ward. And I had many a child in the four-bedded bay that Claire was in. They would be put in a steam tent, they would be stridorous, and they would be given antibiotics and steroids and I would sit by the bedside for a long period of time and to see was the child going to start

breathe more easily or was the airway going to cause trouble and the patient would then need to be intensive care, me having taken him to theatre on the way there. It's in my statement. That's why I know that because the intensive care bay only has four beds and two HDU beds, that obtaining placement of an intensive care for Claire just would not have been --
Q. It doesn't say that. It says:
"[He] made a mistake seeking [not obtaining, seeking]."
It's a slightly different thing. There are two points from what you just said. First of all, the winter months. This was October, not the middle of the flu season in January or February.
A. Oh, by October you're getting admissions to the intensive care unit, it starts to be full of children.
Q. Did you in fact check up on the occupancy figures for PICU on that night before you actually gave your advices to Dr Webb?
A. No. But my point is that seeking placement of a child who doesn't need airway protection -- we now have a paediatric intensive care which has 12 beds in it. The population of Northern Ireland hasn't increased three times. They're not all funded, but the fact is you do now, with relative ease, get a child like Claire

into an intensive care unit bed. But in 1996, for Claire to be moved to intensive care unit at a stage when she didn't need airway protection, there's every likelihood that an acute emergency will have come in during the night and Claire could have been displaced out of intensive care, without having had any airway preservation.

So all I can say is that I spoke to Dr Webb and took him through that scenario and I said, "You're being very harsh on yourself here", as clinicians and nurses tend to be on themselves when things go wrong. And I felt it was appropriate for me to point out to this doctor. But it's his -- and, as I've said at the bottom of this statement, I absolutely would say to every witness that I was advising about the witness statement, it was their witness statement and theirs alone. They had to sign it. And we will come on to Dr Sands', which will demonstrate -- in fact, I can hardly think of a case file that wouldn't be a better example of the way I tried to do my job. And you'll see that in Dr Sands'.

Q. We'll follow that up. We might have a short break first, but we'll certainly follow it up. Dr Webb has told this inquiry that he still believes that he made a mistake in not seeking a placement for Claire that afternoon in PICU. In other words, he was trying in his

statement to be transparent and honest, and you were trying to stop that information getting through and to shield the Trust from any criticism, even self-criticism.

A. Well, I wouldn't accept that.

Q. All right. Very well. The trail continues at 139-100-001. This is just for the sake of completeness. This is the steps by which the statement then came back up. Your office rings Dr Webb to ask him to e-mail the statement up. His secretary has said they are not allowed to do that because of patient details:

"Even though I pointed out Claire was our patient."

She needed to check with Dr Webb, and then it goes on to a page of scribbles at 139-099-001.

A. The is vital page of scribbles. Could we show that, please? Here we are, 28 July 2005. He phones up to have a conversation with my secretary about putting his statement in e-mail form. And as you see I've mentioned, I was concerned about some embarrassment to Dr Webb if he referred to "Dr Stein" throughout his witness statement. So that in fact was a major reason why we needed to have it redrafted. So I'm in the office at the time that Dr Webb and my secretary have a telephone conversation and I'm asked, do I want to speak to him, and I did want to speak to him, and I went

through what I've just been through with you, and I followed it up with a letter, you'll see then, which is dated --

Q. There's no note there by your secretary of any telephone conversation between you and Dr Webb, is there?

A. There isn't. But that's what happened.

Q. So we move on then, I think, 28 July, to 139-097-001.

A. And I think I explained that, that the reason that -- I'm pretty good on making file notes about what happens, as you'll have discovered from this file. But the particular circumstance was that the telephone call was taken -- the secretary's office is several rooms away. Therefore, I suspect that the telephone call was transferred down to my office after my secretary had got the administrative details of his e-mail address, and I then had a conversation with him without the file being in my hands. But the letter that goes to him --

THE CHAIRMAN: 139-096-001, dated 31 July.

A. Yes. If you just read that letter, you might not be aware that it had arisen out of a telephone conversation because it is really making clear that the change that we have made in an e-mail version that it doesn't slip through the net. His witness statement, as you know, was a very long witness statement, and Dr Webb's manner of dealing with correspondence, you'll have become aware

that it's ... He doesn't deal with correspondence the way I deal correspondence. Let's put it just like that.

THE CHAIRMAN: Okay.

A. So I wanted to be jolly sure that he didn't print off a copy of his long statement and sign it and send it back to Walby. I needed to make sure that he took on board that our conversation had meant that he was happy that the use of the word "mistake" was not appropriate in a coroner's witness statement. And I would have expected him to return to his defence organisation again and say," What do you think of this?". I don't know whether he did and it wasn't for me to prompt him further.

MR STEWART: Yes. A couple of questions here. You say in the second paragraph:

"Statements are usually first-hand accounts of your own actions leaving others to fill in their proportion of the patient management. But in this case, I felt your more comprehensive style of statement is appropriate in this particular case."

So you would say that normally you wouldn't have comment and opinion, but in this case your comprehensive style of statement is appropriate; is that what you meant?

A. Well, Dr Steen also took that route of providing a very

long witness statement. That was the way -- I certainly wouldn't have tried to constrain somebody in terms of the length of their statement.

THE CHAIRMAN: It makes it a bit harder to understand how, given the length of statements they've provided, that some issues were still missed at the inquest. If Dr Webb goes to the trouble of providing a longer than usual witness statement and Dr Steen goes to the trouble of providing a longer than usual witness statement, and in doing so they scrutinise the notes and records, because that is the basis for doing it, it does make it rather difficult to understand how things were still missed.

A. Could I put an almost contrary view?

THE CHAIRMAN: Go on.

A. If Dr Steen had provided a witness statement which took up matters at 3 am and went from there onwards, I think what would have happened would have been that the coroner would have asked for statements from other members of staff and he wouldn't have maybe gone by name, but I think that what would have happened would be that I would have written to Dr Stevenson, Dr Roger Stevenson, and I think that if Dr Roger Stevenson at that time had been asked to make a witness statement, he would have spotted within the hour, as Professor Young

referred to, that he had made major mistakes in his drug calculations. And I think he would have gone to his defence organisation and said, "Will you look after me while we prepare statements?". I think his statement probably would then, Dr Stevenson's, would not have come through the Trust because those were major drug errors, which I think he and his defence organisation would have considered would have been important that they're reported in a correct way.

THE CHAIRMAN: But that's curious because, to use Professor Young's term, if you expected Dr Stevenson to spot the wrong drug administration within the hour, how would you not expect Dr Webb to spot the wrong drug administration within the hour because he was the doctor who had decided which drugs were to be given, and he's also the doctor who Dr Stevenson depended on for advising him of what the rate of administration should be?

A. Well, it is curious, but there's no doubt that it concentrates the mind if you're being asked to comment on your own actions. And Dr Webb, in the same way, if he had only concentrated in his witness statement on his own actions, it would have meant that we maybe would have ended up with a broader range of statements, and I feel if Dr Stevenson -- because Dr Stevenson's entries

are not very many.

THE CHAIRMAN: You see, I don't understand how Dr Stevenson would pick up on the wrong drug administrations because he was a very junior house officer in paediatrics, he didn't know what the administration should be. The person to pick up on the wrong drug administration is the prescribing doctor.

A. Well, he would pick up on the calculations.

THE CHAIRMAN: Yes, that's one element. There are two different issues. One is the wrong calculation of the phenytoin. The other issue is the wrong -- not the wrong calculation of midazolam, but the wrong administration of midazolam.

A. Yes. I think that would have opened up in that if a witness statement went in from Dr Stevenson that just dealt with the error in the dosage, that would have opened up the -- the coroner would have got an independent report from a clinical pharmacologist and it would have taken a different route. But the fact is you sir, needed to get 28 witness statements from witnesses across the world on this, and therefore, in hindsight, I now see what would have got to the nub of it much quicker. But it is with hindsight now and I was acting on the instructions of the coroner, who asked for four witness statements, and at the end of the day received

four and wrote back to me saying, "I don't need any more".

MR FORTUNE: Sir, I'm reluctant to enter this debate and I'm certainly reluctant to give evidence. The procedure for obtaining statements depends very much on individual coroners because some coroners, in my experience, want a report from a consultant as to his or her hands-on care, not a report saying, "And this is what happened", referring to many other hands. I cannot speak for Mr Leckey, but certainly the practice does vary from coroner to coroner.

THE CHAIRMAN: Thank you very much. Mr Stewart, is there anything further on this letter or not?

MR STEWART: Just a couple of points, which will only take a moment.

Why was it that you wanted to redraft onto a police witness pre-printed pro forma statement page?

A. Well, if I take you to the document that you had up before, 133-003-003, number 5 asks that the final version of the statement must then be presented in standard format for signature by the witness. So that is where I believe it comes from. All I can say is that when I started doing this work in 1999, witness statements were being made out by this system and they were being put on to these forms and there was a police

constable from Grosvenor Road Police Station -- and it was the same police officer over a number of years, so it's not as if it changed -- it was a duty of his to call into the Royal every 10 days or so and collect the bunch of witness statements that we had collected in all the various cases. And I have to say, I had on average 65 cases a year that I was collecting witness statements for. So there were quite a number of witness statements being collected. So this police officer was collecting these witness statements and taking them away and he had obviously some method of processing them in order that they get to the coroner's office.

Q. And he didn't complain to you?

A. No.

Q. The coroner normally put those statements and redrafted them on to separate paper, which was the coroner's own paper. Dr Webb's accepting all other statements went on to that coroner's paper. That seems to be the standard paper. Why didn't you get hold of some of that?

A. Well, what happened was that I started to get complaints from the coroner that I was lagging behind in providing the witness statements, which he'd requested months ago. When I would go to the file, I would find a photocopy of the witness statement and a note that it had been collected by the Grosvenor Road police, and therefore

there was an issue as to where these statements were going. And on some occasions, they were found and then on occasions they couldn't be found. This could be very unfortunate because the doctor by that stage is likely to have moved to Australia in a registrar training year, the coroner requires a signed -- an original, signed witness statement, and therefore these witness statements being produced in this standard format were able to be e-mailed again to the witness, wherever they were, and they could print it off and sign a version, sign it, and then send it back to us when they were lost.

So this was the method that made collecting witness statements for the coroner easily doable in the time frame that was required. I am not aware of the coroner ever having said that he didn't like this standard format. The standard format, which is referred to in this document, I had assumed was the standard format that he was happy with.

MR STEWART: I see. That's very helpful. Thank you.

THE CHAIRMAN: Okay. We'll take a break for 10 minutes for the stenographer and resume at 3.45. Thank you very much.

(3.35 pm)

(A short break)

(3.55 pm)

THE CHAIRMAN: I think you're going to move on from Dr Webb now.

MR STEWART: Yes --

A. May I just make one short point?

THE CHAIRMAN: Please do, and then I have a point I want to ask you about.

A. My third witness statement, the fourth paragraph, which we didn't touch upon, but I wanted to just say that I wasn't working in a vacuum, and therefore I'm just going to read:

"When Dr Webb made his witness statement in 2005, I had been dealing with Trust witness statements for six years. Many had been sent to the Trust's solicitors for approval, and I had become aware that the type of comment that Dr Webb was making could expect to be queried if legal advice was obtained."

And I hadn't made that point earlier.

THE CHAIRMAN: Thank you. Let me ask you about my point. It's not specifically about the statement, but it's about Dr Webb, because we received a document yesterday, which is 139-166-001 going into 002. This was the letter which was one of the ones for which privilege was waived yesterday by the Trust. It's to you from Mr Daly of Brangam Bagnall.

A. Yes.

THE CHAIRMAN: The point I am interested in particular is on the second page on the right-hand side. If you go to the two-line paragraph:

"Dr Webb is also of the view that the family were fully aware of the extent of Claire's illness."

How do you read that? What do you think that Mr Daly was telling you about Dr Webb's view of what Mr and Mrs Roberts understood?

A. Well, I have listened to the views of the doctors and nurses who seem to have thought that Claire was ill, and he doesn't really say at what stage he and Dr Webb ... Was she seriously ill, does he mean, or she was moderately ill? Because it ... He must be surely only referring to the period between lunchtime and 5 pm. He can't be referring -- because he would have no knowledge after 5 pm because he'd left the hospital.

THE CHAIRMAN: Yes, but the reason that he left the hospital at the time when he did and the fact that he left the hospital at all was because he thought that Claire, while ill, was going to recover. That was his evidence. His evidence was that's what he expected to happen. In fact, his note said:

"CT scan in the morning if she doesn't wake up."

Also, beyond that, if he thought she was going to

deteriorate in the devastating way that she did, he would not have left.

Mr and Mrs Roberts, as you know from following this segment of the inquiry, were also of the view that while Claire was ill, there was no threat to her life. So when Mr Daly writes to you and says:

"The family were fully aware of the extent of Claire's illness."

It's a curious way of describing Mr and Mrs Roberts being fully aware that Claire was ill, but likely to recover. First of all, do you agree with that?

A. Yes. But the issue is that a diagnosis of viral encephalitis is a devastating diagnosis to be made if it was your child. Because I have medical knowledge, maybe I take it seriously, but there may be mild viral encephalitis and major, serious ones, and so Dr Webb, I suppose, in the range of work that he does, will have known that a possible viral encephalitis diagnosis is serious, as indeed must be the status epilepticus.

THE CHAIRMAN: You see, the trouble, and I'm sure you're ahead of me on this, is this: two of the indicators that Claire was not expected to die were, firstly, that Dr Webb left the hospital at about 5 or 6 o'clock on the Tuesday evening in the expectation that she was going to recover and, secondly, Mr and Mrs Roberts then left the

hospital with their sons at 9 o'clock that night with the same expectation. Dr Webb has said: if I thought that she was at real risk of deteriorating and dying in the way she did, I would not have left. And I accept that from Dr Webb. He doesn't look to me to be the sort of guy who just clears off home because he wants to see something on television. He looks to me to be the sort of doctor who will stay around if he thinks that there is a real risk that one of his patients is going to deteriorate and die.

A. Yes.

THE CHAIRMAN: Similarly, Mr and Mrs Roberts, having kept at their daughter's bedside with their in-laws and between each other and their sons all day, are highly unlikely to have left at 9 o'clock that night if anybody had indicated to them that Claire was at risk of dying. Right? So when Dr Webb is reported by Mr Daly as saying in this note that:

"The family were fully aware of the extent of the deceased's illness."

It seems to me that it must mean that they were aware of the illness to the extent that she was likely to recover because that was Dr Webb's view when he left the Royal on the Tuesday evening and it was the Roberts' view when they left the Royal, and I'm wondering how

that sits with the description given by Mr Daly. I'm asking you because --

A. Of course --

THE CHAIRMAN: You weren't there [OVERSPEAKING] but this letter went to you.

A. It did.

THE CHAIRMAN: When you read this letter or when you read it now, does it not look to you as if Dr Webb is saying immediately before the inquest that the family knew very well that Claire was very gravely ill and that her life was at risk?

A. You would take that out of that.

THE CHAIRMAN: You would? But isn't it curious that that's not what Dr Webb has said to the inquiry and isn't it curious that that's not what Mr and Mrs Roberts were given to understand?

A. You would need to remind me ... Would I have been fully aware of ... This didn't just come out at the inquest in Mr and Mrs Roberts' statements, it would have been in their earlier letters and meetings with the clinicians in 2004.

THE CHAIRMAN: I think, if it wasn't spelt out, it was implicit. I can't say off the top of my head that it was spelt out, but I'm sure it was implicit in their queries.

A. The difficulty is, it would have been nice if Mr Daly had written another sentence to -- it almost could be read either way, that the extent of the deceased's illness was not too great. Just using the word "extent" --

THE CHAIRMAN: The problem is if they were fully aware that the extent of Claire's illness wasn't very great, then that doesn't make sense because the extent of her illness was so great that she died overnight.

A. Yes.

THE CHAIRMAN: I understand why you're trying to make some sense of this, but that suggestion doesn't really fit. Anyway, it might be -- I'm raising it with you because this was a letter to you. I understand that you were not part of any discussion or part of that discussion between Dr Webb and Mr Daly and what I just have to consider at the moment is whether I need to recall Dr Webb on that issue. But we'll leave it.

Mr McAlinden?

MR McALINDEN: You do have the consultation note, which I presume preceded that letter. That's at 140-046-001. You'll see that the consultation note doesn't make any reference to this particular issue.

THE CHAIRMAN: Yes. That's one of the consultation notes with Dr Webb, isn't that right?

MR McALINDEN: Yes.
THE CHAIRMAN: There's a second consultation note when Dr Webb was present with others.
MR McALINDEN: That was the morning of the inquest hearing, which would have been the 25th.
THE CHAIRMAN: That post-dates the letter.
MR McALINDEN: Yes.
THE CHAIRMAN: So it cannot be that.
MR McALINDEN: This is the only documentation that would seem to pre-date this letter.
THE CHAIRMAN: Thank you very much. I'm not sure we can pursue it much further at the moment. It's a bit of a loose end. We'll see how to tidy it up. Thank you.
Mr Stewart.
MR STEWART: Thank you, sir.
Mr Walby, you said you'd like to go through the process of obtaining the statement from Dr Sands. I think you said that you'd like to highlight issues in relation to that procedure.
A. Yes, please.
Q. I have put together a series of the documents which constitute the trail. There may be one or two pieces missing and you've got the pieces. We'll work through it together.
A. Yes.

Q. 139-124-002. Your request on 14 March to Dr Sands to provide a draft statement outlining his part in the care of Claire Roberts. It otherwise proceeds in identical terms to that letter that you sent to Dr Webb.
A. Yes.
Q. I think, some time later, it occurs to you that nothing has come back from Dr Sands because at 139-108-001, a reminder goes to your office. There has been an intervening reminder:
"I look forward to receiving your statement outlining your part ..."
5 June. Then there is a message from you to Andrew Sands on 7 June at 139-106-001 and accompanied by the draft statement at 139-103-005, if that could be placed beside it. That's the first page of it. 7 June, you write:
"Andrew, I have combined your first two sentences into one with which I hope you will agree."
So you have made a suggestion that the initial paragraph of, "I am a registered medical practitioner", be joined on to the second paragraph with --
A. Well, the issue was I felt it was inappropriate for Dr Sands to be standing up at the inquest and starting:
"Concerning the case of Claire Roberts deceased."
That seemed to me an inappropriate way, so I jiggled

around and said:
"May I first express my sympathy with Claire Roberts' parents and wider family."
It was just an example of how Dr Sands had never attended an inquest and wasn't really aware that he would be standing up and being asked to read his statement. And it was purely a format issue.
Q. Yes. Then your e-mail continues:
"Regarding your comments at the end of paragraph 3:
'This was standard fluid therapy at that time. Although I did not prescribe the fluids, I was not aware of contraindication to their use in this type of situation.'"
If we go across to paragraph 3, at the very bottom:
"This was standard fluid therapy at the time, yes, although I did not prescribe the fluids, I was not aware of a contraindication to their use in this type of situation."
A. Yes.
Q. So you're referring to this, regarding your comments:
"Could I suggest we leave this out? The issue of what was and is fluid practice remains under debate and 0.18 N-saline remains 'standard fluid therapy' when monitored adequately. I think that the fact that you did not prescribe the fluids is alluded to in the

previous sentence of your statement. The issue of contraindication remains debatable and you're probably not saying that if you had been the prescribing doctor you would not have used such fluid. All in all, it sounds very defensive and at this stage, if you leave comments out, it's probably better."
That seemed to me to be you suggesting quite clearly that he amend his statement provided to take out a bit on the basis you don't like the way it sounds because it is a bit defensive.
A. He's being defensive, that's what I am saying. These fluids were prescribed, but they weren't prescribed by me, they were prescribed by Dr O'Hare, in parenthesis, the night before. I thought that that really was -- that that was sounding like him defending himself against something he hadn't been charged with and that it should be left out.
Q. But it's still nonetheless a validly-made comment of his knowledge at the time and not irrelevant to the issue being described.
A. Well, again, this falls into the realms of comment in a first-hand witness statement.
Q. No, with respect, it's what he knew.
A. Well, he's fleshing it out further than I thought he needed to. To me, it made it sound as if he was

defending himself over the prescription of the fluids, which, as we have heard others say, was perfectly acceptable by many from the night of 11 pm on the night of the 21st onwards.

Q. I mean, let's suppose that he thought that was relevant and obviously he did think it was relevant, otherwise he wouldn't have said it in the first place, and --

A. That's the point, he didn't say it in the first place.

Q. Well, he did. He said this was standard fluid therapy at the time --

A. No. But he didn't say that in his -- if you look at my note, I then talked to him the following day and he's -- we were discussing his witness statement. And he said he was happy with my change to the first sentence. His defence organisation inserted the two sentences I referred to and he was going back to them.

Q. Thank you. There it is, you're absolutely right:

"Happy with the change to the first sentence."

In paragraph 2:

"His defence organisation inserted the two sentences I referred to and he ..."

A. And he is going to back to them.

Q. Thank you.

A. That reinforced my view that I had been right, that these were defensive sentences put in by his defence

organisation. And he went back to them.

Q. Yes. I can see that you think and can say that shows that I have a good nose for that type of slightly jarring comment, but the point remains whether or whether not you should have suggested that it be taken out, whether that was truly your correct response if you were assisting the coroner.

A. If you go on to the final version of his statement, he does go back to his defence --

Q. Can we, before we get to the final version, go through the steps that take us there?

A. Yes.

Q. The next step is indeed that he comes back to you at 139-103-001. This is from Andrew to you, 4 July:

"Please find attached modified draft statement, which has been approved by MPS."

The Medical Protection Society. So after your discussion, I take it he then goes back to them. Do they allow him to retain it or do they consent to its omission?

A. They leave the first sentence and take out the second.

Q. So it's taken out?

A. So it makes the point that I make suggestions and I only do it once. You don't find a follow-up e-mail from me, saying: hey, you have only taken out the second

sentence, I want the first one out. I made my comment, he went back to his defence organisation and I don't know anything about that conversation, but it ended up with a witness statement which had the first sentence in and the second sentence out, and that's what then went to the coroner without further discussion.

Q. Yes. We can find that coming back to you at 139-103-002. And there's it the third paragraph, which ends:

"This was standard fluid therapy at that time."

With the final sentence there deleted.

The next step after that is you transcribe that on to the police witness paper and you send it off to the coroner. That is under cover of letter 139-101-001. Here we are.

A. Yes.

Q. And it is to Mr Leckey:

"Dear John, I refer to previous correspondence regarding the above named and now enclose an original signed statement obtained from Andrew Sands."

And you send him then the police statement, or a statement that looks as though it's from the police.

What we've described so far is the production of a statement which was written by Dr Sands and it was amended by the Medical Protection Society, then it was

modified by the litigation management office, then it's approved by the Medical Protection Society, and then it's transcribed by you on to police paper and presented to the coroner as an original signed statement obtained. Is that really a transparent way of doing it?

A. I would have used the word "original" to make sure that it's not a photocopy of it. Occasionally, I had to -- because the coroner wanted to get on with things and for some reason, as I suggested to you, the witness statements that went adrift in Grosvenor Road police station, sometimes the coroner would say, "Look, I need to get on with things, send me down your photocopy. It won't do for the inquest, but it'll help me make progress in my enquiries". So my use of the word "original" there was referring to it being originally signed, an original signature on the paper, and not the fact that it had gone through --

THE CHAIRMAN: Not that it was the --

A. Not that it was the first version, yes. In fact, I believe Dr Sands says, "This is the second ..." -- I think he had maybe two drafts and the second one, which dealt with his defence organisation, which I didn't see.

THE CHAIRMAN: Okay.

MR STEWART: Do you have it there?

A. No, we don't have it. The e-mail talks -- you see if you go to, I think it's 139-171-001, you see that's what comes back to me. The lower is the e-mail that you were talking about before. Then we have him thanking me for my comments:

"This is the second draft I have written on the subject."

So he's telling me that, in effect, his defence organisation have previously modified an original one, which I didn't catch sight of.

Q. So by the time this statement gets to the coroner, it has been well and truly vetted.

A. Correct.

MR QUINN: I was just about to raise this point. What goes on in the next e-mail below that, same page, I think Mr Stewart should perhaps read that and make sure he's aware of --

MR STEWART: Read it for me.

MR QUINN: 139-171-001. It's what Mr Walby says about the defensive position. I'll let you read it yourself, then the questions are evident from it.

MR STEWART: Shall I read it out for the record?

A. It's the same e-mail that you've just dealt with.

THE CHAIRMAN: That's what we went through a few minutes ago. It appears twice in the same file, but it is --

A. That is a printing of it with my follow -- with his follow-up back to me, so it is the same as --

Q. Can we go to 090-051-157? To look at:

"This is the original signed statement obtained from Andrew Sands as delivered to the coroner."

Then he in turn transcribes it on to separate paper, 091-009-055. So you see the issue is really whether it's appropriate for you and the Medical Protection Society and everybody else, maybe even solicitors, to get involved in the writing, rewriting, editing and amending of statements without revealing that that has been done.

A. Well, I would be surprised if the coroner thought that this hadn't happened to some degree in every case.

THE CHAIRMAN: That's taken us through two statements, Dr Webb and Dr Sands. I think it certainly covers generically the issues that you would want it cover. Is there another particular statement you want to go through?

A. No. If you've got the message, I am happy to stand over what I did with the witness statements. These are the two which contain material -- the others are, I think, minor typographical ... I had got the sense from senior counsel's opening statement that there was a generic concern about everything I was doing and, therefore,

if I have been able to satisfy you with these two, I don't think we need to go on to the others.

THE CHAIRMAN: I understand that. Mr Fortune, to the extent that Mr Walby was involved in Dr Steen's statement, do you require any issue to be raised about that?

MR FORTUNE: No, sir. I anticipate that the procedure would have been much the same.

THE CHAIRMAN: Yes. And just in general terms, Mr Walby, is that correct?

A. Yes.

THE CHAIRMAN: Thank you very much. Okay.

MR STEWART: Perhaps now we've mentioned Dr Steen, perhaps I could ask you to go through some of your contact with Dr Steen in relation to a slightly different issue. That is at 140-092-001. That's where, Mr Walby, you have forwarded to you by the coroner a copy of Mr Roberts' further statement. This is prior to the inquest. And he asks you in the second paragraph to circulate the Roberts' statement amongst the involved staff and "written responses would be useful at this stage".

So you in compliance with that request send it off to the various witnesses and you send it off, I think, to Dr Steen at 139-086-004. There we are, 6 October 2005. The trail of further e-mails I was

going to take you through, and I can go through five of them, are successive reminders from you to Dr Steen for her to respond to this. Do you remember that?

A. I do.

Q. And various discussions along the way, it seems, where you're trying to persuade her to respond.

A. Well, the situation was that the coroner had invited comments. It has been my experience that sometimes doctors don't wish to comment and they are not under any compunction to comment. Dr Sands and Professor Young did. Dr Webb let it be known that he wasn't going to be making a comment. But I didn't get a yea or nay from Dr Steen, and that's the reason for my note to her. It continues right up until a consultation prior to the inquest, which the Trust solicitor had with Dr Steen, and at which I make a note in the file, you'll see, where I raised it with the Trust solicitor: what do we do about not having got a response from Dr Steen? And his recommendation, you can see, that we don't now do it.

Q. And on what basis was it decided to go ahead without asking her to respond?

MR FORTUNE: Sir, can I interrupt at this stage? Because I'm not sure where this line of questioning is going to take us. Here is Mr Walby doing his best to chase up

a witness who, on the face of it, has been slow in returning a statement requested by Her Majesty's Coroner. Is there anything more sinister to it than a series of "Where is the statement?".

THE CHAIRMAN: Yes, this is not the original statement; this is the response to Mr and Mrs Roberts' statement.

MR FORTUNE: Or indeed just that, sir.

THE CHAIRMAN: In the scale of things, it may not be a very important point, but Professor Young and Dr Sands did have some comments to make. Dr Webb said he didn't have any comments to make and your client simply didn't respond, repeatedly didn't respond, and that's just what Mr Stewart is asking about: what was happening? And I think Mr Walby has now said that -- I think Mr Stewart said it was followed up five times with an absence of response from Dr Steen. I think that might be the point; is it?

MR STEWART: It is. We can go through all the e-mail trail if you'd like, but it's in relation to the professional duty owed by Dr Steen under the GMC regulations to offer all relevant information and to assist the coroner.

MR FORTUNE: Sir, I'm not inviting my learned friend to go through the e-mail traffic. My learned friend can make the point certainly when Dr Steen gives evidence: you were slow in returning a document containing your

comments, if any, in relation to the letter of Mr Roberts of 29 September 2005.

THE CHAIRMAN: Thank you.

MR STEWART: The inquest took place, and a verdict was given, you had a reason to be dissatisfied with the finding of the coroner and you weren't entirely certain that the coroner had got the right end of the stick and you wanted to make sure this point was corrected.

A. Yes.

Q. Would that be a fair summary of what you were concerned about?

A. Well, it wasn't so much the right end of the stick, it was that he had failed to record in his verdict that there had been a reduction of the fifth-normal saline on the evening of 22 October, whereas Dr Steen's witness statement clearly said that that had occurred. His recording of her answers to the question didn't say that, and therefore his verdict, when it appeared, suggested to me that it was looking as if the Trust, the hospital, had not initiated even what it thought was the correct thing to be doing if you find this condition. And therefore, I wanted that to be corrected for an additional reason than getting the verdict right, that the chairman was going to be having to consider whether or not he should add this case to his list for the

inquiry.

I was present at the inquiry's hearing in February 2005 where the chairman had referred to, in response to Mr Coyle, that he wasn't going to get into the situation of dealing with five, 10 or 15 cases for the inquiry because it would take far too long and he wanted the salient points to be heard. He wanted the salient cases to be heard at the inquiry.

I was of the knowledge at that stage that there were three other deaths. Mr Coyle came back and said when he felt that he had other cases, there were other cases of living hyponatraemia, they weren't deaths, so he retracted what he had started -- the chairman making his comment. But although Mr Coyle may not have been aware of any deaths, I was aware of three deaths which the inquiry chairman was considering as to whether he should add them to the inquiry. And none of the three deaths are ones that you've heard mentioned here. The chairman will know of those. I take it you don't want me to mention their names.

THE CHAIRMAN: No, thank you.

A. There were presumably others which I was not aware of, and therefore the chairman was going to have to make a decision as to which cases he thought would be most appropriate to conduct a full inquiry, which I'm fully

supportive of and I think was the right thing to happen.

I felt that if all Mr O'Hara got was the verdict on Claire Roberts, that he might add it to the inquiry on the basis of it being a -- as we heard Professor Young refer to it as, and I hadn't heard this -- this hypernatraemic as opposed to euvolemic. Euvolemic hyponatraemia. I hadn't really taken on board that there were three types of hyponatraemia -- hypervolemic, euvolemic and hypovolemic -- and that this case was falling into the case of euvolemic hyponatraemia. And I suspect, Mr Chairman, at that stage that you weren't aware your inquiry would be moving into an area to deal with other than the situation where far too much fifth-normal saline had been given to a child. And that is the basis of me wanting to make sure that the verdict properly reflected that, that there had been a reduction of the ...

THE CHAIRMAN: To ensure, in effect, that whatever decision I made was based on the correct information?

A. Yes.

THE CHAIRMAN: And the line which you were concerned about in the coroner's verdict was: that blood test, referring to the 121 blood test, should have been repeated and, at the same time, there should have been a reduction in fluids.

A. Yes.
THE CHAIRMAN: And your concern was that there was a reduction -- there's a bit of a debate about that issue -- but --
A. I agree.
THE CHAIRMAN: -- there should have been a reduction in fluids at about 11.30. Dr Stewart's note says that there was to be a reduction in fluids to two-thirds, you weren't sure whether Mr Leckey had in fact picked that up and conveyed it accurately in the sentence towards the end of his verdict.
A. Yes.
THE CHAIRMAN: Thank you.
MR STEWART: Had you ever, before this, sought to persuade the coroner to amend his finding?
A. No.
Q. Have you since?
A. I don't think he's made a mistake since.
Q. And have you had other deaths referred to inquiries since?
A. No.
MR STEWART: Thank you very much. I have no further questions.
THE CHAIRMAN: Can I just raise one point with you, Mr Walby? I'm just curious about it. Maybe in the way

we've handled the evidence, it hasn't emerged. Yesterday or the afternoon before we were told that the reason privilege was being waived by the Trust for some documents was that there was a particular document which you might want to refer to in your evidence. It's 139-164-001. Mr McAlinden will correct me if I'm wrong, but I understand that -- sorry, could you bring the second page as well, please?
A. That's it.
THE CHAIRMAN: In case we've overlooked or skipped past something too quickly, what I understand is that you wanted to be able to refer to this document for which privilege has been claimed and, in particular, you wanted to refer to what I think is your handwritten note in the bottom right of the first page; is that correct?
A. That's part of it, but there are ... This letter appears in two versions. There's one without my handwriting on it and sometimes it's e-mailed and ... I thought that the issue of the 121 on the two separate occasions would come up.
You heard evidence yesterday that discussed that. Initially it was thought -- but you're now clear.
There's a page in the file, 139-167-001. This page is a single page out of Dr Webb's witness statement, in which, once the issue had come up about there being more

than one measure of 121, I was asked to make sure all the doctors were aware of all the results, and therefore those are my personal annotations on Dr Webb's table because it was the quickest way to do it, given that we were in the middle of the inquest. Dr Webb in fact has a 122, which is incorrect there.
THE CHAIRMAN: Yes.
A. So that lists the two series of -- and those were distributed to the doctors so they were aware of those.
THE CHAIRMAN: And the handwritten sequence of figures between the 22nd and the 23rd, that's your handwriting?
A. That's all my writing.
THE CHAIRMAN: That's adding in the results which were obtained on the 23rd; is that correct?
A. Yes. Dr Webb had not got -- I suspect the last column of results was maybe from a PICU sheet. You'll remember that there's a set on the 22nd, a set of results written in the notes and then there's a margin note beside Dr Steen. So that demonstrates that the two 121s had to be from different blood tests.
THE CHAIRMAN: And that was almost certainly taken after Claire was moved to PICU?
A. No, I think not. No, no, because she wasn't moved to PICU until the 23rd. So there seems to have been -- and there has been evidence on it before -- and I don't want

to give evidence about it -- but I am pretty sure you have evidence that Dr Sands has made comment about the two sets of blood tests.
THE CHAIRMAN: Let's just look at this quickly. If you look at 090-022-056, in the top left of that page, on the right-hand page on the screen, the 121 is the reading which came back at about 11 or 11.30, and it's in the notes of 11.30. That's the first reading of 121.
A. Yes.
THE CHAIRMAN: The second entry -- if you could take down, please, the page on the left-hand side of the screen, page 55, and put up 57 alongside page 56. Down on the right-hand side of the screen, that is the second reading of 121.
A. Yes.
THE CHAIRMAN: That page starts with the 4 am entry, which is after she's in PICU.
A. Yes. But the blood test results are coming. But the time the blood was taken, we don't know.
THE CHAIRMAN: Okay. We'll agree it's later than 11.30. It's most probably at around the time of her collapse because it doesn't appear that any other doctor saw her between Dr Stewart seeing her and her collapse.
A. No.
THE CHAIRMAN: So whatever the precise time, it's at about

the time that her condition had deteriorated with the result that she went to PICU, whether the test was actually taken in PICU is --

A. So if you go back to the letter that I had wanted to be referred to then.

THE CHAIRMAN: 139-164-001. That's the point you're making in the last paragraph on the first page?

A. Yes, that I made sure that the doctors each had a copy of that page so they knew what was being talked about -- if you go to the second page of this letter --

THE CHAIRMAN: Yes, the two together, please. Thank you.

A. -- in case there was any doubt about it from Mr Daly's letter to me:

"This death does not appear to fit within the terms of reference to that inquiry and counsel will make a point to the coroner in due course."

It's just to highlight the fact that I wasn't going out to a flyer to suggest that this case was absolutely at one with the terms of reference of your inquiry, sir.

THE CHAIRMAN: Okay. I understand.

A. I'm well aware it's turned out to be appropriate to be in the inquiry.

THE CHAIRMAN: Is there some point about your handwritten note at the bottom of the first page or does that not matter?

A. It doesn't matter. It was really just that I was concerned that matters may come up that you might have asked where this copy -- how this copy page appeared, and I needed to be able to demonstrate because there was every likelihood that it might have done.

THE CHAIRMAN: Okay, thank you very much.

Mr Quinn, have you any questions?

MR QUINN: I have a number of questions. One of them I can deal with very quickly. That is the comment about the coroner sending Mr Roberts' statement to the Trust.

I want, through you, sir, to ask the question: was there any mention of the clinician's statement being sent to Mr Roberts for comment by the coroner or the Trust? Because it would seem very unfair if not. What happens here is the coroner, after receiving the statement from Mr Roberts, sends it to the Trust for comment: here is what Mr Roberts is going to say. Yet there's no reciprocal agreement in relation to the statements by the clinicians. Why would that be? Why would that be fair?

MR McALINDEN: Mr Chairman, that's an issue, if it is an issue in this case, for the coroner to address. It's certainly not an issue for Mr Walby to address.

MR FORTUNE: That would be my submission as well, so far as Dr Steen is concerned.

THE CHAIRMAN: I can understand how Mr and Mrs Roberts must feel a bit sore about this, to put it gently, that they see what might appear to them to be a fairly cosy relationship between the Trust and the coroner to the extent that their statement goes to the Trust for the comments of the doctors, but they do not have a reciprocal position in seeing the Trust statements for their comments to go to the coroner. But to the extent that that is appropriate or inappropriate, I think it's a matter which, if need be, you can raise or I can raise with the coronial service.

MR QUINN: It's something Mr Roberts wanted on the record. We realise we can't ask this witness to answer that. It was a comment and I made sure it was a comment when I first approached it.

The second point I have is in relation to document 139-161-001, if that could be brought up. The question I want to ask, Mr Chairman, is this. The first line of that document states:

"This inquest ended on 4 May 2006 with no criticism of the Trust's care of this patient."

In light of what has been said in relation to the settlement of any clinical negligence claim brought because of the blood test issue, how does that sit with the evidence that we have? So what we have here is

Mr Peter Walby writing this letter on 12 May 2006, yet still having the mind that after the inquest, had any negligence claim been brought, the Trust were at fault. So how do those two things sit together?

A. They sit together in that, as I said earlier, an inquest -- the purpose of an inquest is not to apportion blame. Therefore, I think if you want to bring up -- I was there as the coroner read out his verdict. So although when it says -- it appears shortly ... When he read it out, I heard it, and if you go to it, does it indeed contain criticism of the Trust's care of the patient? I'm not sure I have a reference to the verdict.

MR QUINN: That's not the point, Mr Walby, about whether or not the coroner criticises the trust. It's what you do in relation to what's in your mind. You're writing in one e-mail that there was no criticism by the coroner of the Trust, yet you know the Trust are at fault. So how does that sit together?

A. They're different things.

MR QUINN: In your mind.

THE CHAIRMAN: Are you suggesting that: well, thankfully there was no criticism of the Trust, even though any medical negligence case is open and shut?

A. That indeed was the case, but on the other hand

that's ... That's just a factual statement of what occurred.

MR QUINN: I take it no further, sir. The last point I have is this: could two documents be put up together? 139-149-001 and, beside it, 139-135-001. You will see, Mr Walby, on the second paragraph, the last few lines, where it says:

"... under the care of consultant paediatrician Dr Heather Steen with the provisional diagnosis of viral illness."

It's the second paragraph, the last three lines, if they could be highlighted. When one looks at the other letter, you will see that you have written to the coroner again after Christmas and, in the last, paragraph it reads:

"It has also been pointed out to me that in my original letter to you of 16 December 2004, I referred to Claire Roberts' provisional diagnosis as simply being that of a viral illness, whereas the admitting registrar had gone further and considered it to be possibly encephalitis."

We know that the registrar Dr O'Hare stroked out encephalitis, so where did you get that information from to provide to the coroner if it is wrong?

A. If you go to the A&E entry, you'll see that's what her

diagnosis is.

THE CHAIRMAN: But she had encephalitis and then she deleted it, didn't she?

A. Not on that page she didn't. This is a child arriving into casualty. That's the ward note that you're talking about. This is the ...

MR STEWART: It's at 090-012-014.

A. You see the primary diagnosis: "query encephalitis". She may well have changed her mind, but that is the patient arriving in the A&E department with a diagnosis of query encephalitis.

MR STEWART: For the sake of completeness, she was admitted to hospital and the same doctor makes a note on page 090-022-052, if that might be placed side by side. You can see at the top:

"1. Viral illness. 2. Encephalitis."

And the same doctor then crosses "encephalitis" out.

A. Yes.

MR QUINN: So was there a possibility of encephalitis when that same doctor, Dr O'Hare, has crossed it out?

A. The wording of -- can you put up beside that what I have said in the second letter?

MR QUINN: That's the letter at 139-135-001.

MR STEWART: It's not the same doctor who crossed it out, it's a separate doctor.

A. Is that not the same doctor?

MR QUINN: It's the SHO, yes. So are you saying that that -- and could I ask then to put up, just to complete --

THE CHAIRMAN: Sorry, the point is Mr Walby says the admitting registrar had gone further and considered it to be possibly encephalitis. It's Dr O'Hare who had written encephalitis, which she then deleted, and she's the registrar.

MR QUINN: That's correct, that's the point I'm making.

THE CHAIRMAN: And she's the only registrar.

MR QUINN: Because the other doctor was a SHO.

A. Can you go back to that ... Back to the A&E page?

THE CHAIRMAN: If you take down the right-hand page and bring up 090-012-014, I think. You'll see that the name of the doctor is Dr Puthucheary, it's on the top line, the doctor's name.

A. Yes. Are you telling me that after Dr O'Hare writes "admit", Dr Puthucheary then comes back and writes "query encephalitis"? I must admit -- I stand to be corrected and would like to look at the original chart if it's material, but that's where it has come from. I have taken it that that was also Dr O'Hare writing "query encephalitis", because normally you would expect the registrar who has been called by an SHO to put

a query diagnosis so that the ward knows what to expect.

THE CHAIRMAN: Let me put it this way: even if that is Dr O'Hare's "query encephalitis" at the bottom of the left-hand page, since you know from the records that she then deleted that, deleted encephalitis on her detailed examination of Claire, why do you alert the coroner to the fact or to the point that the admitting registrar had gone further and considered it to be possibly encephalitis when she had originally contemplated encephalitis and then dismissed it?

A. Well, I wrote to the coroner my two-page letter and I copied it to the medical director. I didn't have any expectation that it would go any further than that. You'll see that there's a handwritten note on the bottom of 139-148-007.

MR QUINN: 001. It's Dr Steen's handwritten note.

A. Yes. That is me:

"I hear you have ..."

So then some time -- when I met Dr McBride, he said to me, "Dr Steen thinks you've got some mistakes or errors in your letter". So I then, as you can see, a couple of days later, was writing to Dr Steen asking her for her witness statement, and I put a handwritten note at the bottom asking her to identify these errors. Because don't forget, under normal circumstances the

consultant responsible for the patient would be referring the death to the coroner, so I don't think it would have been at all inappropriate for Dr Steen to be making additions or corrections to me because, as we now know, it maybe should have been reported in 1996 by Dr Steen.

THE CHAIRMAN: With all due respect, she's eight years late.

A. Yes, you saw where I was going with that. So I wanted to know what the errors were.

THE CHAIRMAN: But I think the point is that there's a real question mark about whether in fact it is an error. Because what your letter ends up doing, even if it's something you're not fully alert to, it ends up inserting possibly what Dr O'Hare might have thought at one point, but omitting that Dr O'Hare did not think that within an hour or so. So it's not correcting an error; in fact, if anything, it's potentially misleading. That's the point.

A. Well, that certainly was not my intention.

THE CHAIRMAN: I'm more concerned with the result than with intention, Mr Walby, and I'm not accusing you of deliberately misleading the coroner. But I'm concerned that before you write to the coroner to correct something of which the coroner has been advised of before, the person who's pointing it out to you in order

for you to give that information and you yourself, in providing that information, really need to be quite sure that you are correcting an error in the first place. And my concern is, whether you are in fact doing that, to the extent you rely on "query encephalitis" on page 14 on the screen, is that not very quickly superseded by Dr O'Hare deleting encephalitis after Claire's admission?

A. Well, I think that the wording of my letter is ... It's now gone from the screen again, but the wording of my letter, I thought, talks about her initial ... I mean, lots of diagnoses changed over the --

THE CHAIRMAN: Okay. It may be we can take it no further.

MR QUINN: Sir, there are just two other points.

One, does that mean then that the error identified by Dr Steen is that particular error, ie that Dr Steen has identified that you've missed out a provisional diagnosis of the other part of the diagnosis, possibly encephalitis? Was that Dr Steen's prompting to cause you to change it?

A. Yes, I met Dr Steen in the Children's Hospital in the course, I think, of my clinical duties and I said to her as well that -- there wasn't a written response to this, I don't think you'll find, and that was what I then put into the second letter.

MR QUINN: Lastly, why did Dr Steen have a copy of the letter to Mr Leckey when you told us earlier that it went to the medical director?

A. Exactly.

MR QUINN: Was she the medical director?

A. No. You'll need to ask the medical director.

MR QUINN: So that was then distributed amongst the clinicians for comment?

A. I think if you go back to the transcript you will see that I was surprised. I sent a copy to the medical director and I had no expectation that it would go anywhere else.

MR QUINN: Thank you.

MR STEWART: May I, for the sake of completeness, and for accuracy and for the record, indicate that Mr Reid has informed me that the entry "query encephalitis" was made by Dr Puthucheary, and this is confirmed in the witness statement WS134/1 at page 7. And also he refers to:

"Identify [in 15(a)] who made the primary diagnosis of 'query encephalitis' and state when this diagnosis was made and the basis thereof."

The answer is:

"I wrote the diagnosis of encephalitis."

A. That's my mistake then. I should have written "the SHO in casualty" rather than "the admitting registrar".

THE CHAIRMAN: Any other questions before I come to Mr McAlinden? No? Mr McAlinden, have you anything?

Mr Walby, there were a number of things you wanted to tell us and I hope we have given you a chance to say everything. Unless there is anything you want to add, your evidence is complete.

A. Well, I've covered everything, but I would just like to say that my task here has been made an awful lot easier by the work of the litigation management office staff in keeping the files so that I was able to go through everything -- and it's all there -- as opposed to hospital notes, which tend to be a bit patchy. So I'd like to thank them for having maintained the files the way they have done.

THE CHAIRMAN: Thank you very much. You're now free to leave. Thank you for your time.

(The witness withdrew)

Tomorrow, we've got Dr Rooney and then Mr and Mrs Roberts. I've been asked if it's possible to sit tomorrow morning at 9.30.

MR McALINDEN: I have checked with Dr Rooney this afternoon and she will be here tomorrow morning at 9 with a view to commencing her evidence at 9.30.

THE CHAIRMAN: Unless that causes any great difficulties, we'll sit at 9.30 tomorrow morning. Thank you very

much.

(5.00 pm)

(The hearing adjourned until 9.30 am the following day)

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