Thursday, 6 December 2012

(10.30 am)

Governance opening by MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning.

If I just take the opportunity to do one matter of housekeeping before I start with the opening. There are two documents that the inquiry legal team prepared to try and assist. They mirror documents of a similar type that you'd have seen in the opening case, which was Adam's.

The first concerns the list of persons. You would have seen that there was a schedule of persons that was provided in relation to clinical matters in Claire's case. There has been a schedule of persons that relates primarily to the governance aspect of the case, and that's a schedule that you will be able to pull up and check what the involvement of the person was, what statements or reports they've previously provided and whether it's intended that they should be called as a witness. In due course, we will provide a schedule that indicates, on the clinical side, all those witnesses on whose written evidence we relied solely and in due course we will do that for governance, indicate those witnesses on whose written evidence we are solely relying.

So that is one document. The other document is a chronology. I just pull that up very quickly now to show you how it works. It's at 310-021-001. There you see it, and because Claire's case spanned quite a period of time, so it's divided into a number of schedules. That's the first schedule. You can see that it actually pre-dates -- an attempt to set what the position was from the governance and hospital management point of view at the time Claire was admitted.

So in place were a number of protocols, guidance, circulars and practices and so forth, and also publications. So you can see those running down with the date on the far left-hand side.

If one moves through -- I'm not going to take you through this, this is just to indicate how it works -- you will get to a second schedule, which is from Claire's death until the notification of the results of the limited autopsy on 21 March. It is a similar thing, except in this case it sets out -- if I take you to that, 003. There you see that form has changed now so you now have the events in relation to children and you've got the reference and then "Any other developments".

For example, another development, if we turn the page to 004, if you bear in mind that this is taking you

to 21 March 1997, which is when the limited autopsy results were in. And you can see there on the bottom one for 10 January 1997, there is at that stage a letter from the Chief Medical Officer to the chief executives of the Trust, and it is asking them to put into effect the agreement in the letter of 13 November 1996 to Sir Kenneth Calman, which you would have seen earlier.

So what is happening is not only are you seeing the events as they relate to Claire and, in due course, other children -- because other children, unfortunately, were admitted and died before we got to the next part of Claire's case -- but it also has this running list on the far right as to what was happening for generally.

If we can go to 006, for example, that's the third schedule and that's the main events in the period between the notification of the results of the limited autopsy and the UTV broadcast on 21 October 2004. Here you see, if we go down through it, what exactly was going on and we identify when other children die. For example, you'll see that at 010: there is the 14 April 2000, when Lucy dies; 19 June 2001, Raychel has died, and so on.

You are increasingly seeing more activity, if I can put it that way, on the far right, as higher up in the structure there are events or publications being

produced. And on it goes until one gets to the fourth schedule, which is at 015, and that's just the title of. One then moves from the UTV broadcast on 21 October 2004 to the inclusion of Claire's case in the work of the inquiry, which was announced on 30 May 2008.

That goes through in a similar way, showing you what was happening, on the left-hand column, which was more directly pertinent to Claire's case and those of the other children, whereas on the far right you have what was happening at a broader level and, very often, a departmental level.

So that is a schedule that we hope will assist as you try and get some sense of what was happening that particularly bears on Claire and how her parents were being informed or not informed as to events relating to her from the span of her death up until the time her case became part of this inquiry.

Mr Chairman and everyone else, you have heard the evidence on the clinical aspects of the case and the first of the post-death events, if I can call it that, which is the autopsy. Because that is really the first investigation into what happened to Claire. And that evidence has been heard over a period of very nearly eight weeks from 15 October through to 5 December. In the course of that, I am sure that those in here,

certainly you, Mr Chairman, from your interventions, have begun to see certain themes arising out of that clinical evidence. One of which -- and I'm not seeking to put these in orders of importance -- is the consultant responsibility, and I don't mean identifying who the consultant was. I mean who was the consultant who should have had the overall charge of Claire's care and should have been seeing if there was going to be any specialist intervention, seeing how that fitted into an overall plan for her care. Who was the person who had that responsibility?

That is a theme that has arisen because it has considerable ramifications. It also leads into the role of the consultant. One will recall that Dr Steen described the paediatric service at the Children's Hospital as being consultant-led, meaning that the consultants were not based on the ward. And in Claire's case, her consultant would not only have not been based on the ward, but her contract required her to be working in the community and, in fact, only to be in the Children's Hospital -- I believe it was for two days, which might have been two mornings.

So that itself raised issues to do with: if you are going to have such a system, how do you ensure that there is continuity of care, that there is appropriate

cover, that there are effective communications between that consultant and the junior doctors and the nursing staff and any specialist who should be brought in to assist with the case. We will be trying to explore with the witnesses the extent to which any consideration was being given that if you are going to have a system like that, how do you put in place measures that will ensure that that system produces the correct level of care for the children.

And that then itself moves into theme that has arisen, which is, it may be that if you are going to operate a system like that, it puts quite a bit of emphasis on the quality and adequacy of the paperwork. Because it may be that's what the junior doctors have available to them when they're updating the consultant who's not based on the ward, and to some extent it may be that that paperwork and the observations recorded in it of the junior team and nurses are a substitute for the consultant being able to actually look at the patient, which is what happens periodically if a consultant is on the ward. If the consultant's not going to be based on the ward, they're going to need a way to be updated as to what is happening about the patient, so they can make decisions as to when they feel intervention is necessary or they particularly perhaps

have to attend. And that paperwork, Mr Chairman, the deficiencies in it have been exposed during the course of the clinical part of this case and I will say a little more about that later on, but I'm just drawing out some of the themes from the clinical hearing.

That also moves into another area, apart from just the communications between the clinicians and the basic material that they have to update the consultants, it also moves into an area to do with cover. So if you are going to have the consultants who are in charge of the children who have responsibility for their care and treatment, and not based in the ward, and may not, for that matter, be based in the hospital full-time, then one needs to think about how is appropriate cover being provided, particularly, as it happened in this case, when the consultant -- even on the day or the morning when they're supposed to be in the hospital -- may have other calls upon their time, and it seemed that that may well have been the case with Dr Steen. So what was the arrangement in those circumstances?

And as it happened, on that particular day, it happened that the registrar, who is based on the ward, and therefore is the most senior person -- and an awful lot, therefore, rides on the registrar in a system like that. In that case, the registrar was conducting

a clinic in the afternoon. So the question is now: what are the arrangements for cover in those circumstances? Because it seems that for Claire's case, in the afternoon, which turned out to be a significant period during her admission, perhaps the most senior person there was a senior house officer, whose experience in paediatric matters was not considerable. And also, as it happened, the ward sister was not there either, and there may be very good reasons why she wasn't there, but if you're running that sort of system and you don't have your consultant there because that's not your system, you don't have your registrar there and you are missing your experienced nurse, then that calls into question how a system like that has the potential to break down if not very much changes in the personnel that are available.

That itself leads on to the cover over the evening, and the evidence was there about the registrar and their access to the consultants, and also the calls on their time, literally the number of beds that the registrars were required to provide service and cover for over the evening.

Then on the final point, which is really what one is talking about, is resources, is the services, and throughout this one has been very much aware that this

is the Children's Hospital, this is the place where the paediatric expertise resides, it services the whole of Northern Ireland, and yet issues were raised as to the extent to which it provides services when they might be required in the interests of the child's care. In this particular case, one was talking about CT scans and EEGs. Not only is the Children's Hospital there, but so also is the neurological unit, also serving the whole of the region, and it'll be a matter in due course when you, Mr Chairman, consider and determine on the clinical matters, the extent to which the availability of the CT scan and EEG in any way affected the way Claire's treatment progressed.

Then finally, before I start to open matters proper and move from these preliminary thoughts, there is the question of the communications with the parents, which is an issue that runs through the entire period of time, not just when Claire was admitted, but after she had suffered her respiratory arrest and her collapse: who were the people who were supposed to be informing them, how they went about that, and how a situation could arise in those circumstances when it would appear, according to the nurses and the clinicians, although they were aware of how ill Claire was, significantly, the parents were not.

So Mr Chairman, those are the themes that have come out of the clinical phase of Claire's case, and the task in this governance hospital management phase is to look at those issues from the perspective of the practices, systems and protocols in place that were either there to ensure that the difficulties of the kind that I have alluded to did not arise or, if they did arise, that there was a system for considering them, identifying why that had happened in that way, what might need to be put in place to ensure that the risk of such a thing happening again was minimised and how the trust that families have in their health system could be restored by the quality of the information that is given to them once the issues and problems are recognised and properly analysed.

Mr Chairman, I turn now to the governance issues proper. To some extent, Mr Chairman, they share a time and a place and a context with Adam's case, and the issues which foreshadow the future work of the inquiry in relation to the deaths of Raychel Ferguson and Conor Mitchell. Both Claire and Adam died in the same ward of the same hospital within 11 months of each other, and when Claire died some of the doctors working in intensive care had been there for Adam: Doctors Webb and Taylor were involved with both and the names of

Doctors McKaigue and Crean appear in both and the clinical governance structures applicable to both were the same and most of the senior personnel in the clinical management structure were still in post.

So there was a real opportunity, if it had been taken, to learn from Adam's case and to use that to either ensure that Claire's case didn't happen in the way that it did or, should it happen for any reason, that they had a structure there to evaluate what was happening and to try and improve matters for the future.

Hyponatraemia, which is at the heart of this public inquiry, was an issue which had been considered by Doctors Taylor, McKaigue and Crean in their preparation for Adam's inquest, just four months before Claire's death. They had referenced the Arieff article, as we've come to call it, on hyponatraemia in their formalised recommendations for the coroner, and the content of the Arieff paper was relevant to Claire's condition when one considers its full title, "Hyponatraemia and death or permanent brain damage in healthy children".

Dr Taylor considered that this paper had wider significance in terms of alerting the profession to the potential risks of dilutional hyponatraemia and Dr Bartholome has recalled how the events surrounding this inquest, that is Adam's inquest, had been known to

her and to most of the doctors in the Children's Hospital. Dr McBride, who was then the medical director, has emphasised to the inquiry how Claire's death did, however:

"Reinforce for me the critical importance of ensuring that clinical practice continually evolved in line with emerging evidence."

And the poignancy about this part of the inquiry's work is that exactly the same thing might have been said about Adam's death and, during the course of the governance hearing in Adam's case, you heard evidence relating to the extent to which such a sentiment had actually informed action following Adam's death. No new governance initiatives of significance appear to have occurred in the period between November 1995 and October 1996. The Children's Hospital continued as the regional paediatric teaching hospital.

However, and as is evident from the inquiry witness statements of Dr Shields and Ms Chambers, at the very time of Claire's admission to the Children's Hospital, as part of the Royal Group of Hospitals, it was actively pursuing accreditation from the King's Fund Organisational Audit. Indeed, Dr Steen, Claire's consultant paediatrician, may herself have been involved in arrangements for a mock survey as part of the

preparation for the King's Fund survey on the very Tuesday afternoon that she might otherwise have been involved in the ward round examining Claire and directing her treatment.

Nevertheless, the work of the audit committee, medical records committee and the clinical risk management committee seemingly continued as before. The Trust board deliberated its business, but seems to have been more concerned with corporate matters than patient matters, and a review of the board minutes from the Royal Hospitals Trust for the period of December 1995 to December 1996 reveals only three references to specific clinical incidents, and there is no reference to the death of Adam Strain. And notwithstanding such elements of clinical governance as may have been in place during that period, it is now clear that in Claire's case, just as in Adam's, there was no formal report of the death at the time of the death to the clinical lead of the paediatric directorate, nor to the director of nursing or the medical director. There was no reporting of Claire's death to the chief executive or to the board. And it will be a matter for you, Mr Chairman, to determine the extent to which her death was actually noted within the structures of governance.

In Claire's case, just as in Adam's, there was no

internal hospital investigation into the death. In neither case is there conclusive evidence of the death being reviewed at audit or mortality meetings. In neither case is there any documentation to suggest that any learning was extracted from what was known, whether to be shared by way of continuous professional development or otherwise incorporated into teaching.

The evidence that has been given of the neurological grand rounds and the debate they apparently engender, it was there, and it's claimed that there was such a grand round for Claire's case. However, since they're not recorded in any way, the only evidence of such a debate leading to actual learning is what happens afterwards, and it'll be a matter to be determined whether the subsequent events indicate that there was any real learning from any grand round there might have been into Claire's case.

And by reason of the failure to report the deaths to the directorate clinical lead in the Children's Hospital, there was no opportunity for an overview to be taken and the relevance of the Arieff paper to general paediatric practice to have been appreciated.

Dr Mulholland was clinical lead at the time of Adam's death. He was told nothing and he didn't seek to find out. Dr Hicks, who succeeded him, was denied the

opportunity of learning about hyponatraemia in Adam's case because Dr Murnaghan's plans for a seminar were not communicated to her, apparently, and in any event those plans were subsequently abandoned or they were just simply forgotten about.

The medical negligence case concerning Adam's treatment and care was still alive and ongoing at the time Claire was admitted and it had become clear after Adam's inquest that there was no real likelihood of successfully defending the legal action. Yet there is no evidence to suggest that the Director of Risk and Litigation Management took any steps to draw clinical lessons from the litigation, nor were any steps taken to ensure that performance failings or care management problems or adverse clinical incidents were reported. The convention simply seems to have been that clinicians were left to themselves to determine whether a medical error had arisen or an adverse clinical incident had occurred and perhaps, if so, what to do about it.

It will be a question for you to determine, Mr Chairman, whether such self-regulation was consonant with clinical governance, best practice and the interests of healthcare standards.

By the time the role of hyponatraemia in Claire's death was being questioned in 2004 and 2006, clinical

governance had developed. Clear protocols on adverse incident reporting and root-cause analysis investigation was available, mechanisms had seemingly been put in place in order that lessons learnt from clinical audit, from adverse event monitoring, near miss monitoring, patient complaints and clinical negligence claims were routinely translated into better practice. The information and the systems were there and yet even then there still was no investigation into Claire's case. And so again, it will be a matter for you, Mr Chairman, to determine whether misinformation was given to both Claire's parents and the coroner and whether there was a culture of defensiveness to criticism amongst the medical community and, if so, its likely significance.

And in particular, the point of having guidance and protocols and paper practices, if they don't get translated into actual systems whose effectiveness is monitored and evaluated, and for which people can be held accountable, and the extent to which that actually happened in relation to these children's cases lies at the heart of this part of the investigation.

If I turn now to the specifics of Claire's case and start with staffing levels. Broader responsibility for the provision of 24-hour cover to patients rests with the paediatric clinical directorate. Dr MacFaul, the

inquiry's expert on governance matters, expresses some reservations about the levels of staffing and workload in that the resident medical staffing out of hours in the clinical hospital was thought by him to be low, given the range of responsibilities undertaken, and he referred in his oral evidence particularly to Dr Bartholome, who was the registrar in the night of 22 October and into the morning of 23 October 1996, which proved to be a critical time for Claire.

He refers to that as being clearly an unreasonable workload, thus early consultant involvement in complex or unusual cases was rendered all the more relevant given the limited level of medical staffing otherwise available in the evening. And Dr Steen advises that consultants only have a small amount of time allocated to ward round and have fixed commitments at other times, often off site, for example at clinics, which is the earlier theme that I had drawn attention to.

Some discussion of workload pressures appears in the Royal Group of Hospitals' strategy for Children's Services, "Getting it together", so termed, and that was published in 1996. This policy document received broad input from Doctors Mulholland, Hicks and Crean, in conjunction with Mr Clarke, the paediatric directorate manager.

It recognised that workload pressures were becoming evident and I quote from it:

"It was acknowledged that nursing and medical staff are under considerable pressure of work and there were cases where mothers felt that standards of care were inadequate or insensitive. The first phase of the redevelopment of the Royal Belfast Hospital for Sick Children will alleviate some of these problems, but the Trust is concerned that the pressure on staff has continued to intensify."

And it concluded that there was:

"A shortfall in staffing across the range of clinical professions, which continues to inhibit the provision of comprehensive assessment, treatment and rehabilitation services in a number of specialties."

And Dr Bartholome has confirmed in her evidence to the inquiry that this was an issue that had been raised with management.

So in relation to staffing levels, it will be recalled, if one recites the bare facts as they emerged in the clinical part of Claire's case, Dr O'Hare says that there was one registrar covering, I think, about 120 patients, which included four intensive care unit beds, and she worked a 36-hour shift between the 21st to 22 October. She was the sole registrar on duty in the

Children's Hospital between 5 o'clock on 22 October, that's the Tuesday, and 4 am on the Wednesday, 23rd. And she was responsible for 114 inpatients in 12 wards, in addition to covering the A&E department, which dealt with about 100 patients per day, half of whom were seen after 5 o'clock. So that is Dr O'Hare when Claire first comes in and Dr Bartholome over the evening when Claire deteriorated and into the early morning when she suffered her collapse. Dr Sands, her registrar, agrees in relation to there being a single registrar in charge of the Children's Hospital overnight, that that was an onerous job, a big responsibility.

Furthermore, as I've already pointed out, one Tuesday afternoon in four, he was engaged with the clinic of Dr Nan Hill, and we still are exploring the cover arrangements for that. Dr Bartholome gives her view that the relative inexperience of SHOs on duty was a worry because you had to depend on junior staff who were very inexperienced:

"As a safety issue, it was always a big concern because children can become sick very quickly and I would have to keep an eye on every junior doctor, and this is part of the role of the registrar."

There was no night sister on Allen Ward, rather the night sister would have covered the entire hospital.

The ward sister, Sister Pollock, stated that when she could not cover Allen Ward, an F-grade sister would act as back-up. However, because there would not seem to be any F-grade sisters in post until November 1996, she conceded it was a fairly common event to have an E-grade sister take charge. So in October 1996 it would appear that Allen Ward would fall under the responsibility of an E-grade sister during the day and under a ward sister at night who was also charged with covering the rest of the Children's Hospital.

Further, and in addition, there was no permanent nurse manager in post in the paediatric directorate in 1996. Three of the sisters in the Children's Hospital were acting into this position and had the responsibility for different wards and departments of the Children's Hospital.

The effect of that, at a purely governance level, not so much the clinical level, is something that we are hoping to understand better and explore further in the oral hearings. I move now to communications with parents.

The department's charter for patients and clients, March 1992, accords a right:

"... to be kept informed about your progress. Your relatives and friends are also entitled to be informed."

Accordingly, if it is accepted that the patient has a right to information about his condition, it follows that the professional practitioners involved in his care have a duty to provide such information.

During the oral hearings on clinical matters you heard evidence, Mr Chairman, from the clinicians in respect of their impressions of the seriousness of Claire's condition; I won't take you to it. In particular, you heard from Dr Steen. She referred to the picture over the night:

"She's getting more and more complex, a sicker and sicker child with more complications."

Dr Sands, you heard, considered her to be "very neurologically unwell". Dr Bartholome also accepts there is no doubt she was the sickest patient on the ward at that time.

The issue is the extent to which any of that was adequately communicated to Claire's parents. The addition of the paediatric prescriber refers to status epilepticus, which was the condition that Claire was thought to have throughout her admission:

"Once seizures controlled, institute maintenance therapy, keep patients informed and supported."

That's what they were directed to do.

Dr Stevenson has acknowledged in his evidence that

he was ward based and he would have been the point of contact, and the issue is if he was the point of contact, what was the level of his understanding so that he could provide an effective channel for the parents for communication? That is a clinical question, but it's also a governance question. If that's the system you're going to put in place so that it is possible to have a doctor at that level of inexperience there, then what is that doctor's support in order to ensure that your obligations to the parents to keep them informed is being discharged?

It is quite clear from the evidence of the parents that if the clinicians did understand the seriousness of Claire's condition, then they simply failed to communicate that properly to her parents. I won't go through the aspects of their evidence which makes that absolutely clear because, Mr Chairman, you heard it. And in fact, Dr Steen in her own evidence on 15 October 2012 said:

"I think we failed the parents completely around communication. I failed to and the team failed to get through to the Roberts just how sick Claire was."

That might be the first time that Claire's parents were able to hear that acknowledgment.

Whatever the recollection of the clinicians is as to

what they told the parents, there seems to have been no comprehensive record made of that. And the GMC "Good medical practice guidelines" direct that:

"Doctors, in providing care, must keep clear, accurate and contemporaneous patient records, which report information given to parents."

The nursing expert for the inquiry, Ms Ramsay, has said that in her opinion, as a minimum, there should have been a record of the information given to Claire's parents, their understanding and concerns. If that is so, then what might have warranted review is, if the clinicians thought they were communicating to the parents, but the parents failed to understand, how could that be? How could their ability to communicate important information to parents be so lacking that the parents have failed to understand the most fundamental thing, which is: how sick is my child? That is something that might have been worthy of a review. Not everybody's ability to communicate such sensitive information is perfect and that is something that might have been worth considering along with how to improve that.

Allied with that is to improve the system for recording it so at least there's some way of knowing what they think they're telling the parents, and that

might be a starting place for understanding why it is that the parents did not grasp how ill their child was. Seemingly, the only internal review touching upon communication with Claire's family was conducted by Professor Young in 2004, and he formed the conclusion:

"The communication with the family at the time of Claire's death seemed to have been reasonably good. However, some aspects of Claire's condition may not have been disclosed at the time, such as hyponatraemia."

There is no evidence that the records of Claire's case were ever subjected to audit scrutiny and there is little evidence of the impact, if any, that the multidisciplinary medical records committee, which the chief executive states was in place, had upon the quality of the records in this significant respect. And there is no evidence that the system for medical records scrutiny was functioning efficiently.

The GMC "Good Medical Practice" code provides a reminder that:

"To establish a successful relationship between doctor and patient, the doctor must listen to patients."

It's axiomatic that listening is essential to oral communication, and the evidence from Claire's parents is, if they were listening, then they didn't hear them accurately about a number of aspects of Claire's history

that they were seeking to identify to them. You will have heard, Mr Chairman, about the issues to do with the seizures. Dr Webb had formed the view that he was being told that Claire had suffered a seizure on the Monday. Mrs Roberts is of the view that she told him no such thing.

That miscommunication, that misunderstanding, that's an important question, because it allowed Dr Webb to feed that kind of information into part of the formulation of his differential diagnosis. There are other issues on accuracy. Perhaps the most telling of them for the family, anyway, can be seen in the autopsy request form, I won't take you to the details of all of that because you have heard about it, and you have heard about that in the clinical context. But from the governance context, what is the significance of that? The significance of that is that the evidence from the pathologists is that their time is so constrained in terms of being able to conduct these autopsies that they must necessarily rely to a large extent on the autopsy request form and the clinical history provided in it. And that clinical history is providing the context in which they are going to view their investigation during the course of autopsy. So it is significant for them and it was significant for Dr Herron because he formed

the view that Claire had actually had diarrhoea, which was part of his thinking as to the likelihood of certain differential diagnoses when he went to try and conduct a clinicopathological correlation.

But she hadn't had diarrhoea. But that's what he thought because that was how he interpreted that form. So what's on the paper can prove to be important, and Mr Chairman, you have heard throughout how some of the errors get consolidated as they move on and are relied upon by others later on in the system of either Claire's care or the evaluation as to what happened to her.

The final issue in relation to communications concerns trust. The preamble to the GMC "Good Medical Practice" guidance for doctors proceeds from the central premise that:

"Patients must be able to trust doctors with their lives and well-being, and to justify that trust, we as a profession, have a duty to maintain a good standard of practice and care and to show respect for human life and, in particular, as a doctor you must listen to patients and respect their view and give patients information in a way they can understand."

And in emphasis of this concept of trust, paragraph 11 of that guidance continues:

"The successful relationship between doctors and

patients depends on trust, to establish and maintain that trust you must give patients information they ask for or need about their condition, its treatment and prognosis."

It may therefore be inferred that withholding information is potentially damaging to public trust and confidence in the medical profession.

You may wish to consider, Mr Chairman, the extent to which the damage to the public trust done by failures in communication with the parents is something that should have been a concern to the clinicians and administrators involved in the Children's Hospital and evident in its procedures. It was certainly a matter of concern to the department as it was part of the reasons for the establishment of this inquiry. The minister stated:

"I believe it is of the highest importance that the general public has confidence in the quality and standards of care provided by our Health and Social Services. This is why I recently announced that I had appointed John O'Hara QC to conduct an independent inquiry."

And it's also reflected in the terms of reference for this inquiry:

"The communications with and explanations given to the respective families and others by the relevant

authorities."

That is a specific issue that is to be the subject matter of this inquiry.

Mr Chairman, how that was reflected in the interactions with Claire's parents, even then, even at the time that the inquiry was established, that is once Claire's case became known, that's something to be considered.

Communication, of course, as I have indicated extends on to the communications between clinicians and communications between the nurses and between the clinicians and the nurses. And I have said something about that already.

Where does one get the source of that? Well, part of the source of effective communications is medical records and record keeping. And high quality healthcare records are the foundation which allows high quality evidence-based healthcare to be provided. And information has most value, of course, when it is accurate, comprehensive, up-to-date, accessible and targeted at clinical need. It is also necessary for clinical and other types of audit review and research.

Mr Chairman, there are a number of guidelines that were referred to during the course of the clinical hearing relating to the need to keep clear, accurate,

contemporaneous patient records. For example, that comes from "Good Medical Practice", that's 1995. Nurses were also subject to standards for records and record-keeping in 1993. Miss Duffin, who was Director of Nursing Services, has stated that the Trust medical records committee had produced a policy procedure, which used the UKCC guidelines as its base. Well, one will see how that informed action.

A number of issues arose in relation to the records relating to Claire's case. Amongst them, worthy of note for the governance perspective, is the nursing evaluation on Monday the 21st, which omits to record the results of an urine test, although both "urine direct" and "O+S" are ticked. The serum sodium of 132 is entered into Claire's clinical notes at midnight without any reference to the time the sample was taken or the time the result was actually received. Mr Chairman, you will know from the evidence that Dr Webb gave, the confusion that arose for him in terms of guiding Claire's treatment and formulating her differential diagnosis in thinking that that result, rightly or wrongly, whether he should or he shouldn't, but his evidence was that he did think that that result emanated from the morning as opposed to the previous evening.

Then there are the numerous errors, if one calls

them that way, or mistakes made in the recording of the medication that was prescribed or administered to Claire. And leaving aside whether dosages were incorrectly recorded, there is also the issue of not being entirely sure when the clinicians are actually signing off for things, when it's intended they should be administering. Some of that information you have heard during the course of the clinical hearing and I don't wish to go into it now because some of it is a clinical matter. But the extent to which there were systems in place that should have avoided that sort of thing or, if it happened, were there to review it, understand why it happened and put in place steps to ensure that the chances of it happening again were minimised, that's the work of this part of the hearing, Mr Chairman.

So if I then move on to the issue of audit. Consensus guidelines, which are the guidelines essentially that operated, provide an agreed standard against which practice can be measured. And in order to audit the processes of care readily, reference to such guidelines or agreed standards is critical, and the absence of guidelines may, therefore, lead to substandard audit. And the sharing of experience and results from audit or review is a powerful mechanism for

improving clinical guidelines.

The Royal Hospital's annual audit report of 1993/1994 announced its medical audit programme with the assertion that it had developed an effective organisational framework for medical audit, which:

"... supports and encourages changes in clinical practice as a natural part of organisation-wide quality assurance."

And the management executive stressed the need for programmes of audit in its management plan for 1995/1996 to 1997/1998 with reference to better practice. It required that:

"Specifically, units should ensure that there is a clear policy on clinical audit as part of a programme to improve all aspects of service quality -- not just clinical outcomes -- support and evaluation of quality improved programmes, multidisciplinary approaches to the development of best practice in service delivery."

And the introduction of clinical audit implied that practice would be evaluated against some sort of agreed standard to establish better practice. The presence of agreed clinical guidelines, therefore, becomes fundamental and, in the opinion of Mr MacFaul, if audit is examining, as it was to do, quality, the extent of clinical records, availability, the appropriateness of

facilities for diagnosis and treatment, communications -- and he goes on to observe that:

"Given the focus in the 1990s on clinical audit with its implicit requirements for standards against which to judge practice, it is noteworthy and a shortcoming that a range of guidance was not available in print for the staff from early 1990s. And thus the absence of guidelines leads to less good quality and substandard clinical audit. This again constitutes shortcomings in the quality of clinical governance at that time within the Children's Hospital and, indeed, within the Trust generally."

And linked to the targets set by the Children's Services Strategy for the introduction of guidelines is the target that it set for the adoption of a clinical audit programme oriented towards the development of clinical guidelines, monitoring variance in the use of guidelines and assessing the clinical effectiveness of services with an effective clinical information system, which would facilitate the introduction and implementation of clinical guidelines.

The responsibility for any failings in the introduction of clinical guidelines can be traced through the hierarchies of accountability within the Trust, and it will be a matter for you, Mr Chairman, to

determine the reason for any delay in the introduction of clinical guidelines and whether this may have been linked to shortcomings in the Trust's programme of audit.

It is not at all certain that Claire's death was presented at any audit review or mortality meeting. The systems in operation for both audit and review were developing in the mid-1990s and were described in the evidence received by the inquiry in respect of the governance issues arising in Adam's case.

These processes did not, however, engage the nursing staff. Staff Nurse McRandal gave evidence that no one spoke to her about Claire's case after her death and Nurse Jordan denied any recollection of any discussion after Claire's death about what happened or about lessons that could have been learned and stated that she was never asked to be part of any investigation or audit, nor did any nursing manager or any senior nurses ever speak to her about Claire Roberts' death.

Notwithstanding that, Mr Clarke, the directorate manager within the paediatric directorate of the Children's Hospital, confirms that in 1996 there was a site-wide clinical audit process in operation and the paediatric clinicians would have participated in this process. This process included mortality meetings,

discussed within the context of paediatric clinical audit meetings, together with the neurological/neuroscience grand rounds.

Dr Herron has found evidence to suggest that the case was prepared for a neuroscience grand round, but there's no record of the meetings and, Mr Chairman, you would have heard, so far as Dr Herron and Dr Mirakhur have stated, the benefit of those grand rounds is that apparently it engenders a rather spirited debate amongst clinicians, aimed at trying to understand what happens in the child's case, and ordinarily one would think that that was a very positive development that such a thing happened. But you also heard there's absolutely no record of what happens in there and the reason for that, it is said, is because that might be inimicable to free debate.

But a consequence of that is that it's not possible to correlate what action is actually taken after that to any deficiencies that were discussed during the course of the grand round, nor is there a way for the parents to have access to any of what was discussed there, including any criticisms that might have been made there in relation to their child's care.

If we pass on to audit, Dr Steen has no recollection of audit, but would have expected Claire's case to be

presented at a mortality meeting once the post-mortem result was complete. The audit minutes were taken in such a manner as to preclude any possibility of patient identification and the DLS has informed the inquiry that the Trust's understanding is that Claire's case was not discussed at any paediatric morbidity meetings and it is therefore not possible to know whether Claire Roberts' death was discussed at any particular meeting and the attendance register has not been retained.

Dr McKaigue believes that the case was discussed and he claims to have been present. But if it was discussed, then the consequences, the result, the product of the discussion don't seem to be evident in what happened thereafter. Mr Chairman, you may wish to consider that the likelihood of any learning emerging from processes that are designed to leave no paper trail to be questionable.

THE CHAIRMAN: Yes, but the fundamental point is that we have yet to hear a single witness give any evidence of anything that changed as a result of any audit, and we look forward to seeing whether any of the witnesses who return for governance or who come fresh for governance can identify a single point which was learned from Claire's death.

MS ANYADIKE-DANES: Thank you, Mr Chairman, that is exactly

it.

If all those procedures and processes were in place in the way some suggest they were, it's absolutely difficult to understand how Claire's death and the presence in relation to it of hyponatraemia would not have featured at any meeting, could not have emerged, and how her parents could have been allowed to stay for so long without recognising that her case, like the others, involved this particular condition.

If we then to go to adverse incident reporting. That's another tool in the management governance toolkit that should assist. Dr Steen has informed the inquiry that she would not have expected that she would have reported Claire's death to other members of staff as at that time it was felt that the sequence of events leading to her death was known and there were no areas of concern around her care.

Dr Hicks, her clinical lead, would not have expected the death to have been brought to her attention unless it was thought that there had been an untoward event, but who are the people to have formed the view that there is an untoward event? If the treating clinicians don't, then it's very unlikely to find its way up to the clinical lead.

Staff Nurse Pollock would certainly have expected to

have been informed if there was going to be an adverse incidence report, but anyway, she wasn't informed and she made no report herself. So Claire's death goes unreported in 1996 and there is no investigation into her death prior to December 2004. No report in respect of the death was furnished to the clinical lead, who was responsible for the services of the Children's Hospital. It would have been the responsibility of the clinicians involved to advise their clinical director or directorate management team in the first instance, but as I have just cited from Dr Steen's evidence, she didn't see there was that sort of problem, so presumably there's going to be no such reporting.

As Dr MacFaul observes, significant clinical incidents and adverse outcomes should be reported within a Trust structure. The first stage of any such process, however, is recognition of the event in the first place. In respect of the management of Claire, this recognition simply doesn't seem to have happened.

Guidance on the reporting of untoward incidents was available from as early as June 1991, and that was in a circular, and this covered the reporting by hospitals of untoward incidents to the Health and Social Services board where there was a suggestion of a failure in professional standards of care and treatment. And the

Royal Group of Hospitals would have had procedures in place to enable this reporting. The system appears to have operated until at least April 1993, when the Royal Hospital became a Trust, but was perhaps thereafter abandoned in line with the intention that the Trust be able to operate within maximum operational freedom and autonomy, and the system for gathering reports within the Children's Hospital seems to have lapsed and there is no evidence that any steps were taken to encourage the reporting of untoward incidents involving a failure in standards other than relying upon clinicians to report their own mistakes or the mistakes of each other.

The medical risk management group chaired by the medical director with high level representation from Dr Murnaghan and the Director of Nursing had responsibility for clinical risk management and undertook specific responsibility for the reporting of untoward incidents, clinical ones. Dr Murnaghan was also the Director of Risk and Litigation Management, and as such had a very particular knowledge of hyponatraemia derived from Adam Strain's case and it's unclear how the medical risk management group discharged its responsibilities. Indeed, it is not at all clear that it did anything in relation to the reporting of untoward clinical incidents. Mr McKee recalls that, prior to

2000, adverse clinical events were reported using a statement book held in the respective clinical area and details of such incidents as recorded were forwarded to the Director of Nursing and the Director of Medical Administration and these were reviewed and followed up to ensure that appropriate actions were taken.

Well, had Claire's death been reported, then an immediate investigation could have been followed in order to provide the Director of Medical Administration and the Director of Nursing with a detailed written report. Knowledge of the case and the implications of hyponatraemia would thereby have been circulated at the highest levels of governance and it's a matter for speculation as to what difference that could have made to the growing medical consciousness of hyponatraemia and the risks attaching to Solution No. 18 and fluid management. But as we await to hear, it doesn't seem to have happened.

Had Claire's death been subject to scrutiny in 1996 as an adverse incident, it is likely that it would have been referred to the coroner and that would have provided an additional forum for discussion and learning and could have served as a driver for dissemination, particularly as that coroner would only recently have conducted the inquest into Adam's case and would have

heard what they said they were going to do in relation to his case in terms of spreading the message about hyponatraemia.

That Adam and Claire should have died within a year of each other in the same intensive care ward of the same children's hospital without prompting medical comment on the broader lessons of fluid management and the prevention of hyponatraemia is striking and an apparent failure of clinical governance, which will be more fully explored in the oral hearing.

So, Mr Chairman, if I come now to the final phase of this, which is the incidence and events of 2004 to 2006. We start with the UTV broadcast. It's a documentary called "When Hospitals Kill". And that went out on 21 October. The investigative focus was on the role of hyponatraemia, the role that it had played in the deaths of Lucy Crawford, Adam Strain and Raychel Ferguson, and whether there was any cause to suspect a cover-up. The programme was the product of many months of work and had involved contact and correspondence with the Royal Group of Hospitals. And it is to be assumed that the Royal Group of Hospitals was aware in advance of the date of the broadcast and the general content of the programme. Indeed, correspondence was directed, on 7 October 2004, by the Trust's solicitor, Mr George Brangam, to the UTV

producer of the programme to express:

"In the light of the programme makers' unacceptable behaviour, it is with the utmost regret that the Trust cannot participate in the programme or co-operate."

And to suggest legal proceedings unless certain allegations be retracted. So it's to be supposed that matters were being followed at the highest levels of governance.

Claire's parents watched the programme. Mr Roberts described that the circumstances and the unfortunate outcomes of the three children detailed in the programme were so similar to Claire's outcome. An extraordinary thing you might think, Mr Chairman, that a person without any medical training whatsoever on something as technical and complex as hyponatraemia can watch a programme and recognise in that something that related to his own child's condition, who had died many years before then.

So the following day, Mr Roberts telephones the Royal Victoria Hospital's press office and he speaks to a lady he thought was Dympna, who stated the Royal Victoria Hospital were expecting calls following the Insight programme:

"She advised me that she would arrange a meeting with a Dr Nichola Rooney. And Dr Rooney contacted me

later on Friday the 22nd and arranged a meeting for Monday the 25th."

And Mr Roberts continues in a statement he made for the inquiry:

"My wife and I met with Dr Rooney on Monday 25 October at the Royal Victoria Hospital. Dr Rooney informed my wife and I that she would organise a review of Claire's medical notes with regard to fluid management, fluid type and the amount of fluid given and she would also arrange for a review of Claire's treatment from Monday 21 October to Tuesday 22 October. Dr Rooney contacted me by telephone on Monday 1 November 2004 to say that Claire's notes had been passed on to medical staff for review."

Mr Roberts further states in his inquiry witness statement that -- and this is worth reciting in full:

"Dr Rooney informed me that Dr Steen, Dr Webb, Dr Hicks and Dr Sands would carry out the review and a meeting would be arranged in two to three weeks' time. I contacted Dr Rooney by telephone on Monday 22nd for an update on the review of Claire's medical notes and a meeting date. Dr Rooney informed me that Dr Steen had all Claire's notes and Dr Steen would be able to chart Claire's treatment. Dr Rooney also advised me that another senior consultant would be reviewing Claire's

fluid management. She contacted me by telephone on Wednesday 24 November to inform me that Dr Steen had prepared a document, detailing Claire's treatment.

"Dr Rooney advised me that she would like the medical director, Dr McBride, and a professor from Queen's, Professor Young, to look at the document. She informed me that she would then arrange a meeting on 7 November with my wife and I, together with Dr Steen, Dr McBride, Professor Young and Dr Sands."

The inquiry has sought, but has not received, a copy of the document prepared by Dr Steen in relation to Claire's treatment, unless it's the undated, untitled synopsis of the case records, provided to the inquiry by Dr Rooney. It would seem that contingency planning had resulted in the re-deployment of Dr Nichola Rooney, the psychology service manager, to deal with the Royal Group of Hospitals' response to enquiries related to the UTV programme. The extent to which contingency planning also encompassed the review of other cases in which hyponatraemia was implicated or might have been implicated is as yet unknown, but we will pursue it. It is however clear that, by October 2004, two-and-a-half years had passed since the department had published its guidance on the prevention of hyponatraemia and a level of general knowledge of

hyponatraemia within the medical profession may be assumed from the general circulation of information by the department and the Ulster Medical Society. So that should have informed any comprehensive review that you might have hoped the Children's Hospital would have undertaken in relation to past cases.

Such was the public disquiet provoked by that UTV programme that, as you know, Mr Chairman, this public inquiry was instituted. Dr McBride, the medical director of the Royal Hospitals, directed the handling of Mr and Mrs Roberts' complaint. To that end, he personally asked Claire's medical records be recovered from files. He reviewed the notes and felt it appropriate to request Professor Young, a consultant in clinical biochemistry, to review the medical and nursing records, to ascertain whether hyponatraemia could possibly have been a contributing factor to Claire's death. He did not otherwise consider the "Complaints: listening, acting, improving" guidance on the implementation of the HPSS complaints procedure of 1996, which defines a complaint as:

"'An expression of dissatisfaction requiring a response' because whereas [and this is him] Mr and Mrs Roberts have raised significant concerns in respect of their daughter Claire and her subsequent death, I am

not aware at this stage or at any time subsequently that Mr and Mrs Roberts made a formal complaint to the Trust."

Unfortunately the fact that that wasn't considered to be a formal complaint appears to have had implications for how it was actually treated. That's another matter to be pursued, whether one looks to the sense of what's happening or the label that's put on top of it.

The permanent secretary of the department wrote to the Chair of the Royal Group of Hospitals on 28 October 2004 to formally require that:

"All documentation relating to the cases of Lucy Crawford, Raychel Ferguson and Adam Strain be secured and kept safe and, if necessary, be made available for independent examination."

And it's to be hoped that the Trust applied the same rigorous approach to all the documentation relating to Claire Roberts. I suspect we'll find out when we pursue matters further in the oral hearing.

Professor Young did not provide a written opinion, but rather his advice was given verbally by telephone. Dr McBride was to write to Mr and Mrs Roberts:

"Our medical case note review has suggested that there may have been a care management problem

in relation to hyponatraemia and this may have significantly contributed to Claire's deterioration and death."

In this context, "care management problem" is defined by the procedure for investigation and review of adverse incidents as:

"Actions or omissions by staff in the process of care."

The intervening years between Claire's death in 1996 and the review of her case in 2004 witness a sea change in clinical governance and the approach to adverse clinical incidents. Dr Carson, the medical director, was responsible for a series of governance initiatives, or, most notably: clinical excellence, 1997; clinical governance 1999; clinical governance report, 1999 to 2000; clinical governance action plan, 2000 to 2001. These mark the increasing importance of a culture of accountability, or at least the increasing stated importance of developing a culture of accountability.

The Royal Hospitals' annual report 2004 to 2005 emphasised, at page 5:

"A framework for learning in line with good governance and our commitment to openness and transparency. The Royal Hospital will acknowledge to patients and the public when things go wrong and to

systematically ascertain what happened, how it happened and why, so that we can do all that is possible to ensure lessons are learned to prevent a recurrence."

The report further states:

"We have introduced root-cause analysis, which ensures that the learning from adverse events is included in the process and systems of patient care to ensure that we do our reasonable best to prevent further adverse incidents or harm to those in our care, and this procedure is the current model recommended by the National Patient Safety Agency in England and is currently being deployed in the 'Department of Health and Social Services: Public safety in Northern Ireland', through the work of the clinical governance support team."

So let's look at the investigation into Claire's death. Dr McBride was alert to the possibility that the acts and omissions of the Royal Group of Hospitals' staff in the Children's Hospital may have contributed to Claire's death. In those circumstances, it is noteworthy that he chose not to initiate an investigation. It is to be noted that, as Dr McBride himself does, the Trust had introduced, from 2003, training in root-cause analysis of serious untoward clinical incidents. Indeed, the work of this inquiry

might have been assisted if there had been such an investigation. And Dr McBride had noted:

"With hindsight and experience, root-cause analysis may have identified different learning over and above that identified in the case note review and coroner's inquest and may also have provided further answers for Mr and Mrs Roberts into the circumstances of Claire's death. This may have been the case even though eight years had passed since Claire's tragic death, during which time practice had changed and formal guidance on the prevention and management of hyponatraemia had been issued. However, at the time, taking into account the changes in practice in the intervening years, I was concerned that any further Trust investigation could potentially compromise or prejudice statutory investigations."

The department's interim guidance on reporting and follow-up on serious adverse incidents, which was published in July 2004, advises that:

"In those situations, where a body considers that an independent review is appropriate, it is important that those who will be conducting it are seen to be completely independent. In addition, such reviews should normally be conducted by a multi-professional team rather than by one individual. It is also

important that the department is made aware of the review at the outset."

Dr McBride recalls that:

"Given the context of Mr Roberts contacting the Trust and the level of public concern, it would have been my practice to advise the Chief Executive and Chair, particularly as Claire's death was subsequently referred to the coroner. Further, and at my direction, a serious adverse incident report was forwarded to the department in March 2006 following the notification of the date of the coroner's inquest in accordance with the departmental circular."

And that circular is "Reporting and follow-up on serious adverse incidents":

"It's my understanding [he goes on to say] that the former Eastern Health and Social Care board was also informed at this time as was required under guidance. A serious adverse incident report was forwarded to the department and [dated 28 March 2006] summarised Claire's history and stated, in October 2004, after reviewing notes, it was considered in retrospect that the known hyponatraemia, which was treated, may have had a part to play in the medical condition leading to death. It is for the inquiry to assess the accuracy of this report."

And Dr McBride further notes on 31 August 2006:

"The department has been informed as per the circular and have requested a further background briefing, which I will provide."

That briefing document, Mr Chairman, has not yet been provided to the inquiry, although it has been sought.

It is unclear why Dr McBride chose not to make the reports pursuant to the interim guidance of the 2004 circular immediately after the matter was brought to his attention. This guidance is couched in similar terms to the later 2006 circular and states at paragraph 15:

"The department will expect urgent local action to be taken to investigate and manage adverse incidents. In addition, it requires that where a serious adverse incident occurs and the senior manager considers that the incident is likely to be of public concern, he should provide the department with a brief report within 72 hours of the incident being discovered."

Unless the 2004 guidance had gone unnoted in some way, the department issued an additional circular in 2005 to restate the guidance previously given and to:

"Underline the need for HPSS organisations to report serious adverse incidents in line with the 2004 circular."

It's not apparent that any investigation into

Claire's treatment or death was pursued at that time, and in a letter to the inquiry, the DLS advised that:

"There were no investigations into Claire's death prior to December 2004. Nor is it clear that the Royal Group of Hospitals conducted any investigation after December 2004 and it is to be regretted that this opportunity to assist the work of both the coroner and this inquiry was not taken."

So then if I pass on to the meetings with the Roberts. The e-mail correspondence passing between Dr McBride, Professor Young and Mr Peter Walby, who was the Associate Medical Director of the Litigation and Management office of the Royal Group of Hospitals Trust, on the day before the meeting scheduled with Mr and Mrs Roberts for 7 December 2004 reveals some of the preparation for that meeting.

Professor Young was then employed as a consultant by the Royal Group of Hospitals and was based at the Royal Victoria Hospital site. He had discussed the case with Dr Steen and had exposed areas of disagreement with her in relation to the case. These are his words:

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

Additionally, Dr McBride clearly recalls that he met

with Professor Young and Dr Steen in or about 6 December 2004. This meeting was not formally minuted, but Dr McBride recounts:

"The outcome was that I was advised by Professor Young that hyponatraemia may have contributed to Claire's death. I asked that Professor Young's opinion be communicated to Mr and Mrs Roberts. I indicated that I wished Dr Nichola Rooney to be present at the meeting to support the family. It was confirmed that Professor Young, Dr Steen and Dr Nichola Rooney would attend the meeting with Mr and Mrs Roberts and communicate Professor Young's opinion that hyponatraemia may have contributed to Claire's deterioration and death. I determined that in the light of Professor Young's opinion, the Trust would now refer the case to the coroner and I asked that Mr and Mrs Roberts should be informed of this decision at the meeting."

On the morning of Tuesday 7 December, Mr and Mrs Roberts, Dr Rooney, Dr Sands, Dr Steen and Professor Young all met at the clinical psychology department of the Children's Hospital to discuss and address the unanswered questions and concerns regarding Claire. Dr Rooney opened the meeting, she outlined the issues and her secretary prepared a detailed four-page

typewritten minute of the discussions. And Dr Steen charted Claire's progress with reference to the medical notes and allowed Professor Young to field the questions relating to the fluid administration. Dr Rooney summarised the issues discussed and then left it to Mr and Mrs Roberts to decide whether they would seek further information or meetings or if they wished the matter to be referred to the coroner.

The content of Dr Rooney's minute of this meeting is noteworthy in a number of respects. Despite the fact that reassurance was given to Mr and Mrs Roberts that questions they feel still remain unanswered regarding Claire's death will be addressed, that the Trust would meet with them at any time to help them in any way possible, and that the Trust wants to be completely open in this case and will be happy to meet with Mr and Mrs Roberts again, Dr MacFaul believes that the approach to and the conduct of the meeting and the minute could be open to criticism. In particular, he says that consideration should have been given to the commissioning of an independent written report from a paediatric neurologist in these circumstances and that Professor Young may not have been recorded as independent, as he was employed by the Trust at the time.

The clinical paediatric lead within the Children's Hospital, Dr Hicks, was not there, and in his view she should have been a part of the general governance management. She should have reviewed the death and it's to be regretted that Dr Hicks was not there as she seems to have been particularly qualified to assist in the understanding of Claire's case, because not only was she the clinical lead, she was a consultant paediatric neurologist who had previously treated Claire when she was a baby and was the lead at the time when Dr Webb was providing his specialist assistance. She was qualified in medico-legal ethical issues and had been selected by Dr Murnaghan for inclusion in the seminar group that he was seeking to set up to review the lessons to be learned from Adam Strain's case which is, of course, as you know, the inquest for which was just four months before Claire's death.

There are also a number of inaccuracies and omissions contained in that minute in relation to the information given to Mr and Mrs Roberts and those seemingly went uncorrected. It's also to be noted that there's actually no reference to the autopsy report in the discussions, or at least if there was, there's no reference to them in the actual minute. The content of that autopsy report was relevant to all the issues that

were under discussion and it's not clear whether it had actually been made available to Professor Young or Dr Rooney at the time, and if it hadn't been, it's certainly not clear were it wouldn't have been.

Dr Steen appears, at least in the record of the minute, to have remained silent as to the post-mortem conclusions and seemingly didn't share the document prepared by her in respect of the care and treatment given to Claire. Or if she did, again, it's not something that's recorded.

Claire's medical notes and records were available and they might have been shared with Mr and Mrs Roberts to help them in understanding what was being described to them as the passage of Claire's admission and the diagnoses that were made and the treatment that was given to her.

Dr Steen is recorded as providing an explanation to Mr and Mrs Roberts as to how an illness such as Claire's can arise: viruses known as enteroviruses can enter the body via the stomach and can then cause swelling of the brain and it's not always a case that children with low sodium levels will result in swelling of the brain and that it's very difficult to evaluate how much the fluids contributed to the situation. The word "hyponatraemia" doesn't appear in Dr Rooney's minute and no reference

was made in the minute to the drug errors in relation to the midazolam and phenytoin, and you will have heard all the evidence in relation to the extent of the overdose of those particular drugs.

So it will be a matter for you, Mr Chairman, to consider and determine whether that constituted a failing in clinical governance review. That was the new era of 2004, that was an attempt to provide an open explanation to the family. That's what the Trust or the clinicians were seeking to do. Whether they succeeded in that is a matter to be determined ultimately by you.

But this is what, after that, the Roberts still wanted to know. They wrote a letter on 8 December 2004, raising a number of questions, and some of them, perhaps the most significant, are these:

"Does the full post-mortem report make any reference to hyponatraemia? Will the cause of Claire's death be reviewed by the Children's Hospital? Given that Claire's death was sudden, unexpected and without a clear diagnosis, why was the coroner not informed or an inquest held?"

And, Mr Chairman, it is perhaps noteworthy that at least two of those issues are matters that we are still having to consider in this inquiry. So if it was, if those questions were considered and answers were

provided to the Roberts, then it may be that there is a question mark as to the sufficiency of that.

Then Dr McBride directed Mr Walby to coordinate the notes of meetings and report to date so that:

"You are in a position to share this information with the coroner."

And on 16 December 2004, Mr Walby wrote to report the matter to the coroner formally. He described how having been examined by paediatric neurologist, Dr David Webb, Claire was considered to have a postictal acute encephalopathy and she was treated as such. She developed hyponatraemia and consideration was given to whether this was from the fluid overload with low-sodium fluids or a stress-induced antidiuretic hormone effect and her fluid management was altered.

You have heard the clinical evidence, Mr Chairman, and it will be a matter for you to determine whether indeed consideration was given as to whether the hyponatraemia she developed was from the fluid overload and, if it was, whether that consideration is effectively confined to the note of a very junior doctor at 11.30 on the Tuesday evening.

Dr Walby recounts how:

"Dr Steen also considered that there were errors in my letter and I requested her to provide corrections for

me to forward to the coroner."

So Dr Steen was given the opportunity to edit the information being given to the coroner and she took that and emphasised as part of doing that that the admitting registrar had formed a provisional diagnosis of possible encephalitis. And while that is the case, what she didn't also provide by way of information to the coroner in her review of that letter was that the admitting registrar had subsequently deleted that as a possible diagnosis.

If we move now on to the issues to do with the coroner and the inquest. It was Mr Walby's task to liaise with the coroner's office and to obtain statements from the staff involved in Claire's case. It is to be assumed that these statements were intended to form the basis of the inquest depositions and they appear to have been typed on pro forma PSNI witness statement sheets. This was apparently on the basis that this was the historical format preferred by the coroner. So Dr Steen's statement is dated March 2005 and that pre-dates the PSNI investigation. Dr Steen seems to have been reminded several times during the course of the five months it took her to furnish her statement to Mr Walby to produce it. The inquiry has not been provided with copies of statements from all the staff

involved in Claire's case, such as were envisaged by Professor Young when he advised Dr McBride.

The process for taking witness statements to be used in a coroner's inquest and other court proceedings is covered by a departmental protocol published in 2002. A different view of best practice was, however, expressed by the coroner in his letter dated 30 January 2004 to the medical director, Michael McBride, and this is that he says in "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 agree that in future I would agree to a police officer interviewing those involved and the present system would be discontinued."

This prompted Mr Walby to seek advice from the solicitor, Mr Brangam, on the basis that:

"The coroner's approach would seem to me to be a backward step."

No advices were forthcoming from the solicitor and Mr Walby took no steps, apparently, to follow the coroner's advices. He wrote to Mr Brangam on 21 March 2005 to advise:

"As you know, we are still operating the old system."

In respect of the preparation for Claire's inquest, the PSNI were not involved. Mr Walby simply arranged for witness statements to be written on PSNI paper without the involvement of the PSNI. Mr Walby also arranged for legal advisers to approve the statements prior to release, corrected and redrafted statements, permitted professional indemnity insurers to comment on and approve doctors' statements. As to whether this approach would have constituted best practice by anybody's standards is a matter for the inquiry and

certainly whether it complied with what the coroner had in mind is a matter to be considered. And Mr Chairman, you have already heard evidence in relation to Dr Webb's evidence here in the inquiry as to how he had provided his detailed witness statement, informed by the clinical notes and records, signed the witness statement and nonetheless that was amended for him, sent back, and he incorporated that amendment and presumably re-signed it and sent it on as his statement to the coroner. Why? Well, we don't know, but one of the changes that was made is his concession that he believed he had made a mistake.

Mr Walby's job description specifies his duty:

"To assist the coroner with enquiries and the preparation of statements prior to inquest."

And his job description also requires him:

"To give advice and support to staff involved in coroner's cases."

So on one hand, he is tasked to assist the coroner; on the other hand, he's giving advice and support to staff who may themselves -- their conduct, in any event -- be called into question in a coroner's case. It is a matter for you, Mr Chairman, to determine the possible impact on good governance of any tension that there may have been to those two obligations and the

requirement that Mr Walby discharge them both and wear his two hats.

Indeed, it is for you also to determine, Mr Chairman, whether it was appropriate for the Royal Group of Hospitals to transfer sole responsibility for proper investigation to the coroner rather than conducting a simultaneous analysis itself, which might have assisted the learning all the time the coroner is pursuing his statutory obligations, and it might have assisted Mr and Mrs Roberts, the PSNI and indeed this inquiry. And as part of the process of informing the coroner, the comprehensive reply from Dr Rooney on behalf of hospital dated 12 January 2005 was forwarded to the coroner on 25 January 2005 with the observation that:

"I will leave it to you whether you wish to forward them to Dr Bingham to assist in the compilation of his report."

And further inaccuracies were supplied to the coroner, not in consequence of any independent investigation, but rather and in part on the basis of Dr Steen's own interpretation of Claire's case and her medical record.

So now, finally, Mr Chairman, to the inquest. Mr Walby's preparation for inquest included

consultations on 3 April 2006 with Dr Steen, Dr Sands and Dr Webb together with the trust solicitor and, on 7 April 2006, with Professor Young. The inquest into Claire's death was opened on 4 May 2006 by the coroner. Dr Bingham gave his evidence. He considered that the admission diagnosis was reasonable and that acute encephalopathy was a likely cause of her presenting illness. He did not consider the serum sodium concentration of 132 to be a likely cause. He considered it reasonable to have given Claire IV fluid and noted that she was given the fluid used as a standard in 1996 within the recommended volume for full maintenance fluid therapy. He believed that there were, however, reasons why Claire might have required fluid restrictions:

"Namely a lower level of her metabolism and possibly reduced urinary output due to secretion of ADH, which may accompany encephalopathy and nausea and vomiting."

And he concluded:

"If the reported sodium level of 121 was accurate, then it was the likely cause of her deterioration and death."

Dr Maconochie, who was also engaged as an expert, considered:

"A diagnosis of encephalitis/encephalopathy and/or

non-convulsive status epilepticus to be quite probable given her past history of seizures."

He regarded the management of those diagnoses to have been appropriate and did not comment on hyponatraemia because he wasn't charged to. He considered Dr Webb and the other members of the team looking after Claire had given careful and informed advice and, at the inquest, he gave his opinion as to the cause of death to be:

"Cerebral oedema, encephalitis/encephalopathy, and hyponatraemia, and thirdly, status epilepticus."

And Dr Bingham agreed with Dr Maconochie's formulation.

So the inquest verdict given as cause of death was:

"Cerebral oedema due to meningoencephalitis, hyponatraemia due to ADH production, and status epilepticus."

And the coroner found that the degree of hyponatraemia suffered contributed to the development of the cerebral oedema, which caused her death, but also that the meningoencephalitis and status epilepticus were also causes, albeit he couldn't determine the proportional contribution of each cause. And as a result of all of that, a new registration of death certificate was issued on 10 May 2006 with the cause of

death amended to reflect the coroner's verdict at inquest. So that's what the coroner found and it will be part of what you consider as coming out of the clinical hearings whether any of that could have been found earlier if better consideration had been given to Claire's treatment during life, and if that hadn't been possible and she died as she did, then whether if there had been proper investigation following it, what the coroner found could have been found also and could have identified the reasons why that had occurred, rather than Claire's family having to wait quite so long to hear in this inquiry some of the concessions that they have heard and now, in this part of the inquiry, to try and understand whether the systems that should have been in place were indeed in place and, if they were, how it was that they were unable to either prevent what happened or to ensure that something positive was learnt from what happened.

That really is the area of course, Mr Chairman, of this part of the inquiry. There is a much more detailed opening, obviously, and I haven't sought to go through it all. What I was trying to do is pull together some of the strands of it and I hope that nobody will take what I have said here as a substitution for the full opening: that has all the detail, it's fully referenced,

and that really is the place where we have set out all the evidence that we have found to date and the reasons why we are pursuing the courses that we are in the course of this hearing.

THE CHAIRMAN: Thank you very much. That's a very good balance between the full written opening, which is available to everybody, and the summary of it. Thank you.

Mr Quinn, I presume you're going to be a little while, are you, in opening?

MR QUINN: I would say no more than 45 minutes.

MR GREEN: Before my learned friend starts the opening on behalf of the Roberts, the parents, may I make a point which is a point that concerns Dr Sands, about a particular passage in the opening? I am in your hands as to whether you want to hear from me now.

THE CHAIRMAN: Would you speak to Ms Anyadike-Danes during the break and decide between you? I'll deal with any point after the break.

MR GREEN: I have spoken to Mr Quinn about it.

THE CHAIRMAN: Why don't you speak during the break and we'll pick it up at 12.15? Thank you.

(12.10 pm)

(A short break)

(12.20 pm)

Governance opening by MR QUINN

MR QUINN: First of all, Mr Chairman, I want to thank Michael McCrea of counsel and John Ferguson, my solicitor, together with the Roberts family for their input and assistance with the opening statement on behalf of the family. Secondly, we're greatly encouraged by Ms Anyadike-Danes' opening, her abridged verbal opening statement, which we agree is very well pointed. We agree that it addresses a number of issues that we see as extremely important in the case and I want now to try and highlight some of those issues that the family want particular attention drawn to.

The inquiry has a very detailed and comprehensive opening on the governance issues, there's a written opening on the governance issues prepared by Ms Anyadike-Danes and her team. This sets out the evidence received relating to governance and lists the governance issues that the inquiry team feel relevant and important. It also quotes and highlights some of the clinical evidence and how it relates to governance.

The Roberts family fully support the governance opening prepared by the inquiry team. However, they want they to deal with the governance issues on a more personal level and examine how they affect Claire and her family and examine their relevance, particularly

in relation to the safekeeping of children who are treated at the Royal Belfast Hospital for Sick Children in the future.

Of course, the family want the full list of governance issues investigated and support that investigation. But they see some of those issues as more pertinent to them and, hopefully, these are issues upon which they can comment and provide some useful input that may assist this inquiry.

Having listened to the evidence relating to the clinical issues, the family are aware that the inquiry has already identified numerous errors, oversights and shortcomings in Claire's diagnosis, treatment and management.

Of course, the family want to know why the treating clinicians responsible for her care in 1996 repeatedly failed to identify the errors and still deny them to this day. The family acknowledge that mistakes are made in every walk of life and it is doubtful that anyone sitting in this room today has not made a mistake in their professional career. Some of those mistakes have very little impact on our lives and careers. Some of those mistakes may have led to embarrassment or, even worse, professional criticism and admonishment.

However, in this case, a catalogue of errors led to

the death of a child. Tragic incidents occur in every walk of life. Children are lost in boating accidents when on family holidays, they're killed in the back of their parents' cars when a serious crash occurs, and we have heard of numerous farming accidents -- in fact, I have been involved in quite a few where an unfortunate father tragically crushes a child in a tractor accident.

Those mistakes are open to investigation and criticism, but in Claire's case nothing seems to have been properly investigated. There has been little or no criticism levelled at anyone and, most tragically, it would seem that for a number of years after the death of Claire, nothing changed at the Children's Hospital. There are a number of points that appear in the table of content in the opening document that Mr and Mrs Roberts feel are more relevant to users of the hospital and the contact with medical staff and hospital administration. They feel they can perhaps help the inquiry with the evidence on those issues and those include: communication with parents; children with learning disabilities; medical records and general record keeping; drug administration and keeping parents informed about the administration of drugs; post death events; post-mortem request procedures; conduct of the autopsy, in particular where the autopsy was limited to

brain only; the autopsy request form; the autopsy report; and informing the parents about the contents of the contents of the report in plain and simple language; the adverse incident reporting; the investigations into Claire's death immediately after her death in 1996; and thereafter, the investigations that arose out of the UTV documentary in 2004; and the investigations leading up to the inquest in 2006.

Today, Mr Chairman, you have said -- and I endorse this and the family endorse it -- it seems that no one has yet identified a single point that was learned from Claire's death.

The parents' approach. Fundamental to how the parents approach this case is their belief that the doctors who were treating Claire did not realise how ill she really was. Once you accept this basic premise, then everything else falls into place. The parents believe that they were misled throughout the course of events from around the time of Claire's death to the start of this inquiry. They were never given a proper and adequate explanation of what happened to Claire, what treatment she received and what caused her death.

She was admitted to the Children's Hospital with a tummy bug at 8 pm on Monday 21 October 1996. By 4 am on the 23 October, she was beyond help. The shocking fact

is that, just over 30 hours post admission, she was dead. The cause of death has been a matter of debate and dispute, but what no one can ever dispute is that Mr and Mrs Roberts have waiting 16 years to discover what actually happened to Claire.

Alan and Jennifer Roberts, like the other parents in this inquiry, have no medical expertise. However, like all parents in the inquiry, they have a good firm grounding in common sense, and they have an excellent memory of what went on because we are dealing with a child of their family, and that memory is pertinent to that child. So when Dr Bartholome, in hindsight, agreed and Dr Sands told the inquiry that undoubtedly Claire was the sickest child on the ward, this came as a complete shock to them. Dr Sands has gone so far as to say that Claire had "a major neurological problem" and that "she was very neurologically unwell".

The parents are now more than a little confused as they have heard in the last few days that Dr Webb may not fully agree with that assessment of Claire's condition.

THE CHAIRMAN: Well, he's quite a way away from it because he went home on the Tuesday evening expecting Claire to improve and recover gradually.

MR QUINN: Exactly. So he is long way away from it.

We also know that the nurses did not seem to be very concerned and although Dr Sands maintains that he did tell the staff she was very unwell, that view does not seem to have been transmitted to the parents by either Dr Sands or the staff and this is a major issue that we want to have investigated.

To set the scene for what happened later in relation to the governance issues, any neutral observer with a fair amount of common sense would have to ask the following questions: if she was the sickest child on the ward, then why did Dr Steen not see her first thing in the morning on 22 October? Why did she not see her after the ward round if Dr Sands assessed her as being very seriously ill or perhaps just before -- that is Dr Steen -- went to her clinic? Why did she not come back after her clinic at around 5 pm when she was fully aware -- or should have been fully aware -- that Dr Webb was seeing her patient?

Of course, all of that makes sense when you take into account Dr Steen's comment that it was disgraceful that her parents were not told how ill Claire really was. The answer and the fundamental truth is that the parents were not told how ill Claire was because most of the doctors didn't realise how ill she was. In fact, it is probably the case that no one realised how ill she

was and, if they did, they certainly did not transmit that to the parents when they were present at the Royal Victoria Hospital.

Why did Dr Webb leave at 5 pm if Claire was the sickest child on the ward? His treatment plan had not been implemented so he did not know what results would be produced if he left the child described as the sickest child on the ward and went home without arranging for any other cover. The conclusion I would bring out of that, Mr Chairman, is that he didn't realise at all.

Why did Dr Webb not inform the parents that she was very sick? The parents went home at 9.15 and the inquiry has seen what effect that has had upon the parents when they gave evidence. They would never have left the hospital had they been properly informed. The communication process between doctors and nurses and between the staff and the hospital users should be examined by this inquiry.

Why did Dr Webb not advise the parents that they shouldn't go home until Claire showed some improvement? Why did the nurses let Mr and Mrs Roberts leave the hospital at 9.15 pm? In fact, the evidence would suggest that the nursing staff were quite nonchalant about them leaving and gave them no cause for concern

whatsoever. The answer may be that the nurses weren't told, weren't aware, and did not appreciate that Claire was very neurologically ill. Why did the doctors act as they did if, in fact, they did realise that Claire was very neurologically ill and could be described as the sickest child on the ward?

Why did Dr Bartholome not engage with the consultant on call when they got the blood results at around 11.30 pm on 22 October? Why were the parents not called back to the ward at that point? Because at that point, they realised that Claire was ill. Even the most junior doctor on the ward, Dr Stewart, was aware that they had a serious problem on their hands. So we have a registrar who, on her own evidence, is run off her feet and yet no one calls for assistance from more senior clinicians and no one informs the parents. It is on these fundamental issues of common sense that the parents want an answer. The system for dealing with such emergencies should be fully reviewed by this inquiry.

Let's put the parents' evidence in to the framework of events on 21, 22 and 23 October 1996. They say that Dr Sands never told them that Claire had a major neurological problem and that he was going to get an opinion from a neurologist, that she may require

investigations such as an EEG or a CT scan.

If he had, this would have immediately raised serious concern. The alarm bells would have been ringing and Mr and Mrs Roberts definitely would never have left the hospital. Once again, you can see how this fits with the fundamental point that Mr and Mrs Roberts make and they want this expressed -- and I repeat it on their behalf -- they don't believe that the doctors realised how ill Claire really was.

THE CHAIRMAN: And if that's right, then it makes it difficult to understand how at 4 o'clock on Wednesday morning a decision was taken not to refer to the coroner and a decision was taken to limit the autopsy to brain only. If Dr Steen hadn't come back at 5 o'clock and if Dr Webb had gone home and Dr Sands had gone home -- with some level of concern but not a great level of concern -- then Claire's death became entirely unexpected at 4 in the morning.

MR QUINN: Exactly.

THE CHAIRMAN: And one couldn't be sufficiently confident, on this approach, of the cause of her death to decide not to have a full autopsy and not to refer to the coroner.

MR QUINN: Exactly because no one was aware that she was ill. It was totally unexpected and unexplained.

I make the point: what explanation were they given about their daughter's sudden and totally unexpected death? What happened then was they had a meeting with Dr Steen and Dr Webb in relation to the brain coning and the brainstem tests. They are adamant that they were told that Claire had died of a viral illness and no other specific information was given, and they will tell this inquiry when they give evidence on the governance points that that is correct. Hyponatraemia or fluid management was never mentioned. Quite justifiably, the parents are angry that a simple procedure like a blood test was not carried out. The chairman of this inquiry has repeatedly made the point that something as simple as a blood test could have turned this case around. The witnesses are still disputing responsibility over the blood test, but it would seem to be an undisputed fact that had bloods been done at an earlier stage and the sodium level discovered, then Claire would have been alive today, and in fact, Mr Chairman, you recall that Dr Webb was still disputing that point when he gave evidence.

Even at 11.30 on 22 October, when the SHO Dr Stewart realised that the patient might be suffering from hyponatraemia, no one with any experience had the time to examine Claire. We have heard from the experts that

even at that late stage there was some chance of saving Claire.

It would seem that it was only at this point that the SHO appreciated that Claire was very ill. If it was appreciated by other staff, then why was there no emergency procedure put in place when Dr Stewart contacted Dr Bartholome? There is a question mark as to whether or not she may have been beyond help at that stage, but unfortunately her condition was not fully appreciated and even though the notes suggest that the fluids were restricted, the mathematical calculations of the fluids shows that, in fact, when one takes into account the intravenous drug infusions, the fluids were actually increased.

Further, there should have been more discussion about whether sodium should have been added to the fluids, and you'll see that is a note made by Dr Stewart on the medical records. The bottom line is that she was failed by the system as there does not seem to be any clear guidelines on what should have happened in this type of case and a review of the system may save lives in the future.

The problems with staffing levels, the skill and experience of the doctors diagnosing and advising the treatment and the information that the parents are given

on the ward are individual to each case. All families are aware that in busy hospitals there are always risks and children fall between the gaps in the care regime and do not get correct treatment quickly enough. Mr and Mrs Roberts and their extended family know that there are risks when children go into hospital. They may have been able to deal with Claire's death had a proper investigation been carried out and a full and frank explanation given to them in late 1996 or early 1997.

However, in this case, Alan and Jennifer Roberts were misled. They believe they were misled in relation to the explanation given for Claire's death or, at the very least, they didn't get the whole truth. In the beginning they were given a limited version of what happened in Claire's treatment, but as things went on, they make the case that they were actually misled on certain issues that fall within the governance of this case.

Then I ask: should the coroner have been involved in 1996? This leads us into the question about why Claire's death was not referred to the coroner. We have now heard evidence from Dr Scott-Jupp, an expert paediatrician, who seems to have no doubt that because of an uncertain diagnosis, ie not a firm diagnosis, that this was an indicator for reporting the case to

the coroner. That's in the transcript of 4 December 2012.

The parents will say in evidence that they feel that a doctor has a statutory and ethical duty to inform the coroner of the sudden death of a child. They want to make the point that when a child's death is sudden and unexpected, and without clear diagnosis, then it should be referred to the coroner. If the clinicians were in any doubt whatsoever, they should have referred it to the coroner. The family want to know why it wasn't referred, given the uncertainty of the diagnosis and the doubts that were in the clinicians' mind at that time.

Autopsy request form. They are now aware that the autopsy request form was full of misleading information. I opened the family's case on the clinical issues highlighting several errors on this form, errors that the family say should not have been on the form because the information was never given by them. That's the family. They acknowledge the work done by the inquiry on this is issue. They find it ironic that the clinical notes are brief, but that the autopsy report form is full of information, albeit mostly wrong. They have now heard Dr Herron agreeing with the proposition that if the information provided on the form was factually

incorrect, then it would influence the way that he would approach his pathology investigations. Simply stated, if the clinical summary is wrong, then it is probably repeated throughout the investigation and the mistake is compounded. That was confirmed by Dr Herron.

What they wanted was for someone to stand up and say, "We made a mistake, we are sorry and we hope that we can put things right so that this doesn't happen to another child". The most distressing part of the case is that this is precisely what did not happen. Instead, Mr and Mrs Roberts had to wait until 2004 when a documentary was aired by Ulster Television in relation to children who died from hyponatraemia before they saw the link between the cases and started the second part of their investigations.

Brain-only autopsy. Was the brain-only autopsy appropriate? One thing that sticks with the parents is that Dr Herron, the pathologist, stated that "brain only" was underlined. That is on the request form. And he had never seen that before. We now have Dr Scott-Jupp's evidence on this, and he is of the opinion that if the parents consent, then a full autopsy is more appropriate as it may provide more information that would assist in reaching a conclusion about a child's death. They also find it interesting that the

pathology evidence is that the level of an inflammation found is low grade, sub-acute, and on a scale of 1 to 10, it rates as a 1 or 2. Experts such as Professor Harding and Dr Squier state that there is no evidence of acquired infection. Further, Dr Squier's evidence on 5 December 2012 is clear on this point, relating to brain-only autopsy. She said:

"In 1996, [she] would always expect to do a full autopsy unless the parents do not consent."

However, at a meeting on 3 March 1997, Mr and Mrs Roberts were told by Dr Steen and Dr Webb that the post-mortem had concluded that a viral infection was responsible for the brain swelling, though the virus itself could not be identified.

Then we come to the events, Mr Chairman, after the 2004 UTV documentary, and what happened after that. In her witness statement at WS143/1, Dr Steen states that she has no recollection of the events other than Claire's parents were aware of low sodium being implicated as this is what jogged their memory and resulted in them contacting the Trust to discuss Claire's death.

The Roberts will say that this statement is incorrect. They were never aware of hyponatraemia or Claire's low sodium level until after the meeting with

the clinicians and Professor Young on 7 December at the Children's Hospital. They contacted the hospital because the TV programme had highlighted that the wrong type of fluid had been administered to children featured in the programme. Their first enquiry with the hospital was in relation to the fluid management, fluid type and amount of fluid given. You will hear of this when they given their evidence at the inquiry on 13 December.

I'm indebted to Ms Anyadike-Danes for highlighting this issue and going through the correspondence in detail, which saves me the trouble of going into it any further. However, I want to mention the meeting of 7 December and what happened during that meeting. When the parents attended the meeting, the parents were told that Professor Young was going to conduct an independent investigation.

I stress this -- and I stress this for the transcript -- they were in no doubt that Professor Young was introduced to them by Dr Rooney as someone who would carry out an independent investigation. That's the evidence they will give. And that investigation was into the events surrounding Claire's death. They now challenge Professor Young's independence. It became clear after reading the files, examining the correspondence and e-mails, that Professor Young was in

contact with the various clinicians who had charge of Claire's care during her admission to hospital on 21, 22 and 23 October 1996.

Of particular relevance is the contents of file 139, which could loosely be described as the coroner's investigation file relating to the Royal Victoria Hospital and this death. There are a number of issues relating to the correspondence in that file that cause us concern. The parents want the full file investigated and the letter of 5 October 2012, which I will attach to the opening, from their solicitors, Messrs Ferguson & Company, to the inquiry solicitor sets out in detail the issues raised by the family.

They want to make the following points in this opening -- and I stress at this stage that Mr and Mrs Roberts have had a substantial input into this area of the opening. I wonder if you'd be kind enough to pull up document 139-153-001.

This is an e-mail from Professor Young to Michael McBride dated 6 December 2004. What has to be realised here is this is the day before the meeting with Mr and Mrs Roberts on 7 December, when he was put forward, that is Professor Young was put forward, as an independent investigator. When you look at the contents of that e-mail, you can see that he met with

Heather Steen on the afternoon of 6 December and that they had a discussion about hyponatraemia. I will read out what is relevant:

"We met with Heather Steen this afternoon and reached a measure of agreement about the role of the hyponatraemia. She wants to be present at the meeting tomorrow and will deal with any questions about the clinical journey, while I deal with the fluid issues. Hopefully this will work. Heather has definite views about the significance of the fluid management, which are not quite the same as mine. Nichola will offer the parents the opportunity to meet with me separately if they wish to. Heather thinks it is important that someone should speak to David Webb in Dublin so that he is informed about what is happening. Do you want to do this or will I try to contact him?"

I've already mentioned that he has met Dr Steen on the 6th, they reached a agreement, and she wanted to present the clinical journey while he deals with fluid issues. And he comments, "Hopefully, this will work". We want to know what will work, what is he working at? The parents want to know what this means.

They also want to know who else was at the meeting when the e-mail opens with "we met Heather Steen this afternoon." We want that investigated.

At the end of the email, Dr Steen recommends someone should speak to David Webb in Dublin "so that he is informed about what is happening". What was happening? We were expecting an independent review to happen. What was happening in Dublin? Why should Dr Webb be informed about what was happening? Why would Professor Young contact Dr Webb to tell him what is happening when he is carrying out an independent investigation? If he is contacting him for information, that would be a different matter, but why is he contacting him about what's happening?

Referring to the note of the meeting of 7 December, which is reference 089-002-005, Professor Young added that:

"At the time of Claire's treatment, there was a lack of awareness of low sodium."

However, Dr MacFaul, who is an expert to the inquiry, will say that, from 1994 onwards, there was an awareness of fluid management, hyponatraemia and encephalopathy.

It was during this meeting that the parents first heard that, on admission to hospital, Claire's sodium level was 132, but had later fallen to 121. It was at this same meeting that they were first advised that she had received Solution No. 18. This was the first time

they were advised that a blood check to test the sodium level had not been carried out between admission and approximately 24 hours later.

However, they were not advised of the implication of the lack of blood testing. Further, Professor Young made no comment about the mistakes in treating Claire: the absence of appropriate tests, the poor record keeping, or the overdose of drugs.

The letter of 12 January 2012, which is reference 096-018-113, from Nichola Rooney, who chaired the meeting of 7 December 2004. Mr and Mrs Roberts are critical of this meeting and this is a letter of explanation arising out of it. It should be noted that Dr Steen and Professor Young rely on the medical charts. It's paragraph 3 in the first page of the letter, please. It'll be 111.

If you look at the third paragraph:

"I know it has been difficult to fully answer some of the very specific questions as Dr Steen and Dr Young could only reply on the documentation available in the medical chart and their knowledge of the practices of the time."

So clearly, Professor Young and Dr Steen have the charts.

We therefore must assume that they have read them,

checked them and reviewed the notes and charts, and that they reviewed the treatment and the drug therapy.

The Roberts then want to draw attention to these references. Reference 5(a), that was page 113 of the same document, paragraph 5(a) of the same letter, please. It's 112.

At 5(a), the last sentence:

"It is not possible to say whether a change in the amount and type of fluids would have made any difference in Claire's case as she was very ill for other reasons."

The parents were never told about any other reasons. They were never told she was very ill and that a neurologist was summoned or that a CT scan was organised. In fact, they were never told at this meeting for the day after. What evidence, tests or results did Dr Steen have other than the sudden fall in sodium level within 23 hours? It seems some clinicians are still in denial and perhaps a proper review could have come up with some answers.

Let's go to the next page, please, 113, reference 6(b).

THE CHAIRMAN: If you pause there. When Mrs Roberts met Dr Webb at about 5 o'clock on the Tuesday afternoon, did she know that he was a neurologist?

MR QUINN: No. So far as I'm aware, she knew he was

a doctor, but not whatever specialist he was. She wasn't aware of what he did.

THE CHAIRMAN: Or the fact that he was being called in meant something different from Dr Sands?

MR QUINN: No. She was not aware that he was a neurologist, I'm certain of that.

THE CHAIRMAN: Thank you.

MR QUINN: 6(b) records:

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

During this period, it must be pointed out that Claire's Glasgow Coma Scale reading fell from 9 to 6 during the same period. There was no improvement in Claire's condition due to an incorrect diagnosis, medication overdoses and an incorrect fluid plan.

Why would the doctors not act? Why did they not act when the GCS dropped to 6? We now know that Dr Webb changed his statement at Mr Walby's request where it relates to dealing with the issue of PICU referral. We know that, and Ms Anyadike-Danes actually opened her part of the case and mentioned that particular point.

THE CHAIRMAN: There's even an issue about whether you wait until the Glasgow Coma Scale drops to 6.

MR QUINN: There is. The parents would make the case that there should have been more attention paid when it went down below 9.

Let's go to the next paragraph, 7(b) in the next letter. The parents were here being assured that the correct action was taken. In fact, correct action was not taken, and this statement is incorrect. Her fluids were actually increased when one adds in the intravenous fluids. Dr Bartholome failed to turn up and examine Claire at 11.30. No consultant was informed and Claire was unattended for a further three hours before her respiratory arrest at 2.30 am. So the parents feel insulted that someone is trying to tell them that correct action was taken.

No decision was taken on whether to increase sodium levels in fluids, but it was considered by Dr Stewart. The last section of paragraph 9 of the letter sets out the practice of the time, but was this done? So therefore, what we have here is the Royal admitting that there was a best practice in place, so let's have a look at paragraph 9. The practice at the time, as appears in the letter, seems to have been, firstly, to restrict fluid intake and, secondly, to consider administration of fluid with a higher content of sodium if symptoms attributable to hyponatraemia were present.

We now know that neither was done, that there was a mathematical error in the fluid restriction and that no further consideration was given to giving fluids with a higher sodium content. Yet there seems to be an assumption in that letter, Mr Chairman, that it was done. And the point the parents make here is that if a comprehensive review or audit had been carried out at the Children's Hospital, it would have had to conclude and arrive at the conclusion that there were mistakes and system failures.

THE CHAIRMAN: That leads you into a two part issue, doesn't it? Part 1 is: what was the ambit or extent of the exercise being done through Dr Rooney and Professor Young? The second part is: if that was limited, as it appears to have been, should there not have been a more significant investigation and intervention?

MR QUINN: Of course. Of course that's the point.

When you look at paragraph 10 of the letter, if we go through to the next page, please, 114, you will see in paragraph 10:

"Having brought Claire's case to the attention of the medical director, a review of Claire's case note was carried out, with independent advice sought from Queen's University Professor of Medicine."

That seems to suggest that another review of the case notes has been carried out and the parents cannot understand why the mistakes that are now so apparent in the case notes were not detected. By way of papers served yesterday, we now know that Mr Walby also had some input amending this letter. This letter was sent in draft to him by Dr Rooney, and the parents want the inquiry to fully investigate Dr Walby's input into this case. Just for the sake of reference, the letters to Dr Rooney and the amended -- it starts in or about 139-173-001, where there's a string of e-mails and references to Dr Rooney's letter and amendments in handwriting suggested by Mr Walby. Let's go to the inquest then in 2006.

There are a number of points the parents will raise in their evidence, but one of the main issues is that the parents find it absolutely incredible, I can use no other term to describe their feeling about this, that Professor Young's review and analysis of the papers leading up to the inquest -- and those were seen by Dr Steen and Webb and others, and during the public examination during the inquest no one realised that Claire had two substantial overdoses of drugs.

Dr Steen reviewed the clinical notes when making her statement to the coroner and again when making a police

statement, as did Dr Webb. Claire had an overdose of midazolam of more than 300 per cent and an overdose of phenytoin, but that was not picked up by any of the witnesses or experts and in particular it was never mentioned by Dr Steen, Dr Webb or Professor Young.

Did the inquest clear things up for the Roberts? Absolutely not. Not one expert spotted any of the mistakes that were in the notes, even though they all gave evidence. No one criticised the notes for content and structure, lack of timing, dating and signing, and we must question how that would fit with any audit or review of the notes.

Inquiry counsel has highlighted this aspect of the case in the opening statement, but I feel that I must repeat Dr Steen's concession. She states:

"I can in no way defend the quality of my documentation or anyone else's."

That's on 3 October 2012.

She then went on to say:

"Our documentation is poor and we know it's poor."

That's on 15 October 2012.

The fundamental point that the family make is they want to know why the witnesses did not point this out to the coroner. A number of witnesses reviewed the notes for the coroner's case and they discussed various

references in the notes and, in fact, you will see that at reference number 139-156-005 Dr Steen discusses various elements of the notes in her police statement. I know now that this is a statement prepared for the Coroner's Court, may I add.

She reviews the drugs, but fails to mention the overdoses and misses that the prescription records show a massive overdose of 120 milligrams of midazolam, though we do concede there may be an issue as to whether she ever received that, but it is fundamental that it was not picked up in any of the notes. You can see halfway down the third paragraph, five lines down:

"He felt that she continued to be in a status epilepticus and advised commencement of midazolam with a stat dose of 12 milligrams."

It's clear that she has reviewed the notes and has recorded 12 milligrams, yet we know now that that's a 360 per cent overdose. It may be relevant that Dr Sands added to the note the entry "encephalitis/encephalopathy".

THE CHAIRMAN: She has corrected the note, hasn't she? The note says 120. The actual hospital note says 120.

MR QUINN: It does.

THE CHAIRMAN: She has corrected that in her statement.

MR QUINN: The 12 milligrams is from the clinical records.

She hasn't picked up the prescription records. That's the point I'm making. What she says in the statement is an entry taken from the clinical notes when the stat dose of 12 milligrams was prescribed for Claire. But what nobody seems to have picked up in any of the notes is that the prescription records have an entry of 120 milligrams, which is a massive overdose.

THE CHAIRMAN: Yes.

MR QUINN: Going back to the entry "encephalitis/encephalopathy", that entry was undated, unsigned and, obviously, in a different hand and pen than that which appears to have written the note on the ward round. Why was there no criticism of that, Mr Chairman? Why was that not picked up and criticised at the Coroner's Court when this was reviewed by at least four different people and Queen's University?

In relation to this entry made by Dr Sands, "encephalitis/encephalopathy", the parents have a genuine doubt as to why the entry was made as it doesn't fit with the nursing notes. In fact, they will say that it fits with nothing at all in the case.

The family want the issues that were tested in the inquest to be reviewed by this inquiry. They want those issues raised again in light of the expert evidence and the further statements that have been made. For

example, there is a letter from Mr Walby to the coroner, 139-149-001, where in paragraph 3 it states:

"She was examined by a paediatric neurologist, Dr Webb, and he considered her to have a postictal acute encephalopathy and was treated as such. She developed hyponatraemia and consideration was given to whether this was from fluid overload with low-sodium fluids or a stress-induced antidiuretic hormone effect and her fluid management was altered."

What we ask is: did Doctors Steen, Sands or Webb give consideration to fluid overload with low-sodium fluids in 1996? Because the parents were told it was a virus. Was Claire's fluid management considered reviewed in 1996 or at any time before the parents started asking all of these questions in 2004?

The parents will say -- and will give evidence next week -- to say that there was no discussion about fluid overload or low-sodium fluids in 1996. So why were the parents not told about hyponatraemia in 1996? Hyponatraemia appears in the clinical records, it was entered by Dr Stewart, who was probably the most junior doctor on the ward, and then it appears in the intensive care record notes. Why wasn't this raised with the parents?

The clinical mistakes, errors, oversights, lack of

audit and review, limited autopsy, et cetera, meant that Claire slipped through a gaping hole in the safety net provided by the National Health Service. Once she was through that hole, she was dead.

The family believe that the cover-up began after Claire was transferred to PICU and it was recognised that there was no hope of recovery. If the family are not correct about a cover-up, then what did happen in 1996? How can it be explained? How would a neutral observer interpret the evidence? What is the explanation for the events surrounding investigations and information given to the family?

They have already raised issues of concern on file 139 and want to highlight the following as a further small example of what any member of the public with an ounce of common sense would want reviewed and investigated.

In file 139, at reference 139-096-001 -- it's not an e-mail as I've stated -- it's a letter from Mr Walby to Dr Webb dated 31 July 2005. Mr Walby suggested a change to Dr Webb's statement and we can see that in his draft statement, which I don't need to pull up. This has already been covered by Ms Anyadike-Danes in her opening, but I want to emphasise that this has already been highlighted in Dr Webb's evidence of Monday of this

week, but it is something that the parents are particularly concerned about as it looked as though there is a hand steering the evidence behind the scenes and I want to highlight that in other documents.

If we then look at document 139-106-001. We have another piece of correspondence from Mr Walby, this time to Dr Sands, dated 6 June 2005, suggesting that he should leave out a part of his statement. This discusses fluid therapy and concludes paragraph 1 by stating:

"All in all, it sounds very defensive and, at this stage, if you leave your comments out, it is probably better."

The parents would like that examined.

Similarly, at reference 139-148-001, we have correspondence from Mr Walby to Dr Steen dated 22 December. It is worth reading the handwritten note at the bottom:

"I hear you have identified errors in my letter reporting the death to the coroner. If so, perhaps you would let me have corrections so that I can appraise the coroner of this as soon as possible, please."

What errors did Dr Steen -- he addresses her as "Heather" -- identify? And what impact did those errors have? What did Mr Walby do in relation to Dr Steen's

input and why was she adding any input at all?

We've already highlighted the e-mail from Professor Young to Dr McBride on 6 December. We would also like to refer to the e-mail passing between Professor Young and Mr Walby on 10 April 2006, which is 139-038-001. In this e-mail, Professor Young states that Doctors Sands and Steen should be appraised of Dr Webb's comments:

"I think that Andrew Sands and Heather also need to be appraised of David Webb's comments on these issues if they are not already aware of them."

Bear in mind that the inquest in Claire's case was held on 4 May, so what we want to know was why was Professor Young, as an independent investigator, ensuring that the witnesses be appraised of each other's comments? A neutral observer would have to conclude that his independence was compromised. A parent would jump to only one conclusion.

Further additional papers have been served in file 139. We have already raised the issue in relation to Mr Walby's advice to Dr Rooney in relation to her letter of 12 January and the corrections that he advised. The parents also want the inquiry to investigate Professor Young's email to Mr Walby of 7 April 2006, which is 139-170-001. In this e-mail he

discusses various issues that have been raised in Claire's case. Perhaps that could be brought up.

THE CHAIRMAN: They don't have it, I'm afraid. We'll sort that out over the weekend.

MR QUINN: Why was Professor Young corresponding with Peter Walby, who was in the litigation management office, if he was conducting an independent review? Why was the correspondence flowing between the independent reviewer and the litigation office? What is the meaning of the e-mail of 5 May from Mr Walby to Pauline Webb. And I quote the third paragraph, which may again not be on the website yet:

"I spoke to Mr Roberts at the end of the inquest ..."

This is a letter reviewing what was said by Mr Roberts to Peter Walby:

"... and advised him that if he still has concerns, he should write to the chief executive. The clinicians would be happy to meet with the family if that would assist. However, I wish to warn you that there were questions raised, which will properly be answered by the O'Hara inquiry in due course, and you need to be aware of their interest in discussing policy changes, et cetera, arising out of the death of Adam Strain in 1995. I would counsel you against allowing the Roberts

to run their own mini-O'Hara inquiry themselves."

What does that mean? Claire's parents would like those comments to be fully investigated. How were they running a "mini O'Hara inquiry" themselves? There are dozens of issues that have been highlighted in the opening statement prepared by the inquiry team -- and again I am indebted for the abridged version today -- but Mr and Mrs Roberts want to put a personal slant on the opening. They want to make the following points.

Nothing was done after the death of Adam Strain. In fact, the inquest into Adam's death came only a matter of months before Claire's death. What lessons were learnt? Nothing was done after Claire's death. There is no hard evidence or records of any meetings or review procedure, staff or nursing reviews, or the review of any element of supervision or staffing on the wards. Not one part of the system that was in place at the time was reviewed or overhauled, not one member of staff was criticised in any way whatsoever. Why was nothing done after the inquest? And what I mean here is Adam's inquest. Because when we heard evidence from Dr Murnaghan -- who I understand is the medical administrator, not the medical director -- he was asked by the coroner to address the problems and he undertook to do something. So what we have here is a situation

where the coroner requests Dr Murnaghan, being in a position of authority in the Royal Victoria Hospital, to take this on board and do something about it. And when he was asked why he didn't do anything about it in relation to what the coroner requested him to do, he replied "mea culpa". A fitting answer for a man who failed to do anything.

Alan and Jennifer Roberts have reached the inevitable conclusion that no one did anything because no one wanted to raise ripples in an otherwise quite smooth pond. What hurts the parents most is that Claire seems to have died for nothing. The hospital learnt nothing, they did nothing and therefore what else can reasonable-thinking parents make of this other than that there was a general cover-up going on? Why did Claire's parents have to wait 16 years to get to the truth? It is absolutely incredible -- and the parents again instruct me to use those words -- that the public now have to hear that after the death of two children, Adam and Claire, that nothing was done. In fact, hopefully Dr Murnaghan speaks on behalf of the Children's Hospital when he says "mea culpa". Will the clinicians and administrators of the Children's Hospital fall in behind Dr Murnaghan and also acknowledge the blame that falls on them?

Thank you, Mr Chairman.

THE CHAIRMAN: Thank you, Mr Quinn.

Mr Green, I suspect you want to take me back to page?

MR GREEN: 17, sir. If we start with the run in to the passage which has caused some concern to Dr Andrew Sands. It's six lines down from the top, sir:

"It may also be very relevant that Dr Sands added to the note the entry 'encephalitis/encephalopathy', that this entry was undated, unsigned and obviously in a different hand and pen as that which appears to have written the note at the ward round. Why was there no criticism of this entry?"

I make no complaint about that run-in part because Dr Sands now understands, more than anybody, that one is vulnerable to criticism if one makes a note in medical notes and doesn't sign it, date or time it. But it's the next passage which causes particular concern --

THE CHAIRMAN: Sorry, just pausing there, the fact that it's in a different hand and different pen is because it's his writing rather than Dr Stevenson's, isn't that right?

MR GREEN: Absolutely.

THE CHAIRMAN: So that's not the issue.

MR GREEN: That's just the run-in. But then next:

"In relation to this entry made by Dr Sands [and then it is repeated], the parents have a genuine doubt as to why this entry was made as it does not fit with the nursing notes. In fact, they will say that it fits with nothing at all in the case."

May I preface the concern I advance about that by saying that nothing I say now is meant by way of criticism of the parents of Claire Roberts or the fact that they rightly feel entitled to make wide-ranging observations about matters which cause them genuine and ongoing concern. But if we look at it for a moment from Dr Sands' point of view, it appears to him, and you may think there's some force in it, that the way that is put is somewhat loaded with the innuendo that this was perhaps a self-serving addition to the notes after Claire's death in order to give the reader the impression that the picture that Dr Sands was seeing on 22 October was a different one than the picture he was actually seeing in real time.

That causes him real concern. It causes him concern particularly because none of this was put to him for him to deal with when he gave his evidence live on 19 October, and perhaps if this point was to be raised, it would have been better had it been put to him when he gave his live evidence.

Sir, it may be said that we're now on to governance, so different issues are being analysed, but the reality here is that this particular note and the issues surrounding it are at least as relevant to the clinical matters as to the governance side of things.

I therefore ask aloud, as it were, what is to be done about it? It may well be, sir, that you can allay both the concerns of Mr and Mrs Roberts and Dr Sands if you were prepared to make the observation that you will scrutinise all the concerns that are raised during this inquiry process and give all interested parties an opportunity to deal with any such issues if you think that the point comes, for example, when they need to be recalled to speak to them.

But when one looks at it, perhaps at the end of all of the evidence, it may be that this issue isn't as troubling for either Dr Sands or the parents of Claire Roberts as it appears to be on paper now. Drawing the strands together, I can see matters sympathetically from the point of view of the parents, but I hope, sir, you can see them sympathetically from the point of Dr Sands.

THE CHAIRMAN: I can, and I can see the tension between them. What I'll do over the next couple of days is I will re-read the transcript of 19 October to see

exactly the extent to which this point was or was not developed, and if necessary, then we can revisit it at the start of the week with Mr Quinn and take a view as to whether, on this particular point, it may not be necessary to ask Dr Sands to come back to the witness box.

MR GREEN: I'd be grateful for that. If he is to come back, I'd be grateful if he could be called the week after next. It's simply that I have a personal matter which is going to involve my absence for the whole of next week. I mean no discourtesy by my absence.

THE CHAIRMAN: I understand because I don't think you'd have been anticipating the recall of Dr Sands at all. We can work our way around that.

MR GREEN: Thank you, sir. That's all I have to say.

THE CHAIRMAN: Ladies and gentlemen, we'll break for lunch and we'll take Mrs Jackson's evidence at 2 o'clock. Thank you.

(1.15 pm)

(The Short Adjournment)

(2.00 pm)

MRS MARGARET JACKSON (called)

Questions from MR STEWART

MR STEWART: Good afternoon. You have made two statements to the inquiry. One in relation to Adam Strain's case,

WS262/1, and one in relation to this case, WS272/1. Are you content that the inquiry should adopt those statements as your formal evidence?

A. I am, yes.

Q. And also, you made a statement to the police on 2 May 2006. Are you likewise content that that should be admitted to your evidence?

A. Yes.

Q. Thank you.

As part of your witness statement, 272/1, you kindly supplied us with your CV, which is at WS272/1, page 14. I wonder if that might be shown on the screen.

This is relevant, if I can bring you down to two-thirds down the page:

"1993 to July 1996: sister in theatres."

And immediately beneath that:

"July 1996 to May 1998: acting nurse manager responsible for theatres, day procedure unit and intensive care."

And the reason I draw attention to those two entries is that you were theatre sister at the time of Adam Strain's surgery and death in the theatre and you were acting nurse manager for the intensive care unit at the time of Claire's death.

A. That's correct.

Q. In relation to either of those deaths, were you asked to make a statement by the hospital?

A. Not to my recollection, no.

Q. In respect of either of those cases, were you involved in any audit or review?

A. No.

Q. In respect of either of those cases, were you contacted by any investigation into the circumstances of those cases?

A. No.

Q. In relation to your position and role at the time of Claire's admission, you are described as acting nurse manager responsible for a number of particular areas of the hospital. Can you describe what "acting nurse manager" meant at the time?

A. My understanding would be that it wasn't a substantive post. We were not appointed to a permanent post; it was, I suppose, a fill-in. They hadn't -- the posts had been advertised and they weren't filled. And as a result of that, as an interim, I believe that they appointed three of the internal staff to carry out until such times as they did advertise and appoint.

Q. It was a temporary stopgap?

A. Yes. That was my understanding.

Q. How long did that continue for?

A. Approximately two years, I think it was. I think we finished around 1998. I'm not very clear on the exact dates.

THE CHAIRMAN: When the jobs were advertised, do you know why they weren't filled?

A. The applicants were unsuccessful.

THE CHAIRMAN: Okay, thank you.

MR STEWART: There were three sisters acting up as nurse managers.

A. Yes.

Q. Was there subsequently a single individual who performed the role of overall nurse manager?

A. Yes. There was a single person appointed around the middle of 1998, I believe.

Q. So your ambit of responsibility was, as you described it: theatres, day procedure unit and intensive care.

A. Yes.

Q. Was there an equal division of responsibility between the three acting nurse managers?

A. I believe it was more or less equal. I think probably in staff numbers and responsibility, it would have been. The ambulatory care was, in actual fact, A&E and all the outpatient departments, which made quite a substantial group. And then the wards together, they came together naturally, I believe, and would be naturally managed

more easily by one person than mixing them, say, through -- having myself with the acute theatres and so on trying to manage a ward would be more difficult. As well as that, myself and the sister in charge -- the nurse in charge of the ambulatory care areas, we were preparing for transfer of services of our areas into a new building, so we were also heavily involved and increasingly so during that two-year period with that transfer of services, which would have taken us away from trying to manage ward areas.

Q. So you were busy and you had additional responsibilities outside the ward.

A. Yes.

Q. Did you have other duties to perform in addition to your acting nurse manager duties?

A. As in?

Q. Any other ward duties?

A. Not in ward, no. I would have -- in cases of shortage of staff or so, I would have gone back into theatre to help out, that sort of thing. But we had -- not really, no. It was mostly within the areas that we were designated plus the ... We also would have -- sorry, I'm not being very clear. I apologise.

THE CHAIRMAN: Don't worry.

A. We had a rota that we would have been on call, if you

like. We carried a bleep on rota for the whole hospital so there would be one of us available at all times to be contacted by any of the ward or departmental staff who had problems or maybe staffing problems, any type of problem. We would have been on call.

MR STEWART: Were you a natural port of call for somebody with a problem or request for help?

A. That would have been the -- yes, the bleep holder would have been the port of call for that.

THE CHAIRMAN: And the call comes from the sister, does it?

A. The sister or whoever's in charge, their deputy.

MR STEWART: We have had difficulty ascertaining who was the nurse manager with responsibility for Allen Ward, where Claire was at this time in October 1996. What is your recollection?

A. It wasn't me.

Q. Can you remember who you think it might have been?

A. To the best of my recollection, it was Sister Surgenor.

Q. Do you have any reason to remember that as being the case?

A. My recollection was that the jobs were divided initially as theatres, intensive care, ambulatory care, and the wards. After we were appointed, we realised that the night sisters had not been included and they were then added in in discussion, I believe, with the directorate

manager to the wards group. And the specialist nurses, research nurses and the play specialists, the research and specialist nurses being more outpatient driven largely, were added into Mrs Moneypenny's group, which was the ambulatory care.

Q. Did you yourself ever have to, as it were, cover the responsibility of Allen Ward if Sister Surgenor was unavailable?

A. We would, yes, if one of us was on leave or not on duty or not available. Through the bleep we would have covered, but it would have been -- if it was something that had to be dealt with that was other than just, say, a ward problem, initial(?) problem, staffing, something like that, I would certainly have handed it back over to whichever one of them was their area. If it was ambulatory care, I would have directed back to Mrs Moneypenny because I don't have a lot of knowledge of that area and ward areas I have, if you like, even less knowledge. I don't think I have worked in a ward from about 1970 -- the late 1970s.

Q. Did you have a regular system of meeting with the other two nurse managers?

A. It was sort of ad hoc, but it would have been more or less on a daily basis we would have met. I actually shared an office with Mrs Moneypenny. Sister Surgenor

had an office at the back of her own department, but we would have met day and daily and possibly more often. We tried to keep each other up-to-date with what was going on and to deal with things as far as possible together.

Q. So if issues arose, you'd have been aware of them as they arose?

A. I would have been aware of them as they arose, yes.

Q. Did you also have meetings with the sisters on the wards?

A. I would have gone to my own areas when I was on duty on a daily basis, but we had sisters' meetings monthly at which all the sisters and specialist nurses, I think, would have come. I think the play specialist -- play leader would have come and we would have met. Those meetings were minuted.

Q. Would people have brought problems arising in practice to those meetings for discussion?

A. Very often, yes.

Q. Would they have been tabled and put on an agenda for specific --

A. They could have been, yes. If they had them far enough -- we preferred them to be tabled, but sometimes they brought them on the day of the ...

Q. You described in your witness statement something called

directorate meetings.
A. Yes.
Q. What were they?
A. They were meetings that were chaired by the clinical director, I think. And basically, all the medical staff, nursing staff, were invited, and other -- the laboratory people, everybody came together to talk about the issues within the Children's Hospital and report on ... Again, laboratory people would have given reports so they would have had -- I can remember they used to have reports on blood product, changes in practice, that sort of thing would have been brought through there.
Q. Did the nurse managers submit a regular report to the directorate meeting?
A. We give a report on the nurse staffing. That would have been the most common one. Sickness, which was always usually on most months.
THE CHAIRMAN: Would Miss Duffin have been there at that meeting?
A. She would have come to ... She would have been invited, have come to some of them. That wouldn't have been -- she would have come to the sisters' meetings sometimes as well.
MR STEWART: She described when she gave evidence to the inquiry something called "nursing executive team

meetings", which were monthly meetings where she met with nurse managers.
A. Yes, those were trust-wide. I believe those are the ones she's referring to, the executive ones.
Q. Yes.
A. And yes, I'm trying to think, did I ever go to them? I think I may have been to one or two of them -- I think we would have gone when we could, depending on what our workload was.
Q. Would it be fair to say that there was a network --
A. There was a network, yes.
Q. You could gauge what's happening on the wards from the sisters --
A. Yes.
Q. -- and at meetings with the other nurse managers, and that could be brought to the director of nursing, it could be brought to the clinical lead, and so, in theory, you can get issues of concern to you and pass them up the line so somebody with influence and control could address them.
A. Absolutely, yes.
Q. And did that happen?
A. I believe it did, yes. We would have passed on issues within Children's Hospital and Miss Duffin would have visited the Children's Hospital fairly regularly, either

monthly or bi-monthly, depending on her commitments. And she would have visited some of the wards, not every one on each visit. But she would have talked with us about any problems and we had the opportunity to air any problems then with her. As well as that, we could contact her office by phone at any time if we had a major problem that we felt we needed advice with.
THE CHAIRMAN: Who was between you and Miss Duffin in the nursing hierarchy or was there anybody between you and her?
A. I don't recall. She had people in her office who were ... No, I don't think so. I think we would have had a direct link with her, I think.
MR STEWART: I think that's exactly what she said.
Do you think there was much that happened in the Children's Hospital at that time that you didn't know about?
A. I didn't know about?
Q. Yes.
A. Well, it seems to be that I didn't know about Claire's death.
Q. Yes.
A. Well, I may have known that Claire had died, I may not have known her by name, but we would have -- the three of us would have been aware that a patient had died

within the hospital. But we would not -- when I say Claire's death, I wasn't aware there was anything potentially untoward about it.
Q. When a child died, was that something that was looked at because there was a death?
A. Not as routine, no. Not unless there was something untoward.
Q. Was there a view that lessons could be learnt from cases of death?
A. I don't believe that we at that time were reviewing each case. Certainly, within my own department -- and I can really only talk about theatres with any knowledge -- on those very rare occasions when a child sadly died in theatre, we certainly would have reviewed it, reviewed what had happened, talked it through, very often with the anaesthetists and surgeons, because everybody would have got together to talk about if it was preventable, you know, was there something that we could have done, maybe we would have prevented it. And I don't believe we ever did have ... I can only think of ... Well, one child stands out in my mind, and it wasn't at all preventable, but we did sit down and talk about it at length afterwards, both as a nursing group and with the consultant and with the anaesthetist. Sort of a -- just talking it through, you know.

Q. Were cases ever selected at random --
THE CHAIRMAN: Sorry. I understand that, but that makes it all the more difficult for me to understand why there was no such review when Adam died. Because if you specifically and clearly remember a review of the death of another child whose death could not be prevented, then that suggests to me that even in a case where a child -- some children unfortunately have illnesses and conditions which will inevitably kill them very young. The incident you're talking about -- and you are not giving me the child's name and I don't want the child's name -- but you're saying to me that you remember that specific example where, even though the death was unavoidable, you sat down, the doctors sat down, and you talked through it and discussed what had happened and what might be done. But do you understand my difficulty --
A. I do.
THE CHAIRMAN: -- in understanding why that didn't happen in Adam's case, where Adam wasn't expected to die at all?
A. I'm sorry, I may have misled you a little bit. This was very informal, it wasn't a formal review as such.
THE CHAIRMAN: Unfortunately, in Adam's case, whether you would call it an informal or formal review, there doesn't seem to have been any review at all, certainly

not one which involved any nurses. From what you've said, that seems unusual, doesn't it?
A. I have little memory, I must admit, of Adam's death. I'm not quite sure why. I do recall people talking about it, but it would more it was a ...
THE CHAIRMAN: As a tragedy --
A. A tragedy, yes --
THE CHAIRMAN: -- rather than any sort of analysis?
A. Yes. I think, when I talk about it, it's more of a support for the staff, who, you know, would find it difficult and to make sure that everybody is dealing with it appropriately with themselves.
THE CHAIRMAN: I gathered from the discussion that you were suggesting a few minutes ago that part of the reason for this was to see whether anything could be learned from it. You are supporting each other and that, of course, is important. But you're also looking to see if anything can be learnt from it: might there be anything we could do better next time, even if what we did last time wasn't wrong? That sort of thing.
A. Yes. I see, yes. I think that the case I'm thinking of, this other case, it was a totally ... It was our own surgeons, for a start, and we would have had more communication with them, and they would have spent more time with us, talking to us. In Adam's case, the

surgeons were from another hospital and possibly we wouldn't have had the opportunity to talk it through with them in the same way.
MR STEWART: You had some responsibility for training staff and for their continuous professional development.
A. Yes.
Q. If you heard people talking about a death such as Claire's, would you not have thought, "What do the nurses say? Is there a nursing issue here? Let's look at it"?
A. I mean, I have to say that I was not aware of Claire's death and I don't recall ever hearing her death being discussed by anybody. So it would be difficult for me to answer that.
Q. You had issues that you took to the directorate meeting.
A. Mm-hm, yes.
Q. You mentioned staffing levels.
A. Yes.
Q. Wouldn't it be of assistance to know if a death perhaps might touch upon one of the issues that you were interested in?
A. If it had affected theatres or intensive care, then I would certainly have done so, but with wards I wouldn't have had the same knowledge.
Q. But you would have met with the nurse managers on

a daily basis.
A. With Adam Strain, you mean?
Q. No, with Claire's case.
A. In Claire's case? Well, I wouldn't have met with Miss Duffin on a daily basis.
Q. The nurse managers?
A. I would have met with the nurse managers. But I'm not aware that they ever brought to me anything about Claire.
Q. The issue of staffing levels and workloads, was that a pressing concern in 1996?
A. I think that there was concern about staffing. I think that there was always concern, particularly it was more on the grading, but there's always concern about staffing levels.
Q. And indeed, this was a particular responsibility of yours, according to your witness statement:
"Monitoring staff levels, making sure that staff were cost-effectively deployed and effectively managing absence of --
A. I think that was within my own department in particular. But we would have had a cross -- you know, for the whole hospital, particularly for my own area. I would have been responsible for that, yes.
Q. Was it a problem that was discussed at directorate

meetings?
A. It would have been, yes. It would have been highlighted that there were problems.
Q. The inquiry has obtained a document, which is a 1996 strategy for Children's Services called "Getting it together". And the title page is at WS266/1, page 28.
If we look at the cover that, do you recognise that publication from 1996?
A. Yes.
Q. And indeed it had input, I think, from a predecessor of yours, Sister Brush, who was on the team.
A. Yes.
Q. And if we go to page 50 of the document, we'll see a description of current services. If we run through to the tenth line down:
"Though the Royal Belfast Hospital for Sick Children has the advantage having paediatric trained staff in all disciplines, workload pressures are evident, particularly among nursing staff and in certain medical areas."
Was it a particular concern for nurses that they were short staffed?
A. I had very little contact, really, with the wards. If they had concerns, they would have been going to the nurse manager who was responsible for that area. She

might have highlighted it to myself and to the other acting H, but she would have dealt with it herself. I would have been dealing mostly with theatres and intensive care.
Q. Yes. You were present at the meetings when this, as an issue, was discussed.
A. Yes.
Q. What was the problem, why was there a short staffing issue?
A. Um ... I'm sorry, my recollection of that time is a bit vague. Funding, probably. Well, not funding, but there was always a squeeze on funding overall.
Q. Yes.
A. And recruitment was a problem, obtaining the correct staff. There were other calls on the student nurses, as they qualified, and quite a lot of them would have gone away or gone closer to home when they qualified, and we weren't able to recruit them.
THE CHAIRMAN: Back to Tyrone or Fermanagh or somewhere rather than stay in Belfast?
A. Yes, very much so. So I mean, it's always hard to keep up with those you lose, to replace them, and then when you do replace, you're replacing, we found in Northern Ireland, certainly in Belfast here, we found that we were replacing with newly-qualified staff. So

therefore, your skill mix was difficult to maintain.
MR STEWART: I wonder if you can help me with an entry in this strategy document, which is at page 54. Halfway down there's a paragraph commencing:
"The Royal Hospitals have recently reviewed staffing levels and cost pressures within the Royal Belfast Hospital for Sick Children on the basis of current activity levels."
Halfway down is "Nursing staff":
"A review of nursing staff, current work practices and standards of care was recently completed by a project team. The review confirmed that services are under-resourced and that an increase of at least 18.2 wte nursing staff is required to sustain service levels."
That's quite technical management speak. Do you understand that?
A. Yes.
Q. That seems as though there is more or less an ongoing shortfall in staff and that a considerable increase is required to bring it to strength.
THE CHAIRMAN: Can you give me some idea, Mrs Jackson, you need an increase of at least 18.2 working --
A. Full-time equivalents.
THE CHAIRMAN: Give me an idea of how significant that is.

How many nurses, just in round figures, to the best of your memory, would have been working in the Children's Hospital in around 1996? We're talking about 100, 200, 300?
A. I honestly have no recollection of that, I'm sorry.
THE CHAIRMAN: Okay.
A. Sorry.
MR STEWART: The inquiry has already heard evidence in relation to possible shortfalls in staffing levels on Allen Ward in October 1996, specifically 22 October.
At that time, there was no one designated night sister for the ward, but rather one night sister designated for the entirety of the hospital; is that correct?
A. That's correct.
Q. Why was that?
A. I think that that had always been, I suppose -- you could say, historically, it had been and we had not at that time any changes in staffing ... You'd have to make a case for it and that would have to go forward to the directorate and then on to the Trust. And that -- although we would have liked more sisters overall, we hadn't been able to get funding for it. And as you can see, I'm not sure who made that, but it was identified that we did need more staff. But there had only ever

been one night sister and I suppose -- no, there used to be more than that, but they would have overlapped on occasions.

THE CHAIRMAN: There was a time when there was more than one night sister in the Children's Hospital?

A. There used to be -- there would usually be two night sisters covering the week. Or three, there were three night sisters covering the week. That gradually eroded to two, and when one of those night sisters was off, the day sisters would have rotated on to night duty to cover.

MR STEWART: I have just been handed a figure at lunchtime today that, on 22 October, 114 beds were occupied in the Children's Hospital.

A. Right.

Q. Does that sound about average or --

A. At that period, yes, that sounds about right.

Q. And of those beds, 19 were in Allen Ward.

A. Right, yes. That would be ...

Q. And the ward sister on duty in Allen Ward during the day, if she couldn't be there, she had to rely upon back-up, and evidence has been given that she, as a G-grade sister, would then rely upon an F-grade sister, if there was one, to fill in for her. Would it have been your task to ensure this sort of cover in the

event of an absence?

A. No, that would be her responsibility to ensure that she was adequately covered by her own staff.

Q. And then if a G-grade sister or F-grade sister wasn't available, an E-grade sister would step in?

A. Yes.

Q. Was it your responsibility to ensure that there was a proper supply of E, F and G-grade sisters?

A. Within each ward on a daily basis?

Q. Yes.

A. That would be the responsibility of a ward sister to ensure she had adequate staffing on duty that day. If through sickness or unexpected reason, then she would notify what we call nursing admin and whoever was on that day would endeavour to find help from another area if possible, but it would not have been a D grade or an F grade; it would be somebody, probably an E grade or a D grade, who would have gone from another area because they wouldn't have had the knowledge of that particular ward.

THE CHAIRMAN: Was this a recurring problem because you said there was an issue about staffing level and there was also an issue about absences? So was this something that everybody just got on with because you had to?

A. I am finding it difficult to answer about Allen Ward

because it is a ward ... I can answer for my own area. In my own two areas, generally speaking, we would have contacted other staff who were off duty to see if they could come in to help out, and I believe that that would have been the same in the ward areas, that they would have, first and foremost, contacted their own staff to see if any of them could come in.

THE CHAIRMAN: Is there any reason in principle why there would be a difference between the theatre nursing situation and the ward nursing situation in terms of cover and absences and so on?

A. Not in the terms.

THE CHAIRMAN: So you expected your experience in theatres would be similar to the experience that your two acting colleagues had in --

A. I would imagine so, yes.

THE CHAIRMAN: Thank you.

MR STEWART: Did it ever cause you worry that there were staffing shortages?

A. Well, yes, because it put added pressure on the staff that we had in that we were asking them to do extra hours and it put pressure on -- within theatres and intensive care, we weren't able in the same way to fall back on bank and agency staff because there weren't bank paediatric intensive care or theatre staff out there in

those areas. So we were very much reliant upon our own staff to fill in for us.

Q. And did you perceive that as a risk, potentially?

A. There would have been times when the pressures were high and stressful in very busy periods.

Q. And would that have translated into a patient risk?

A. I can't recall ever having to ... No, I would say no because certainly, within my own areas, I believe that we always managed, through the goodwill of the staff, to cover.

THE CHAIRMAN: Sometimes it would have been a struggle --

A. But we managed and I believe generally I would be surprised if you couldn't say the same for the ward areas because the staff were fantastic.

MR STEWART: Was it ever suggested at directorate meetings that it might be a risk as a way, perhaps, of leveraging some --

A. Yes, I think that it could be. What was continually highlighted was the pressure under which the staff were working and continually being asked to -- and during busy periods being contacted on a day and daily basis, "Could you come in today?", "Could you come in?", "No, I can't come in today, but I could come in tomorrow". That sort of thing. And that does put pressure on them when they're at home.

Q. Did the nursing budget come from the Children's Hospital or the Royal Group of Hospitals?
A. From the Children's Hospital, as far as I recall.
Q. Therefore, it wouldn't have been a matter that you'd have brought necessarily to Miss Duffin?
A. I believe Miss Duffin -- we would have informed her that we were having these pressures. She would have been informed.
Q. I'm looking at your job responsibilities from your witness statement and, listed amongst your designated areas, is a monitoring of pharmacy usage. That is a particular responsibility of yours. There was no paediatric pharmacist --
A. No.
Q. -- at that time?
A. We did have pharmacists who were responsible for our ward or department areas, and they would have been contactable.
Q. Yes. I'm quoting from the witness statement of Dr Sean O'Hare at WS295/1, page 4. He was the head of the pharmacy services and, at letter (j), Dr O'Hare has told the inquiry:
"There were no paediatric pharmacists in the Royal Hospitals in 1996. The pharmacy staffing complement for the Royal Hospitals was the lowest of any tertiary care

teaching hospital in the UK. Sheffield Children's Hospital, which is approximately the same size as the RBHSC, had, I believe, seven clinical pharmacists."
Was that an issue that came to your attention as nurse manager?
A. I wasn't aware of what he has said there. We had an issue with the fact that we didn't have a pharmacy within the Children's Hospital, that all our drugs had to come from the Royal and the delays -- and sometimes even from the City Hospital -- and the delays that that could cause, not in treating the patients, but particularly when they were waiting to go home.
Paediatric pharmacists -- I only know that we had pharmacists who would have come over and come into the wards, spent some time in each ward or department. I can't remember how often, and that we had their names that we could contact them if we needed to because -- theatres had a contact person we could contact if we were having problems with drugs. But I don't know whether they were paediatric.
Q. Was a request ever made that a paediatric pharmacist be appointed?
A. Not to my recollection. There may well have been, but I wouldn't have been involved with that.
Q. Reading again from your job responsibilities at WS272/1,

page 3, "risk management" is given in the second grouping of areas and fourth down as yet another responsibility put on your shoulders. What did that mean?
A. Within theatres we worked very much to the National Association of Theatre Nurses guidelines, which included risk management. We used their tool for risk assessment within theatres and we would have -- I would have gone to other theatres within the Royal Trust and we would have done checks of their theatres and they would have come to mine.
Q. Were you aware of the hospital's health and safety policy of November 1993, WS061/2, page 232? This is the cover of it, perhaps you recognise that. And if we go to page 247, this sets out a series of responsibilities given to departmental managers, including ward sisters and charge nurses. Would that, broadly speaking, encompass your role as a nurse manager?
A. I believe, yes, it would.
Q. And the various obligations placed upon these managers are set forth. At paragraph (i):
"Responsibility to ensure investigation and reporting procedures for untoward incidents and accidents are carried out and that corrective action, where indicated, is taken."

What did you understand an untoward incident to be?
A. An incident that was ... That the cause was unknown, why it happened.
Q. Would that encompass an untoward clinical incident?
A. Absolutely, yes.
Q. Well, can I ask you then, what were the reporting procedures for untoward clinical incidents in 1996?
A. Assuming that it was made -- supposing it happened in theatre or a ward, and I had been notified, I would expect to be notified by the nurse in charge or a member of staff in that ward that there was a problem, that there was something that was causing concern. I would then probably have gone to the ward or a department to make an assessment of what had happened and tried to find out just what had happened there and then. If I felt competent to deal with it, I would have dealt with it at that time.
I would also probably have contacted Miss Duffin's office for advice because it would not have been something necessarily that I had dealt with before. I would have discussed it with the medical staff, the medical director -- sorry, not the medical director, the lead clinician, and the directorate manager.
Q. That's if you were notified?
A. If I was notified.

Q. The notification of the matter to you is, in fact, the report. What systems were in place for that report to be made to you?
A. If there were any problems like that, they would have the bleep, they would have bleeped the bleep, whichever one of us was carrying the bleep, and reported to us direct.
THE CHAIRMAN: When you say "they would have bleeped you"?
A. Well, whoever.
THE CHAIRMAN: This procedure is triggered by you being informed that something untoward has happened --
A. Yes.
THE CHAIRMAN: -- and something untoward can be a whole range of things. It's obviously not confined to a child dying.
A. No.
THE CHAIRMAN: There's a whole lot of things way, way below that that can go wrong.
A. Yes.
THE CHAIRMAN: But once you're notified of it, you have the obligation under this to carry out the investigation and so on?
A. Yes.
THE CHAIRMAN: Okay.
MR STEWART: Do you remember anything called a "statement

book" that might have been kept on a ward?
A. Yes.
Q. This is something Mr McKee has described to the inquiry as being a system for the record of untoward incidents. Could you describe it, please?
A. Describe the book?
Q. The system and the book.
A. As far as I remember, it was a triplicate book and it would have been ... The report would have been completed by the individual who was involved. In other words, say it was a child that had fallen and hurt itself or had been injured in a ward or something like that, the nurse who had found it or who it had been reported to would have completed the statement. If it was an untoward incident, it would have been completed by the senior nurse or the senior nurse on duty in the ward or department area. They would have also notified myself, or whichever one of the nurse managers was on the bleep, direct, if ... Supposing it was theatre, I would have expected them to come to me direct, to be honest.
THE CHAIRMAN: Let's take an example. One point that Mr and Mrs Roberts raised on Tuesday night before they left the hospital was to make sure that the side of Claire's bed was up in case she fell out or moved during the night

and fell out. Let's suppose that, by an oversight or pressure on the nurses, that the side of the bed isn't up and a child then falls out of bed during the night. How does that find its way into the statement book?
A. The nurse who was in charge would have written that statement and contacted, if it was at night, the night sister. If it was during the day, whichever one of the three of us was carrying the bleep.
THE CHAIRMAN: And then what happens next?
A. The statement book, they keep a copy for themselves. A copy goes to nursing administration and there's a copy that goes then to ... I think we used to send them, at that time, to the occupational health, which is where the team were based who dealt with them. I can't remember. I think that's where we sent them to. But they went to the Trust management, in other words.
MR STEWART: Let's suppose there was an untoward clinical incident. Let's say a clinical error is made and a patient has suffered harm. Were those things recorded in the statement book?
A. Yes.
Q. Did that happen very often?
A. I can only, again, speak about my own area, but no, not very often. If a nurse was involved, I would expect the nurse to write the statement. If it was a member of the

medical staff, they would be expected to write the statement.
Q. And were you responsible to ensure that that happened, that a nurse made the statement?
A. Yes.
Q. Made the entry?
A. Yes. Within my own area, yes.
Q. How did you enforce that expectation?
A. With the nursing staff?
Q. Yes.
A. By simply telling them that they had to do it and ensuring that they did.
Q. How did you ensure? Did you monitor their performance?
A. Yes, you'd check it and check that it had been completed. It would usually be left for myself or whoever was senior on the next day to send it round to nursing administration. If it was extremely urgent, it would have been taken round immediately or the nurse manager would have been informed.
Q. Was there any monitoring of the nurses' performance to see if indeed they were making any errors?
A. Having reported an error or routinely?
Q. Routinely, randomly, even.
A. Well, when we were doing our monitoring with the -- what's the word I'm looking for?

Q. Audit?
A. The quality audit. When we were doing that, which we did once a year, but other than that, the documentation, we would have reviewed that.
THE CHAIRMAN: I think Mr Stewart is getting at a slightly different point. Once you have a report in the statement book, then you can follow it, but for a report to go into the statement book, a nurse or a doctor -- for your purposes, a nurse -- has to, in a sense, self-report that they've made a mistake.
What Mr Stewart is asking you is: you have a degree of confidence in the honesty and integrity of your nurses, but for any of us, it's not the easiest thing in the world to put up our hands and to say we made a mistake and ten make a report on it; so how do you know if mistakes or adverse incidents are in fact being self-reported? I suppose one way is that you find out by word of mouth later on --
A. Yes.
THE CHAIRMAN: -- and then you bawl out the nurse for not having reported it.
A. Yes. You'd usually hear that something had happened and that it hasn't been reported or something else would have reported it. It's a small area where we were working at that time, very, very small, and nothing

really went unnoticed.
THE CHAIRMAN: Okay.
A. It would be difficult for anything to go unnoticed.
THE CHAIRMAN: Thank you.
MR STEWART: I see. Going back to your list of responsibilities at WS272/1, page 4, in the top section, about five lines down:
"Ensure all staff adhere to hospital and Trust policies."
Another onerous duty placed on you. How did you do that? How did you ensure that staff -- I take it that's nursing staff -- adhered to hospital policies?
A. You'd ensure that they were aware of them, and we had the Trust policies file in each department and ward. If there was any minor or major deviation from any Trust policy, you'd refer them to it and ensure they were fully aware of what it was after that. One particular one that I think would come to mind would be the wearing of jewellery. Some nurses would have difficulty in removing jewellery and you had to remind them quite frequently that it should be removed. That's maybe a minor one, but ...
THE CHAIRMAN: It's an example?
A. An example, yes.
MR STEWART: I was going to ask you about a more major one,

that is Trust policies in relation to record keeping because those policies were based upon UKCC nursing guidelines. I want to give you a quote from Miss Duffin, which appears at WS245/1, page 10. At 24, this is in relation to nursing audit of nursing records, and Miss Duffin has said:
"It was agreed at the nurse executive team that all nurse managers would ensure that nursing records were audited by the ward sisters on a monthly basis to ensure that the records were complying with UKCC guidance. Any areas of concern would have been addressed by the ward sister."
Can I ask you about what you did to ensure that the nursing records in your area of responsibility were in fact audited?
A. I did request charts on, as far as possible, a monthly basis to check that the documentation made by the nurses within theatres was complete and correct, and if there were any errors that I saw within those, then I would have brought them to the attention of the staff.
Q. Did you take a random selection of the records?
A. Yes.
Q. You say "as best you could on a monthly basis". Were there some months --
A. It might have slipped to six months. It might not have

been just on a month.
Q. And would you regularly have had to make recommendations to individuals, to ward sisters, and so forth?
A. I would only have been dealing with my own areas.
Q. Yes.
A. And occasionally, you would have had to just remind them about clarifying their signatures or their names, writing their names properly, that sort of thing, and ensuring that they had dated correctly the dates. Sometimes if you're in a hurry, you might forget to do something like that. But generally speaking, within theatres, the documentation was pretty good.
Q. Because generally speaking, in this case of Claire Roberts, the documentation has not been good.
A. I cannot comment on that.
Q. Have you been following --
A. I have followed some of it as far as --
Q. Has it surprised you that the documentation has been poor, in Dr Steen's words?
A. To the extent that it is, yes, I am quite surprised, although I can ... When a ward is very busy, it can be difficult to complete the documentation as you go along, and there would be the occasion, I would imagine, that you could be called away and maybe it might slip your mind. But documentation on the whole, I found --

certainly within my own areas; I cannot speak for the wards.

Q. If the documentation was poor on Allen Ward, would that suggest to you that an adequate system of monitoring and enforcement of guidance was not in place?

A. I don't think I can comment. I really don't know enough about the ward areas.

Q. Would it have been the responsibility of the nurse manager, had there been a failure in documentation?

A. It would have been the responsibility of the ward sister, the manager and the nurse or nurses concerned. It's all of their responsibility to ensure that the documentation -- it's the nurse manager's responsibility to monitor.

THE CHAIRMAN: And if it has got a bit sloppy or if it's got a bit messy, then just to give a few reminders of the sorts of things you were describing a few minutes ago?

A. Absolutely.

MR STEWART: In relation to the audits that you carried out in theatre or in intensive care, were they then carried across and incorporated into larger audits, multidisciplinary audits?

A. Not at that time.

Q. Would there have been any multidisciplinary consideration of issues arising from any case in

Allen Ward, in the medical wards, at that time?

A. I wouldn't know.

Q. You had, as we touched upon earlier, some responsibility for pharmacy and drug-related matters. In this case, there appear to have been errors in the recording of drugs, prescription of drugs, maybe even the administering of drugs. And these errors went unnoticed. Were you aware of the systems for auditing of drug documentation?

A. I don't recall specific ... No. No, I'm sorry, I don't recall.

Q. If a drug or a medication error was spotted, what would be done with that information?

A. It would be reported immediately to, depending on who was available, but certainly to the doctor, whether it be the junior doctor who was there and then to the consultant.

Q. Would the nurse not have reported it to a ward sister or a nurse manager?

A. Oh yes. Sorry, yes, they would have.

THE CHAIRMAN: Does it go in the statement book?

A. It would have, yes.

THE CHAIRMAN: I think the point that you were focussing on in answer to Mr Stewart's question was that it goes to the doctor because the doctor has to know in order to

decide what's to be done.

A. Yes, what, if anything, needs to be done.

THE CHAIRMAN: Okay.

MR STEWART: Nurse McRandal told the inquiry on 29 October that if medication errors were flagged up, these were referred to the nurse manager to speak to the nurses. Would you have found yourself involved in enforcing and correcting medication errors?

A. Yes.

Q. Was that a regular occurrence?

A. Not in my areas.

Q. In the Children's Hospital, to your knowledge?

A. There may have been, I don't recall the numbers of them. I may not have been aware of them all. Again, they were ward areas.

THE CHAIRMAN: In theatres, are the sisters almost constantly working side by side with the doctors, whereas on the wards they might be working more without the doctors necessarily being around?

A. In theatre, the nurses would not have been normally administering any medications apart from in the recovery ward.

THE CHAIRMAN: Thank you.

MR STEWART: Can I take you back to read you something that appears in that "Getting it together" publication we

looked at earlier at WS266/1, page 52? This is an account of the clinical audit programme and it starts at the top of the page:

"There is an active clinical audit programme within the Royal Belfast Hospital for Sick Children. In addition to regular medical ward audits involving all members of the ward teams, and interface audits with general practitioners, other recent assessments have included ..."

And the third bullet point down is "medication prescribing". Do you have any recollection of audit programmes and assessments and advice on medication prescribing?

A. I don't have any recollection of medication prescribing. That would not have been something that we would have been doing within theatres. I think it was maybe being started in the wards.

Q. One of the striking aspects of this case is that Claire's condition deteriorated on Allen Ward when she was being observed on an hourly basis by nurses. They don't seem to have reacted her condition, and she died. Would you agree that that scenario presents a perfect object lesson to examine to see if there were nursing lessons to be drawn?

A. I really don't feel I can comment. It was in a ward.

Ward areas are not my areas. I wouldn't have enough experience of what was going on in the wards.

Q. So you wouldn't have thought so stark an adverse outcome should be the subject of some form of inquiry at the time?

A. I don't feel I can comment on it, I really don't have enough knowledge.

MR STEWART: I see. Thank you.

I have no further questions, sir.

THE CHAIRMAN: Could I ask just two points, Mrs Jackson?

You have described, and the documents show, that nurses were, in the mid-1990s, overstretched and you have described the problems that that could give rise to. You're struggling sometimes to get the staff in, you're worried about nurses overworking and calling on them too often and them being tired. Is that problem aggravated by the fact that the doctors are also overstretched? For instance, in particular, I'm thinking about through the night -- in Claire's case, Monday night through to Tuesday morning, Tuesday night through to Wednesday morning. There appears to have been on each night a registrar with a very small number of junior doctors. And they were stretched so badly for instance that Dr Bartholome, who everybody seems to regard as an exceptionally good doctor, was called to

see Claire and wasn't able to get to her for about three hours at a time when she was very, very seriously ill. Does that sort of overstretching of the doctors increase the problems which the nurses face?

A. It would certainly increase their stress because they're worried, they want a doctor to look at the patient, or the child needs -- if it's medication that only a doctor can give, and the nurses are aware that it's not being given at the time it should be given. But any shortages, you know, it puts pressure on everybody both ways.

THE CHAIRMAN: A shortage on one level puts pressure on the next level, but a shortage at both levels is potentially catastrophic.

A. It certainly would make things more difficult.

THE CHAIRMAN: It makes managing things more stressful, doesn't it?

A. Yes.

THE CHAIRMAN: I want to ask you about a second issue, which is this -- I know you weren't there and I'm asking you about a hypothetical situation because, as you may have gathered from the evidence, Mr and Mrs Roberts were at Claire's bedside on the Tuesday evening around about 9 o'clock. They had their sons with them and decided to go home for the night. There is an issue about how much

it was recognised that Claire was very seriously ill.

Given your nursing experience, and I know you have said you weren't on wards from perhaps the 1970s, if you as a nurse realised that a child was very, very seriously ill and parents who'd been attentive and had been a constant presence at their child's bedside all day came to you and said, "We're going on now, we'll be back tomorrow morning", however it's phrased, would you do anything to discourage them from leaving or ... If they're leaving because they don't appear to realise that she's very, very ill, but the nurse knows that the child is very, very ill, obviously you can't force them to stay, you can't order people to stay --

A. This is it. Without knowing -- yes.

THE CHAIRMAN: I think the concern is here, the Roberts have a concern about whether the state of Claire's health was truly appreciated.

A. Right.

THE CHAIRMAN: And I may ask you maybe the same point in a different way. If you were a nurse on duty in that ward and you had known how seriously ill Claire was, and you'd seen the Roberts or known that the Roberts were there constantly through the day, and they came to you and said, "Look, we are going on now", would you have tried to do something to suggest to them that maybe they

shouldn't or else ask them to wait and get a doctor to speak to them, whether you do it yourself or whether you do it through a doctor?

A. It's very difficult because I really haven't worked -- I think you need to know ... I would have needed to have known the parents really well and whether there was ... Um ... If I was really sure that the child was unwell, really unwell, and if I felt that the parents didn't appreciate that, but I mean the parents, above all, more so than the nurses in many ways, would know their child.

THE CHAIRMAN: But I think the problem here is that, perhaps unusually -- and one of the things as I understand it the Roberts have the most difficulty coping with -- is the fact that they left the hospital, knowing Claire was unwell, but not knowing she was seriously unwell to the extent that she died during the night. It's just one of a series of missed opportunities that, as I understand it, from them and from their lawyers, that they found very, very difficult to cope with afterwards.

A. I think in the situation I would probably have sort of said, "Right, are you sure you really want to go now? Do you want to wait for a little while?", and tried to ... But it's very difficult when, as I say, I haven't worked in that situation.

THE CHAIRMAN: Are there any other questions for Mrs Jackson? No?

Mrs Jackson, I'm very grateful for you for coming along. I know it is not easy.

A. Thank you for fitting me in today.

THE CHAIRMAN: Not at all. Mrs Jackson is free to leave.

(The witness withdrew)

10 o'clock on Monday. We have got Professor Young and Miss Duffin; is that right?

MR STEWART: Yes.

THE CHAIRMAN: Do you have a view or do you want to discuss with the others who goes first?

MR STEWART: I have no view. I'll certainly accommodate any particular needs.

THE CHAIRMAN: If you want to have a chat about it, it doesn't particularly matter to me who goes first. I suspect Miss Duffin might be rather shorter than Professor Young will be, so whatever suits them. 10 o'clock on Monday.

(3.10 pm)

(The hearing adjourned until 10.00 on Monday 10 December 2012)

I N D E X