

1 Friday, 30 November 2012

2 (9.30 am)

3 DR MEENAKSHI MIRAKHUR (called)

4 Questions from MS ANYADIKE-DANES

5 THE CHAIRMAN: Ms Anyadike-Danes?

6 MS ANYADIKE-DANES: Thank you, Mr Chairman. Good morning.

7 I wonder if I could call Dr Mirakhur, please.

8 Good morning.

9 A. Good morning.

10 Q. Can I just confirm that you have a copy of your CV?

11 A. Yes.

12 Q. Thank you. You have made two statements for the inquiry

13 in this part of the investigation. You had previously

14 made a statement in relation to Adam's case.

15 A. Yes, correct.

16 Q. The series number for the two statements that you made

17 for the inquiry is 247. Your first one was dated 30 May

18 2012 and your second was dated 18 September 2012.

19 Do you adopt those statements as your evidence, subject

20 to anything that you may say in this oral hearing?

21 A. That's correct.

22 Q. Then I wonder if you could help us in relation to your

23 second statement just briefly. If we go to that, it's

24 247/2, starting at page 6. If you see, there's

25 a section there that starts:

1           "I would like to highlight the following three  
2 additional points."

3           And in fact, perhaps it starts a little higher up:

4           "It is important to clarify ... from Dr Squier and  
5 Dr Harding."

6           And then you go on and deal with the section. That  
7 section is very close to a section in Dr Herron's fourth  
8 statement -- just for reference purposes only, it's  
9 224/4 at page 13 -- where he also goes to make comments  
10 on the evidence of Dr Squier and Dr Harding.

11           Can I ask: did the two of you discuss your views  
12 about that evidence before you completed these parts of  
13 your witness statements?

14 A. No, because Dr Squier's comments and Dr Harding's  
15 initial reports came to both of us, so we were both  
16 aware of the issues.

17 Q. Yes.

18 A. And we were both involved in the case, so we had similar  
19 issues.

20 Q. But you didn't discuss them?

21 A. We didn't discuss them formally in any way, but  
22 obviously we were each -- each of us were aware of the  
23 issues and we were aware of the issues which were raised  
24 by Dr Squier and Dr Harding.

25 Q. Thank you. Then I wonder if I could ask you for some

1 guidance on certain aspects of your CV. I'm not going  
2 to go through it in detail because we had your CV for  
3 the purposes of the Adam Strain hearing. It is to be  
4 found at 306-066-001.

5 I think that you became a consultant  
6 neuropathologist and head of the Regional Neuropathology  
7 Service in February 1988 -- and one sees that from  
8 002 -- and in fact continued, so it would appear in that  
9 position, until December 2010; is that right?

10 A. No, there's a slight incorrection [sic] in there because  
11 I became -- I was appointed consultant neuropathologist  
12 in the February of 1988, but I took the headship of  
13 Regional Neuropathology Service in 1997, when Professor  
14 Dame Ingrid Allen retired. So I became the head of  
15 neuropathology in 1997, not in 1988.

16 Q. I understand. So you weren't head of the service at the  
17 time of Claire's death?

18 A. No.

19 Q. Can I ask you, though, if you weren't actually head of  
20 the service, what was your position in it?

21 A. Consultant neuropathologist.

22 Q. And how many consultants were there at the time of  
23 Claire's death?

24 A. Two, myself and Dame Ingrid Allen.

25 Q. And in terms of other trainees, can you recall roughly

1           how many you would have had at that time? Obviously  
2           there was Dr Herron, who was the registrar.

3   A.   Neuropathology is a very specialised subject, so it's  
4           not like we have umpteen trainees like general  
5           histopathologists and it's a very long training in  
6           comparison to general histopathologists, so we have  
7           a dedicated senior registrar in neuropathology, which  
8           at the time was Dr Herron, and then we will have from  
9           time to time histopathology, general histopathologies  
10          [sic] training -- trainees rotating with us for their  
11          experience in neuropathology, which was a requirement of  
12          the College of Pathologists. So they would be able to  
13          have maybe one -- one, our own senior registrar, and one  
14          registrar occasionally rotating from general  
15          histopathology.

16   Q.   But for consistency's sake your full-time complement  
17          would be you, Professor Allen and Dr Herron?

18   A.   That's correct.

19   Q.   When you were giving evidence in Adam's case, one of the  
20          issues there was the extent to which you had been  
21          consulted over the slides that Dr Armour had prepared of  
22          Adam's brain. And I think your evidence at that stage  
23          was you couldn't remember, but if you had been involved,  
24          it would be simply on the basis that you had been shown  
25          certain slides for perhaps discussion purposes with

1 Dr Armour.

2 A. That's correct.

3 Q. As you know now, Dr Armour published a paper directly  
4 in relation to Adam's case in the Journal of Clinical  
5 Pathology in May 1997. Is that a journal that you would  
6 take or look at from time to time?

7 A. I was not even aware of the paper that Dr Armour had  
8 published the paper. And the Journal of Clinical  
9 Pathology is not one of the journals which we would be  
10 consulting from time to time because we would be very  
11 much specific to the neuropathology journals. But for  
12 certain generic issues, we might look into it for  
13 techniques and things like that. But that is not one of  
14 the journals which we will routinely consult. And I was  
15 not aware of the paper that Dr Armour had published.

16 Q. I understand. In your CV, on this page where we are,  
17 you say that you're also involved in supervising the  
18 post-mortem service with the trainees in neuropathology  
19 and then you say that the service takes two forms: one  
20 is day-to-day supervision in the mortuary and discussion  
21 of the case with the trainees, and some of your  
22 clinical colleagues who are involved; and the other is  
23 in the form of a weekly review. If you just pause  
24 there: even though you weren't actually head of the  
25 service at that time, is that still something that you

1           were doing in 1996?

2    A.   That's correct.

3    Q.   So that is a correct description of what you would have

4           been doing at the time of Claire's autopsy?

5    A.   Yes, that's correct.

6    Q.   Then if I ask you about the day-to-day supervision with

7           your trainees. How actually was the work that came into

8           the department arranged or organised?

9    A.   Well, it depends on whether you are dealing in that week

10          for the autopsy service or you are dealing with the

11          biopsy service.

12   Q.   Let's confine ourselves to the autopsy service.

13   A.   Well, what happens is, if I was dealing with the autopsy

14          service that week, the senior registrar in

15          neuropathology would usually ring up the mortuary or the

16          mortuary people will inform us in the department that

17          there is a case and the medical notes are there, so

18          we will then go down and we will look at the medical

19          notes and we will discuss with each other what is to be

20          required to be done.

21   Q.   So can I just ask you to be clear: does that mean that

22          the mortuary request form goes to the mortuary staff?

23   A.   It goes to the mortuary staff, yes.

24   Q.   So that's the first point of contact?

25   A.   That's the first point of contact.

1 Q. I understand. So they would have received the request  
2 for autopsy in relation to Claire and would have  
3 contacted Dr Herron, for example, as your senior  
4 registrar to let him know that we have got this in,  
5 there's a request for a brain-only autopsy.

6 A. That's correct. Then we go down and we look at the  
7 notes and look at the autopsy request form and we  
8 discuss the case. It depends then on the seniority of  
9 the registrar. For instance, Dr Herron at the time of  
10 this particular case was a very senior senior registrar,  
11 he was very close to completing his membership. So  
12 we would then -- then I think the other important thing  
13 is to know that neuropathology is a very small  
14 department -- it is only two consultants there and a  
15 registrar. So while we are dealing with the autopsy  
16 service, that doesn't mean that if there are urgent  
17 specimens or frozen sections coming from the theatre in  
18 the department, we will not be -- the consultant  
19 will not be to and fro between the autopsy room -- the  
20 mortuary and back to the lab.

21 THE CHAIRMAN: When you say "we will go down to the  
22 mortuary", do you mean you and Professor Allen and  
23 Dr Herron, all three of you?

24 A. No, no, it depends on who is the consultant who's  
25 looking after the autopsy service that week.

1 THE CHAIRMAN: So it's either you or Professor Allen?

2 A. Either me or Professor Allen, but that doesn't mean that

3 if I am -- if I'm for the autopsy service and I'm going

4 to go down with Dr Herron and I'm involved elsewhere, if

5 there's an urgent specimen has come through into the

6 lab, that doesn't mean that Dr Herron may not discuss

7 the case with Professor Allen as well, because as

8 I said, it's a very small department, a very small team,

9 and all of us were aware of what was actually happening

10 on that particular day.

11 MS ANYADIKE-DANES: [Inaudible: no microphone] by the sound

12 of it. Is a case ever assigned to a consultant, even

13 though the registrar would discuss it with the other

14 consultant, but is there nominally a consultant who's

15 assigned to a case?

16 A. It's actually assigned to a senior registrar and then

17 the senior registrar can consult with the consultant,

18 whoever is there, and I think it depends on, as I said,

19 upon the seniority of the senior registrar. If the

20 consultant feels that he's a fairly senior senior

21 registrar who is able to, after discussion, manage,

22 that's fine, and the consultant is always available or

23 always is at hand to give advice or supervise as and

24 when it is required.

25 Q. Yes. And given that your name seems to have been



1 associated more with this particular case than, say,  
2 Professor Allen's name, would that mean that you were  
3 the consultant primarily associated with Claire's  
4 autopsy?

5 A. I actually don't remember that, but it is quite possible  
6 that that may be the case.

7 Q. And given that although he is a very senior registrar,  
8 he's not yet a consultant. So does it not have to be  
9 a consultant's responsibility in some way, even in a  
10 formal sense?

11 A. Not necessarily. I mean, if -- senior registrars  
12 everywhere up and down the country do autopsies  
13 independently if they're fairly senior and very close to  
14 their membership exam. It also depends on the  
15 experience of the senior registrar, if they have  
16 performed similar autopsies in a number of cases, and  
17 Dr Herron being the only senior registrar in  
18 neuropathology, he would have dealt with all the  
19 autopsies coming through the department. So his  
20 experience is quite cumulative as against some of the  
21 general trainees who will maybe do -- you know, if they  
22 are trainees and if they attend autopsy cases, they will  
23 do like one case each, whereas if Dr Herron is only  
24 registrar and there are ten autopsies, Dr Herron will do  
25 ten cases. So his experience is much different than the

1           general trainee histopathologist in the department.

2   Q.   So in terms of the pattern of it, the registrar is the

3           person who goes down typically and looks at the medical

4           notes and records so far as you are concerned as to what

5           the practice was?

6   A.   That's correct.

7   Q.   So he would look at that and then there would be some

8           sort of discussion, depending on how many of it he wants

9           --

10   A.   Yes.

11   Q.   -- with the available consultant?

12   A.   That's right.

13   Q.   And the purpose of that discussion is what so far as

14           you are concerned?

15   A.   The purpose of the discussion is that, after having read

16           through the autopsy notes, if there's any issues they

17           wish to clarify or -- mostly it is regarding the

18           technique of the autopsy and, for instance, specific for

19           this case, as it's a brain-only autopsy, there will be

20           issues like we remove the brain and what to look for

21           when you actually open the skull and things like that

22           and so on. And the detailed examination, how to go

23           about it, about the fixation, about the rest of it, how

24           we deal with it, so it's actually more related to the

25           general technique of the autopsy rather than any other

1           issues at the time.

2   Q.   Is it your understanding that it would be common, if the

3           medical notes and records were there, to actually look

4           at them as part of familiarising yourself with the case

5           as opposed to just the autopsy request form?

6   A.   That's correct.

7   Q.   And is there any discussion, so far as you're aware,

8           that happens between the pathologist -- whether it's the

9           senior registrar or one of the consultants -- and the

10          actual referring clinicians?

11  A.   Well, it may happen. One of the things is that the

12          clinical history or the summary, which actually comes

13          down with the autopsy request form -- a pathologist

14          looks at it and if it is not up to them actually ...

15          It is very difficult for them to actually work out when

16          they're looking at the clinical summary whether what has

17          been supplied to them is totally, absolutely sufficient.

18          So they look at the -- and the issues and the clinicians

19          very correctly have actually picked up the important

20          issues which they would want to be dealt with at the

21          time of the autopsy. Sometimes there is informal

22          discussion, you know, telephone discussion or whatever,

23          with the clinicians if the pathologist feels that

24          there's any issues which they need to clarify.

25                 Very, very occasionally -- it depends on the

1        clinicians and all of us are actually very busy in what  
2        we are actually doing -- so the clinicians sometimes can  
3        come themselves to the mortuary and attend the autopsy,  
4        but that varies. That is not a permanent fixture that  
5        they always will come down. So there is a number of  
6        ways where the pathologist can actually communicate with  
7        the clinician in charge.

8    Q. The other thing that you mentioned in here is, apart  
9        from that sort of day-to-day meeting and discussion that  
10       goes on, which is presumably also part of training --

11   A. Yes.

12   Q. -- however senior the registrar is, you also then say  
13       the other form of supervision is weekly organ review.

14   A. That's correct.

15   Q. What was that?

16   A. That is the -- that actually happens more in  
17       neuropathology because the brain is quite often retained  
18       after the autopsy because it has to fix for a number of  
19       weeks for the pathologist to enable it to examine in  
20       more detail. So after a period of fixation -- and  
21       it's -- the process of fixation itself is not a static  
22       process, it is a very active, dynamic process in the  
23       sense that it's not that we fix an organ and it sits  
24       there. It is assessed every week to see what is the  
25       stage at which the organ is fixing.

1           Once the pathologist feels that the appropriate  
2           fixation has been achieved, then the case comes out for  
3           blocking and for detailed examination, first dissection  
4           of the brain, because up until that stage we have not  
5           actually looked at the brain internally, we've only done  
6           a macroscopic naked-eye examination of the external  
7           features of the brain, we've not looked at it internally  
8           in any way. So it's only after fixation. So that's  
9           what actually happens at the organ review session, that  
10          the brain is dissected, looked at in detail, internally,  
11          and then there are tissue sections taken for further  
12          histology.

13   Q.   Okay. Then on the back of the autopsy request form,  
14          there is a place where -- I'm going to bring it to you  
15          in a minute -- where you can indicate for the referring  
16          clinician whether they can attend one of those reviews.

17   A.   Yes.

18   Q.   If I just take you to that, 090-054-184. If we pull  
19          that up. There you see, it says:

20                "Will you or a colleague be attending the review  
21                session at 1.45 on the day of the autopsy?"

22                Is that the same review session as you've been  
23                talking about just now?

24   A.   That's correct.

25   Q.   So that's a time when the pathologist has --

1 A. No, that's not the same, sorry. That's not the same  
2 session. That is the review session on the day of the  
3 autopsy.

4 Q. Yes, that's what I mean.

5 A. That is actually not directly relevant to neuropathology  
6 because we do not actually do any review on the day of  
7 the autopsy.

8 Q. So what's the purpose of that?

9 A. That is mostly for the general autopsies or if there are  
10 any findings in the -- because brain is not looked at on  
11 the day of the autopsy. So what is there for the  
12 clinician to see.

13 Q. So this is a form that is appropriate for all autopsies,  
14 but if you're doing a brain-only, that particular review  
15 isn't helpful because all you're going to do is take the  
16 brain out at that stage?

17 A. That's correct.

18 Q. And that's not something that a clinician can  
19 particularly participate in. They might be interested  
20 when you're looking at the dissections, but at that  
21 stage there's not very much that they can learn?

22 A. Yes. Well, occasionally, even if it is a brain-only  
23 autopsy, occasionally they are more than welcome to come  
24 if they can to come over and look at the brain with us  
25 externally. But the brain is actually not dissected

1           until several weeks later, so there's nothing for them  
2           to look at internally. So that session is not for the  
3           organ review session which we're talking about.

4    Q.   So that's alerting them to when it is that you are going  
5           to actually take the brain out effectively, and then if  
6           they want to come to that they can?

7    A.   Yes.

8    Q.   Dr Herron said in his witness statement at 224/3,  
9           page 5, that there had previously been a tradition  
10           in the department to hold review sessions relating to  
11           autopsies, but that had not been the case for many years  
12           and he didn't believe that the review sessions took  
13           place in 1996, and also that he thought it was highly  
14           unlikely that, even if review sessions did exist at the  
15           time, that Claire's case would have been subject to  
16           review.

17           Then he goes on about the brain-only autopsy and  
18           I presume that that is referring to the point that  
19           you have just made.

20   A.   That's correct.

21   Q.   But in terms of generally speaking, can you comment on  
22           why he was of the view that review sessions were not  
23           actually happening in 1996?

24   A.   Well, it was actually dependent on the pathologist and  
25           the clinician. I mean, if ... It wasn't a routine

1 practice that a review has to happen. But if there  
2 was -- if the pathologist or the clinician felt that  
3 there was a need for the review and also it related to  
4 the training of the registrars, both the pathology  
5 registrars, the neuropathology and the clinical  
6 registrars, because I think they would then come down  
7 along with their consultant in charge and they will  
8 review, take part in the review discussion. But it  
9 wasn't a common practice, it wasn't a regular practice.

10 Q. It wasn't regular to involve the clinicians in it?

11 A. That's right.

12 Q. But it could have afforded an opportunity to discuss in  
13 more detail with the clinicians the clinical aspects of  
14 the case?

15 A. Yes, it could have, but on the other hand, in this -- if  
16 you're talking about this particular case, I don't think  
17 that it would have gained any additional benefit because  
18 we were not looking at the organ at all at the time. So  
19 I'm not sure what additional information the clinician  
20 would have gained if they would have attended or if  
21 there was a review session.

22 Q. If the clinicians don't attend at that stage because not  
23 much is happening, if I can put it that way, do they get  
24 invited to a later stage when you're actually starting  
25 to look at the slides and can be expressing some views



1 as to what you're seeing?

2 A. They're invited for the organ review session which  
3 happens after several weeks, because that is the first  
4 time that we have the clinical history from the autopsy  
5 request form. We have the macroscopic or the naked-eye  
6 examination, autopsy findings of the brain, and now the  
7 brain is being dissected. So at that time, sometimes  
8 the clinicians -- it depends on the clinicians  
9 themselves, you see. They are informed regularly that  
10 this review session is going to happen on such-and-such  
11 a day and such-and-such week, and if they are able to  
12 come, you know, that's fine, but it depended upon the  
13 clinician, whether they were able to attend or not.

14 Q. So that might provide a more useful opportunity to  
15 discuss clinical findings because, at some point in  
16 time, there is going to be an attempt to correlate the  
17 clinical findings with what you see, what the  
18 pathologist sees?

19 A. I think it's a very difficult -- and I think we're  
20 talking about a very difficult territory,  
21 neuropathology, here. Because the findings -- let me  
22 put it this way. For instance, if we are dealing with  
23 something which is like a brain tumour, which is very  
24 obvious on the naked-eye examination, and you're  
25 dissecting the brain and you can actually see it, and

1 the clinician will be able to see it. But in the case  
2 with a naked eye, even when you're dissecting the brain,  
3 and there's not very much to see, it's only the  
4 histology which fine-tunes the pathology later on. So  
5 you can have a discussion with the clinician, they can  
6 have a look at it, but still there may not be anything  
7 to see even after we have dissected the brain  
8 internally. So it vary very much on a case to case  
9 basis depending on the type of case we're dealing with.

10 Q. Maybe I can give you an example. Let's say, for  
11 example, that one was looking to see if there was any  
12 evidence to explain developmental delay or something  
13 like that and you felt, microscopically, you had seen  
14 something, you might want to have some discussion as to  
15 the extent of the developmental delay that the child had  
16 or the severity of seizures that the child had if you  
17 thought you were seeing some evidence of scarring or  
18 something of that sort. That might inform you a little  
19 bit more to assist you in a correlation at some point.  
20 Would that be the sort of thing?

21 A. I think again developmental neuropathology is a very  
22 complex area because there are ... In developmental  
23 neuropathology, you have at one extreme very categorised  
24 clear-cut malformations which are so obvious on the  
25 naked-eye examination. On the other hand, you have

1       other extreme, which is very subtle abnormalities, which  
2       you will not pick up on the naked-eye examinations. So  
3       yes, you can look at the brain and naked-eye looking at  
4       it, even after internal examination, may appear all  
5       right, but it's only when you come to look at the  
6       histology under the microscope that you pick up these  
7       abnormalities. So it depends upon the kind of -- and  
8       I go back to the statement I'm making that it depends on  
9       the kind of case and the kind of malformation, the kind  
10      of neurodevelopmental abnormality and the kind of -- the  
11      nature of the abnormality that you would be able to see  
12      anything, even after when you have dissected the brain.

13    Q. Thank you. Then can I finally ask you, you also said at  
14      004 of your CV, 306-066-004 -- it's quite dark, but it's  
15      just above the bit about the implication of the O'Hara  
16      report. Effectively, I think what you're saying  
17      there is that you were in charge of issues relating to  
18      organ retention and implementing the guidelines  
19      following the O'Hara report on organ retention.

20    A. Yes.

21    Q. If we leave aside the O'Hara report on organ retention  
22      and just deal with issues relating to organ retention.  
23      Was anything like that happening at the Royal in 1996?

24    A. In what way?

25    Q. Were you developing any guidelines, guidance, practices

1           in relation to organ retention at that stage?

2    A.   Well, I think it is -- the guidelines, it's not for me  
3           to develop the guidelines in the sense that the  
4           guidelines were already there at the time from the  
5           college and the best practice guidelines for  
6           neuropathology was the best way to study the brain or  
7           neuropathology is by retaining and fixing the organ.  So  
8           that guideline was already there in 1996/97 from the  
9           College of Pathologists.

10   Q.   Sorry, I think maybe we're at cross-purposes.  I thought  
11          what you were referring to in your CV were issues to do  
12          with how you retain tissues, how you inform families --

13   A.   I don't think that those were clear-cut at the time.

14   Q.   That's what I'm asking you.  When you say that you were  
15          dealing with those issues, if I can put it that way,  
16          were you already starting -- not just you personally,  
17          but the department and within the hospital -- to give  
18          consideration to how those matters would be addressed in  
19          1996?  That's what I'm asking you.

20   A.   I don't think that they were done in detail at that time  
21          because since the new guidelines came after the organ  
22          retention inquiry, then I think the consent form had  
23          changed and there were very detailed, elaborate  
24          information on the consent form, informing the issues  
25          about the organ retention and then obviously the

1 disposal and everything and so on. Those guidelines  
2 were not there at the time of 1996/97.

3 Q. So this statement in your CV didn't relate to anything  
4 that you were necessarily doing in 1996?

5 A. No, this is what I've said: following the organ  
6 retention inquiry.

7 Q. No, I was referring to the part above it, "As head of  
8 neuropathology", but I think we have your point.

9 Can I then ask you about your membership of the  
10 Department of Health sub-groups on aspects of archiving  
11 consent information for adult children and coroners'  
12 autopsies, which is found at 004:

13 "I am on the sub-group, which is steering the  
14 implementation process. This group has been established  
15 by the Department of Health, working on aspects of  
16 archiving, consent, information ... and also coroner's  
17 autopsies."

18 Was that a sub-group that was in existence in 1996?

19 A. No.

20 Q. Thank you. Were you involved in any way in that kind of  
21 aspect of work, archiving and so forth, in 1996?

22 A. I was involved along with Professor Allen on the issues  
23 that we kept a very detailed -- our own departmental  
24 record of what we were doing. And I think those records  
25 were very helpful to us because we could go back

1 a number of years to say, you know, we knew exactly  
2 what was happening to the tissues, and those records  
3 were actually quite detailed and elaborate. So we had  
4 the internal departmental records within the department  
5 at that time.

6 Q. Okay. Can I then ask you about your clinical work at  
7 306-066-002? Just under "Neuropathology, clinical  
8 biopsies and post-mortems", you say that you were  
9 involved in the clinical and laboratory work in the  
10 department and that you took part in the ward rounds  
11 with clinical colleagues in neurology and neurosurgery.

12 A. Yes.

13 Q. Was that something that you did in 1996?

14 A. Yes.

15 Q. Those colleagues, for example, in terms of neurology,  
16 could that have involved Dr Webb?

17 A. Dr Webb at the time, if I could remember correctly, was  
18 a neurologist in the Royal.

19 Q. Yes, he was a paediatric neurologist.

20 A. So the practice at that time was that every Tuesday  
21 morning, there was a clinical neurosciences round. This  
22 involved all the neurologists, all the neurosurgeons,  
23 neuroradiologists, all sister sciences within the  
24 neurosciences group, including neuropathology. That  
25 used to happen every Tuesday morning, every week.

1 THE CHAIRMAN: Including the Children's Hospital?

2 A. The Children's Hospital was only the relevant

3 clinicians. Put it this way: the paediatric

4 neurologists were always there at the time, they were

5 always there because they were part of the neurosciences

6 group. But other clinicians, like the paediatricians,

7 they would only come if they will bring a case or if

8 there was a case or if there was a relevance of a case.

9 It may be a neurological case, but if they felt that

10 another clinician had relevance to the case, then they

11 would come to the ...

12 MS ANYADIKE-DANES: Those Tuesday meetings, are they the

13 same thing as a grand round?

14 A. That's correct.

15 Q. So in other words, Dr Webb, if he was there, who was a

16 consultant paediatric neurologist, he would attend every

17 Tuesday to those grand rounds?

18 A. Yes.

19 Q. And any other clinician whose case you were particularly

20 interested in or presenting that related to them, they

21 would know about it and would come if they were

22 available to come?

23 A. Yes.

24 Q. And that was happening in 1996?

25 A. That's correct.

1 Q. Then finally to ask about accreditation. In your CV,  
2 you refer to -- I think it's on this page actually -- to  
3 the fact that the department had full CPA accreditation  
4 in 1996. You say:  
5 "We have recently (April 2003) been visited by the  
6 CPA and await the outcome."  
7 What was that? Was that a routine audit visit by  
8 the CPA?  
9 A. Yes. That was Clinical Pathological Accreditation and  
10 this was a group of clinicians, senior technicians,  
11 neuropathologists, general pathologists, as the profile  
12 of your department is. They would come and they would  
13 visit and they will look at all aspects of the service,  
14 including health and safety, the clinical practice which  
15 exists, and any other issues which are there. But  
16 basically, they will look at in detail the running of  
17 the service, including the health and safety issues.  
18 Q. How often did they do that?  
19 A. It happens every, I think every three to five years, but  
20 it varies because I think there are so many departments  
21 to actually go through that it's ... It is not always  
22 possible to keep up to the timescale. But it usually  
23 happens about five years or so.  
24 Q. And is that to sort of confirm or reaffirm your  
25 accreditation?



1 A. That's correct.

2 Q. What happened as a result of the one you were waiting  
3 for in April 2003?

4 A. I think the situation changed in 2003/2004, or maybe I  
5 think just before that, after Professor Allen retired,  
6 because I think there was slight reorganisation in the  
7 sense that the ... According to the need of the  
8 department, there was the ... Before we had  
9 histopathology, neuropathology, cytopathology in the  
10 Royal, and histopathology and cytopathology at the City  
11 Hospital. Neuropathology was always at the Royal. But  
12 I think -- I can't remember the exact date, but just  
13 around that time, the organisation and the things that  
14 we came under the umbrella of the tissue pathology and  
15 the cytology, which meant that the ... And this was  
16 purely from administrative point of view, nothing to do  
17 with the working practice. So there was no change in  
18 the working practice. But the tissue pathology came  
19 about, it still had the profile histopathology,  
20 neuropathology and cytology, the profiles were the same.  
21 So at that time, the organisation happened and the --  
22 there were issues regarding -- and again I don't  
23 remember extremely correctly in detail, but there were  
24 issues to do with -- because this management structure  
25 had come, the management structure had changed, so this

1 management structure was very new. So I think they were  
2 still working their way through it, so what happened at  
3 that time was that I think we got partial accreditation  
4 around 2004.

5 Q. Do you know when you got full accreditation?

6 A. Um ...

7 Q. Maybe we can take that up with the DLS.

8 A. I'm not sure.

9 Q. Having accreditation --

10 A. Sorry, to go back, that is to do with entire tissue  
11 pathology, not neuropathology.

12 Q. Presumably that means you have to maintain certain  
13 standards.

14 A. Yes.

15 Q. That's one of the things they are looking at when they  
16 do their audit visit?

17 A. That's correct.

18 Q. And you yourself with involved with audits; isn't that  
19 right?

20 A. That's correct.

21 Q. When you audited, was part of what you were auditing the  
22 time taken to provide autopsy reports and so forth?

23 A. That's correct.

24 Q. Was that your responsibility to organise that?

25 A. That's correct.

1 Q. Were there any concerns about the time that it took to  
2 produce audit reports?

3 A. Well, neuropathology cases are always -- took longer  
4 than the general pathology cases because of the issues  
5 of the fixation of the brain and depending upon the  
6 complexity of the case. And I think one of the things  
7 it is very important to understand is that the audit and  
8 the turnaround time, which we looked at quite a bit  
9 in the audit, is a process; it's not a one-step thing.  
10 So the pathologist's involvement is a point because  
11 we are talking about the period of brain fixation, then  
12 the brain blocking, then the processing in the lab and  
13 then the slides going to the pathologist, the  
14 pathologist looking at the slides, and then the work  
15 coming back into the laboratory for further or  
16 additional work, and then eventually the preparation of  
17 the final report. So it is actually a process, it's not  
18 just, you know, like one point.

19 Q. It takes time?

20 A. It takes time.

21 Q. Just to confirm something -- I realise I'm not entirely  
22 clear when you were explaining it. When I was asking  
23 you about your work with the colleagues and you attended  
24 wards, we can see it in this part of your CV. Then you  
25 went on to describe the meeting where you all gathered

1           together, which was called a grand round.

2    A.   Yes.

3    Q.   Is a grand round distinct from what people who are more

4           familiar with general medicine would understand as

5           a ward round where you literally go round and look

6           at the patients?

7    A.   No, no.  It used to happen in the ...  Because ...

8           I think it would not be right for a number of clinicians

9           because if you're talking about neuropathologists,

10          neurologists, neurosurgeons, the whole lot, to go round

11          a patient in the ward because it would be very

12          disruptive to the patient.

13   Q.   Sorry, I just wanted to confirm.  When you say that this

14          involves taking part in the ward rounds, when you used

15          words in the second line of that section under

16          "neuropathology", do you literally mean ward rounds

17          where you go around and see patients or does that ward

18          round mean a grand round?

19   A.   The ward round means a grand round.  We don't go into

20          the ward, individually round the wards.

21   Q.   Thank you very much.  Then although you weren't the head

22          of the department at that stage, obviously you were the

23          second most senior pathologist there.  The extent to

24          which you were aware of the guidelines -- you have

25          mentioned them yourself just earlier in your evidence.

1 But the ones that we been looking at particularly are  
2 the 1991 guidance -- the report of the working party on  
3 autopsy and audit. Were you aware of that?

4 A. Yes.

5 Q. The 1993 guidelines for post-mortem reports. I think  
6 you said in your witness statement at 224/4, page 3,  
7 that you were aware of that one.

8 A. Yes.

9 Q. And the "Service specification for paediatric and  
10 perinatal histopathology", that is one from the Royal  
11 College of Pathologists of September 1995.

12 A. Yes.

13 Q. Were you aware of that?

14 A. Yes.

15 Q. The practice guidelines for necropsy time for action  
16 1996?

17 A. Yes.

18 Q. And then there are guidelines on autopsy practice, which  
19 were issued by the Royal College in 2002, which to some  
20 extent brought matters up a little bit up-to-date since  
21 the 1993 guidelines.

22 A. Yes.

23 Q. Were you aware of those?

24 A. Yes.

25 Q. Was it any part of your role as a senior

1       neuropathologist in the department to disseminate those  
2       guidelines, make sure everybody in the department was  
3       aware of them or even to formulate your own local  
4       practice?

5    A.  I think ...  There were only three people in the  
6       department, the two consultants and the senior  
7       registrar.  The consultants always -- would always  
8       disseminate the information to the trainees, including  
9       when the general trainees would come to rotate with us,  
10      then specific information about neuropathologists will  
11      be disseminated to them.

12           Then I think the -- you always have within the  
13      guidelines -- there's always a flexibility to cater for  
14      the local needs, for the regional needs.  So I think  
15      that flexibility -- and in my mind I think it is very  
16      important and it says in the College of Pathologists'  
17      guidelines as well that they are guidelines, but they  
18      should be built in with an amount of flexibility to suit  
19      the regional needs.

20   Q.  And did you develop your own practice?  I know you say  
21      actually there were only three of us, but you had other  
22      trainees come and there were other people ancillary to  
23      the service, if I can put it that way, who assisted you  
24      so that you could do the work that you did.  Did  
25      you have any practices that you developed that became

1 reduced to writing in any way or were communicated  
2 amongst all of those so everybody understood what are  
3 the standards that you require, how you wish to have  
4 things done? I don't mean you personally, but the  
5 service.

6 A. Yes. Yes, they were very clear-cut, detailed records  
7 for what we called at that time handbooks, handbooks for  
8 the registrars. There was a handbook for the senior  
9 registrar in neuropathology and also for the general  
10 histopathologists rotating within the department, which  
11 basically had all the guidelines from the College. So  
12 it was nothing new, but it was just a sort of paperwork  
13 which was put together as part of the College guidelines  
14 so that everybody, when they came into the department or  
15 they were rotating in the department, they could  
16 actually see what the guidelines were and what they were  
17 supposed to do and how the service was actually running.

18 Q. And where would that be placed, that handbook?

19 A. They should be in the department. We didn't keep them  
20 personally with us, but they would be -- should be  
21 in the department. They were nothing new, they were  
22 just the guidelines which were collectively taken from  
23 the College.

24 THE CHAIRMAN: Is this a file, doctor, with a 1993  
25 guidelines and 1995 and so on?

1 A. No, it's not like that. It was just a one-off thing,  
2 and then if the guidelines for the -- changed from time  
3 to time, then the trainee would be made aware of the  
4 change.

5 MS ANYADIKE-DANES: So you were bringing those things  
6 together in a convenient reference place for them?

7 A. That's right.

8 Q. And if there was anything local that you particularly  
9 wanted to have done, that would go in there as well.

10 A. That would go in there as well.

11 Q. Thank you. And that's part of their training to be made  
12 aware that that is available?

13 A. Yes, it's just so that everything is in one place and  
14 they don't have to run around to find it for themselves.

15 Q. If we were trying to seek that, do you know what that's  
16 called to request it?

17 A. It used to be called at that time "Handbook for the  
18 senior registrar".

19 Q. Thank you very much.

20 A. But I'm not sure what they call it now.

21 Q. I just want to move on now to the actual process.

22 Earlier on, you helped us by saying where the  
23 autopsy request form would go and who usually would be  
24 the person to go and look at it and what would happen  
25 in relation to the clinical notes and records. If the



1        clinical notes and records were not attached, is that  
2        something that the pathologist would ask for?

3    A.   Usually, the medical records, medical notes will come  
4        with the autopsy request form.   So they were usually  
5        available there.   Now, in this particular case I don't  
6        remember whether that happened or not, so I'm not sure  
7        whether the notes were present at that time or not.

8    Q.   How important is it, do you think, to look at those  
9        notes and records?

10   A.   I think if the clinical summary is fairly relevant to  
11        the case and relevant to what you are going to do,  
12        autopsy-wise, the notes -- the autopsy -- the clinical  
13        summary which comes with the autopsy request form or on  
14        [indistinct] is a very good, detailed snapshot of what  
15        has been in the medical records.   And sometimes the  
16        medical records could actually be quite bulky, quite  
17        large, there may not be enough time to start going over  
18        each and every page.   But as long as you can find  
19        relevant detailed information within the clinical  
20        summary which has been provided that, in most cases, is  
21        sufficient.

22   Q.   But would it be -- I appreciate entirely what you say  
23        about how voluminous some of those notes and records  
24        might be, but if they're not of that character, would it  
25        be good practice to at least look at them?

1     A.  Oh yes.

2     Q.  Thank you.  In this case, if the medical notes and  
3         records had been provided and if a person had had an  
4         opportunity to look at them, there are some things that  
5         would be revealed.  For example, you might have  
6         appreciated that there had been no CT scan until the  
7         child's collapse, so you weren't able to see the  
8         development of the cerebral oedema.  There had been no  
9         EEG so, to that extent, and in that way, the  
10        differential diagnosis of status epilepticus had not  
11        been confirmed in that way.  You might be able to see  
12        that there had been quite a bit of anticonvulsant  
13        medication prescribed to which the child didn't seem to  
14        respond, which might have been relevant to know.  Also,  
15        you would have been able to see what her first serum  
16        sodium level was, you would have known the last one  
17        taken was 121 because that's on the autopsy request  
18        form, but you would have seen what the starting one was.  
19        And although in the autopsy request form it refers to  
20        the fluids having been restricted, you might have  
21        appreciated, if you looked at the fluid balance sheet,  
22        that actually in total the fluids weren't restricted at  
23        a significant point.

24                So you might have been able to pick up that kind of  
25        information, which is not on the clinical summary.

1        Would it have been relevant at all for you to know any  
2        of those things?

3    A.   Well, I think the fluid restriction and all the fluid  
4        management, I think that is outside the expertise of the  
5        pathologist. And it is not up to them to make that  
6        judgment. It's the clinicians who are actually looking  
7        after the electrolyte things of that aspect of the case.  
8        And as regards the CT and EEG, there may or may not  
9        be -- apart from the cerebral oedema which was picked up  
10       in the CT, there may or may not be other changes which  
11       were directly relevant to the case at the time.

12   Q.   Yes. I suppose why I'm asking you that is, of the four  
13        clinical problems that have been indicated in the  
14        autopsy request form, one of them is SIADH -- or  
15        inappropriate ADH, actually, is how it's referred to  
16        there -- which is one explanation for the low sodium.  
17        But if you had been able to appreciate that maybe the  
18        fluids hadn't been restricted and if you had seen the  
19        reference in the note to one of the senior house  
20        officers, who queries whether there might not have been  
21        fluid overload, actually, which is what's led to the  
22        hyponatraemia. Then although that may be not something  
23        that you are looking at microscopically, nonetheless  
24        you're being asked to express a view on those four  
25        problems and it might, might it not, have assisted you

1           in making some comment?

2    A.   Well, again, I think SIADH, fluid restriction and

3           hyponatraemia, they do not show any specific structural

4           features in the brain.  So there's no way a pathologist,

5           by looking at the brain, or even after histology, can

6           say, "Yes, this is hyponatraemia," or, "This is

7           inappropriate ADH", because there are no specific

8           changes.  Cerebral oedema can be due to -- the causes of

9           cerebral oedema are multi -- there are several causes of

10          cerebral oedema, so it's not specific to hyponatraemia

11          or inappropriate ADH.  And as far as the clinical issues

12          about the fluid management and electrolytes are

13          concerned, that is not for the pathologist.  That is

14          outside our expertise to judge on that, on that aspect

15          of the case.

16   Q.   So of the four things that were identified on the

17          autopsy request form as problems, the cerebral oedema is

18          one that was already known --

19   A.   Yes.

20   Q.   -- and was provided to you because there had been

21          a CT scan that showed that?

22   A.   Yes.

23   Q.   The status epilepticus is not something that you can

24          identify as a pathologist?

25   A.   No.

1 Q. It either has been confirmed clinically or not, in one  
2 or other ways.

3 A. Mm-hm.

4 Q. The SIADH is also not something that you can really  
5 assist with --

6 A. Mm-hm.

7 Q. -- as a pathologist? And then the final thing was there  
8 was a query over viral encephalitis. That is something  
9 you could see. Am I right in saying of those four  
10 things there's only one thing you could be expected to,  
11 on the surface anyway, have really contributed a view  
12 to?

13 A. That was cerebral oedema.

14 Q. Yes.

15 A. Yes.

16 Q. Well, and the viral encephalitis.

17 A. I don't think you can actually macroscopically -- naked  
18 eye, you can ... by looking at the brain you can say  
19 that there is viral encephalitis. It's actually with  
20 the detailed histology later on.

21 Q. That's what I mean. When you look at it from the  
22 slides, then you can see how the cells are responding,  
23 whether there's a sufficient pattern of inflammation,  
24 inflammatory response, and so forth --

25 A. Yes.

1 Q. -- you could give some guidance as to whether you  
2 thought that was consistent with an encephalitis.

3 A. That's correct.

4 Q. In terms of the other three problems, other than the  
5 cerebral oedema and the degree of it, which was shown on  
6 the CT scan, are you saying that there's not much more  
7 that you could contribute?

8 A. No, no.

9 Q. In terms of things that weren't recorded on that autopsy  
10 request form, there was some other medication that was  
11 identified there. One therapy was not, which was  
12 midazolam. It's not recorded on there the dose that was  
13 administered to the child. If you had appreciated that  
14 the child had received a significant overdose of the  
15 phenytoin and the midazolam, would that have been  
16 something that might have caused you some concern?

17 A. Again, that is outside my expertise, commenting on the  
18 kind of medication which was administered.

19 Q. No, sorry, I don't mean it from that point of view.  
20 Every doctor has their own duties and responsibilities  
21 as to whether they should refer a death to the coroner.  
22 If you had appreciated that there was an overdose of  
23 that medication, would that have caused you any concern?  
24 Would you have wanted to discuss that with the  
25 clinicians?

1 A. Certainly in the clinical summary, there was no concern  
2 for the pathologist looking at the clinical summary that  
3 there was any issue like that. I think as far as  
4 reporting to the coroner, it's actually the clinician  
5 who is familiar with all the concerns.

6 Q. Yes, that's not quite my question. I said if you had  
7 learnt that, would that have caused you a concern, would  
8 you have wanted to speak to the clinicians about that?

9 A. Well, I ... I don't think that the ... I said that  
10 before also, that I don't think the pathologist would be  
11 involved in any way or would know. It would be outside  
12 their expertise to deal with the issues which are  
13 related to the kind of medication or the drugs which  
14 have been administered to the patient.

15 Q. The reason I ask you that is that I had put a similar  
16 question to Dr Herron and Dr Herron seemed to have  
17 a clear view that if he had appreciated there had been  
18 an overdose of medication, then he would have wanted to  
19 discuss that with his consultant, you, and his view was  
20 -- I don't mean just you, Professor Allen, if  
21 Professor Allen were there -- and, subject to what his  
22 consultant said, he thought that would be a matter for  
23 the coroner. And he also said -- and I'm going to ask  
24 you if you would have done the same thing, that he has  
25 in the past started what started off as a consent

1 autopsy and he had his concerns and that autopsy or that  
2 death was reported to the coroner. Is that something  
3 you've ever done?

4 A. Yes. I mean, if the issues are clearly made out that  
5 there has been any doubt or any evidence that there  
6 might have been such a case, surely the consultant will  
7 have issues -- will raise concern. If the issue of the  
8 overdose was raised or it was clearly spelt out that  
9 that was the case and if the consultant had appreciated  
10 it at the time, certainly there will be concern, and the  
11 matter will be raised as a point of concern with the  
12 clinician in charge of the case.

13 Q. You say you yourself have referred deaths to  
14 the coroner. In what circumstances have you done that?

15 A. I don't think I've referred deaths to the coroner.  
16 Well, I'm not -- it hasn't come across in my practice of  
17 autopsy that I've dealt with an overdose in which I was  
18 concerned. But it was simply a case of a head injury  
19 and I was concerned that I -- we discussed it with the  
20 clinicians and we wondered whether this should be  
21 a coroner's case rather than the state hospital autopsy  
22 because we were concerned, the pathologist looking at  
23 the clinical summary, we were a bit concerned that this  
24 may not be a straightforward head injury. So we raised  
25 this concern with the clinicians and once we raised the



1 concern with the clinicians they felt, yes, maybe  
2 it would be safer to do it that way and to refer it to  
3 the coroner. So pathologists will not directly refer to  
4 the coroner, but they will discuss with the clinician  
5 any concern which they may have at the time of starting  
6 the autopsy and then the clinicians will raise it with  
7 the coroner.

8 Q. Yes. And that could arise either because you see  
9 something in the summary, as you have just said, which  
10 you're not so sure about, or if you have an opportunity  
11 to look at the medical notes and records maybe you see  
12 something there that gives rise to something you'd like  
13 to raise with the clinicians?

14 A. Yes.

15 Q. It could arise in that way?

16 A. Yes.

17 THE CHAIRMAN: Doctor, maybe this doesn't actually arise in  
18 practice, but do you not have your own independent duty  
19 to refer a death to the coroner if you come across  
20 something during the course of your investigation of  
21 a child's death such as Claire's?

22 A. Well, we would discuss it first with the clinicians.  
23 That would be our first --

24 THE CHAIRMAN: And that usually sorts it out?

25 A. -- interface. If we deal that, after discussing with

1           the clinicians it has -- and most of the times, I must  
2           say, it hasn't actually arisen in my practice that if  
3           I had a concern about something and I frankly discussed  
4           it with the clinicians, they would not report it to the  
5           coroner.

6   THE CHAIRMAN:   Thank you.

7   MS ANYADIKE-DANES:   Can I ask you, in 1996, what was your  
8           understanding of the extent to which hyponatraemia could  
9           lead to cerebral oedema?

10   A.   Hyponatraemia ... Any metabolic disorder can cause  
11        cerebral oedema to a certain extent and hyponatraemia is  
12        one of the causes. It is not the only cause.

13   Q.   No, I understand.

14   A.   Even looking at the brain and if you identified that  
15        there is cerebral oedema, you could still not say that  
16        it is due to hyponatraemia.

17   Q.   No, I'm simply benchmarking your understanding of the  
18        process.

19   A.   Yes, hyponatraemia is one of the causes of cerebral  
20        oedema.

21   Q.   And to what extent were you aware that dilutional  
22        hyponatraemia could do that?

23   A.   I am not ... I'm not aware of the ... I don't have ...  
24        Again, it is outside my expertise to comment on the  
25        dilutional hyponatraemia.

1 Q. Just so that I get it right, you were aware that  
2 hyponatraemia could do that?

3 A. Yes.

4 Q. Well, hyponatraemia is simply --

5 A. Dilutional hyponatraemia is also a hyponatraemia.

6 Q. Exactly.

7 A. What I'm saying is that hyponatraemia, no matter  
8 whatever cause it is, whether it is inappropriate ADH or  
9 dilutional, can cause cerebral oedema.

10 Q. And you would have known that in 1996?

11 A. I would have known that, yes.

12 Q. Would you have expected your trainees to know that or  
13 your registrar, for example?

14 A. I think if the case comes and if the trainee is there  
15 at the time doing the autopsy, certainly the trainee, if  
16 they're not aware, the consultant would, when they're  
17 discussing the case with them, will make them aware of  
18 the issue.

19 Q. I'm actually trying to see where the stage of knowledge  
20 has got to, which is obviously evolving and growing.  
21 You were involved in a teaching capacity, not just of  
22 your own trainees, but also at the university. At that  
23 time in 1996, is that something that you would expect  
24 registrars or trainees coming into the department to  
25 appreciate?

1 A. I think it's -- they would know, or should know, as part  
2 of their training the causes of cerebral oedema, not  
3 just hyponatraemia per se. But when you're learning  
4 about neuropathology or you're learning about brain  
5 swelling or cerebral oedema, hyponatraemia is one of the  
6 causes of cerebral oedema, so they would be aware of  
7 hyponatraemia as one of the causes of cerebral oedema.

8 Q. Thank you. Can I move on to discussions with the  
9 clinicians before the post-mortem? Dr MacFaul, who's an  
10 expert for the inquiry, has said that there's no  
11 record -- we don't need to pull it up, but the reference  
12 is 238-002-063 -- that there was any discussion that  
13 took place between the consultant responsible, so  
14 Dr Steen or Dr Webb as the case may be, with the  
15 pathologist, either before or after the report. And  
16 Dr Squier, who's also an expert for the inquiry, has  
17 said in her report at 236-007-010, that a meeting  
18 between the pathologists and the clinicians, either  
19 before or after the autopsy report was finalised, would  
20 have been best practice. Do you accept that that can be  
21 a useful thing to do, to have some discussion between  
22 the pathologist and the clinicians?

23 A. Yes, it is. It did happen. I mean, the autopsy report  
24 itself had a commentary at the end with  
25 a clinicopathological correlation. In the paediatric

1 service, the cases are usually discussed -- all deaths  
2 are usually discussed at the paediatric mortality  
3 meeting and then the third place of  
4 a clinicopathological correlation and discussion with  
5 the clinicians was at the time of the CPC with the  
6 neurosciences on Tuesday morning. So there were three  
7 separate occasions on which the case would have been  
8 discussed or -- as a clinicopathological correlation  
9 with the clinician.

10 Q. I haven't got to the clinicopathological correlation  
11 yet. At the outset, is that something that you think  
12 would be useful to do if you had the opportunity to do  
13 it?

14 A. Yes.

15 Q. And is Claire's the kind of case which might be useful  
16 to do that given that, on the face of it, the  
17 contribution that your service might be able to make to  
18 assisting the clinicians might actually be quite  
19 limited?

20 A. Yes.

21 Q. And that would be worth, even if it's only to manage  
22 expectations, having that discussion?

23 A. Yes.

24 Q. Thank you. Can I just --

25 THE CHAIRMAN: Sorry, let's just confirm that. Do you

1           remember whether there were any discussions with  
2           Dr Steen for --

3    A.   I don't remember the individual names, but I know that  
4           there was -- the case was definitely for the  
5           neurosciences ward rounds and a list of the cases goes  
6           to all the relevant clinicians, which means that apart  
7           from the usual neurologists, neurosurgeons who were  
8           there at the time, and the paediatric neurologists, the  
9           other relevant clinicians who are involved with the care  
10          of the patient, they're informed that the case is going  
11          to be discussed. But I do not recall and I do not  
12          remember whether the relevant clinician in this  
13          particular case attended or not. That I can't recall.

14   THE CHAIRMAN: Do you remember anything in particular about  
15          Claire's case from 1996 or 1997?

16   A.   In what ...

17   THE CHAIRMAN: Well, do you remember being involved in the  
18          investigation of Claire's death in your service? Do you  
19          remember any of the work that you did in producing this  
20          autopsy report?

21   A.   Well, yes, we reported the -- we looked at the case and  
22          we did the detailed histology and the detailed  
23          examination, so we were involved in the preparation of  
24          the report.

25   THE CHAIRMAN: Yes. Sorry, is that something that you

1       remember because you have the documents in front of you  
2       which show it or is it something that you have  
3       a separate memory of?

4    A.   I think it was in 1996/97, so I remember the case as one  
5       of the cases which came through the service and we  
6       provided a full report on the case.

7    THE CHAIRMAN:   Thank you.

8    MS ANYADIKE-DANES:   I want to ask you a little bit about the  
9       limitation on the post-mortem to brain-only.   The  
10       autopsy request form came to you like that.   That was  
11       the restriction that had been placed on it.   And I think  
12       in one of your witness statements you say there's no  
13       explanation of why that restriction was there, but that  
14       was the restriction placed on it, so that was the extent  
15       of your consent, if I can put it that way.

16   A.   Mm-hm.

17   Q.   In Dr Webb's witness statement, 138/1 at page 91, he  
18       says:

19       "I cannot recall my view at the time of Claire's  
20       death, but I believe I would have expected her  
21       post-mortem to have been a full post-mortem, pending the  
22       parents' consent."

23       But he doesn't believe he was involved in the  
24       discussion.

25       The expert Dr Squier was asked that.   Her view was:

1            "In the case of a child who had died suddenly with  
2            no clear clinical diagnosis, I would have expected  
3            a full autopsy."

4            And then she goes on to say that she would have  
5            expected a paediatric pathologist to be consulted or  
6            involved.

7            She also says that -- she queries whether it was in  
8            the circumstances appropriate to restrict the autopsy to  
9            brain-only when a systemic infection was suspected as  
10           the cause of Claire's illness on admission.

11           I wonder if I could ask you whether you think it  
12           might have been more appropriate to have done a full  
13           autopsy, and if I just give you that little bit about  
14           the reference that Dr Squier talks about, the child  
15           dying suddenly. From your point of view, looking at the  
16           autopsy request form -- there's an error in it actually,  
17           but it would have appeared that she was admitted some  
18           time on the 22nd, which was the Tuesday, 22 October, and  
19           suffered her respiratory collapse at 3 o'clock on the  
20           following morning, which would be a very short time  
21           indeed. If you're looking at that and thinking about  
22           the query over the viral encephalitis and the general  
23           presentation and information you've got in your summary,  
24           would it have occurred to you that this is a case that  
25           perhaps could have benefited from a full autopsy?



1 A. I think in this particular case, according to the  
2 clinical history provided and the clinical workup of the  
3 case, it was quite obviously that the disease, the bulk  
4 of the disease, was in the brain. Therefore, in my  
5 mind, at the time, and it was a consented autopsy -- and  
6 it was clear-cut that it was a consented autopsy at the  
7 time. It's not unusual to find such cases limited to an  
8 organ.

9 Q. Yes.

10 A. And there have been cases in the past when the disease  
11 is restricted, say for instance to the heart or the  
12 lung, that it's only a heart-only or lung-only autopsy,  
13 so it's not unusual to have the autopsy restricted to  
14 that particular organ where the bulk of the disease may  
15 well be.

16 Q. Yes.

17 A. It seemed from the report -- and also the clinicians  
18 were able to have the death certificate that they were  
19 fairly happy enough with the course of events, what  
20 actually transpired, that the ... Then of course, with  
21 the discussion with the family and so on, then they were  
22 happy enough for the case to be limited autopsy,  
23 restricted to the brain. And looking at the summary, it  
24 seemed that the most part of the disease was restricted  
25 to the brain. So therefore, it is not unusual to have

1 a limited autopsy in those kinds of cases.

2 Q. Yes. When Dr Herron was giving evidence at the  
3 inquest -- and I appreciate you didn't attend that --  
4 the reference is 090-003-005, he said:

5 "As this was a brain-only autopsy, it is not  
6 possible to comment on other systemic pathology."

7 Sorry, it's actually in your report. I beg your  
8 pardon.

9 A. Yes.

10 Q. Is that indicating that we might have been able to say  
11 something else if there had been full autopsy, but we  
12 didn't do a full autopsy, so this is all we can say?

13 A. I think we're talking here mostly from the point of  
14 inflammation and infection which we thought we found in  
15 the brain. So we wouldn't have actually found very much  
16 else in any of the other organs.

17 Q. It's just that I'm wondering about the way --

18 A. From the point -- what we are saying in the comment  
19 is that it would not be appropriate for us to comment on  
20 what went on or what was the degree of  
21 infection/inflammation in the other organ, if there was  
22 at the time of death. Because sometimes in these cases,  
23 towards the terminal stage or by the time the patient  
24 dies, the disease is very often restricted to the brain,  
25 even though it may have started in the peripheral

1       organs. So you can never, even if you did a full  
2       autopsy, never substantiate that that's where the  
3       disease may have actually started.

4   Q. Yes.

5   A. But we cannot say that if we have done brain-only  
6       autopsy that there was -- and if the other organs ...  
7       If it is restricted to brain, that the -- whether the  
8       infection at the time of the autopsy or at the time of  
9       death was present in the other organs or not.

10  Q. That's really the point that I'm at. If you had had the  
11       opportunity to look at the other organs or a pathologist  
12       had had an opportunity to look at the other organs,  
13       whether they might have been able to given a better  
14       explanation of whether there was indeed present any kind  
15       of viral infection at all, and one of the reasons I ask  
16       you that is because I note that in the comment it says  
17       that it was a "low-grade sub-acute meningoencephalitis".  
18       And Dr Herron, when he gave evidence yesterday, said if  
19       he was giving it on a scale to 0 to 10, he would have it  
20       maybe at 1 to 2, and he conceded in one of his witness  
21       statements it was possible that it actually wasn't  
22       there, but that's what he saw and that was how he  
23       explained what he saw.

24       So given that what was happening in terms of any  
25       kind of inflammatory effect seemed to be of a very low

1       order, and yet the child deteriorated and died  
2       relatively quickly, might it not have helped your  
3       analysis or somebody's analysis to look at what had  
4       happened in the other major organs?

5    A.  I think the ... Again, I think if there was a low-grade  
6       inflammation in the brain, I'm not sure how severe or  
7       how mild or moderate it would have been in the other  
8       organs or how well it would have been appreciated even  
9       if you do look at the thing, especially looking at the  
10      gastrointestinal tract and so on, which is very  
11      difficult to assess in autopsy tissues because of the  
12      autolysis which can take part in the gut. So it is very  
13      difficult to actually say that, what degree of  
14      inflammation or infection might have been present  
15      because histologically it is very difficult to assess.

16           Quite often terminally, the patient may have  
17      a terminal pneumonia in the lungs which is so  
18      non-specific, but it is -- I am not sure what it would  
19      have added eventually to the autopsy report.

20   Q.  I suppose the only point is that we're not sure because  
21       there wasn't that availability. And if the family's  
22       primary concern was actually understanding what had  
23       happened to their child -- and so it's not as in some  
24       cases where the family actually are very concerned to  
25       ensure that any investigation is kept to the minimum.

1        If you don't have a family like that, then if there is  
2        anything to be gained at all to explain what was  
3        happening, is there any reason why you simply wouldn't  
4        do a full autopsy?

5    A.  No, I think if the clinician has felt that it was --  
6        that the full autopsy was required and all the issues  
7        they need to actually look at, but the pathologist is  
8        looking from the point of view simply from the nature of  
9        the consent.  Was the consent given to the brain-only  
10       autopsy?  Where is the bulk of the disease?  And whether  
11       that is going to give us an appropriate cause of death.

12   Q.  Yes.

13   A.  That would have been sufficient for the pathologist  
14       at the time.

15   Q.  Is there ever any discussion between the clinicians and  
16       the pathologists about what the most appropriate form of  
17       autopsy might be?

18   A.  Not in 1993, 1995, 1996.  But I think after the new  
19       Human Tissue Act and so on came through and where the  
20       consent and all those things were discussed, I think  
21       still the consent is still taken by the clinicians --

22   Q.  Sorry, I mean before consent.  Is there any discussion  
23       before the clinician actually goes to the family and  
24       discusses it so that the clinician maybe --

25   A.  Not at that time.

1 Q. Would that happen now?

2 A. That would occasionally sometimes happen now, yes.

3 I have been involved myself in occasional cases where

4 the clinicians have discussed with us that such-and-such

5 is the case and would do you think would be the --

6 should be the nature of the autopsy. It happens now.

7 Q. On the basis of that information so they can inform the

8 families better?

9 A. Yes.

10 Q. Thank you. Then if I can move on to the actual conduct

11 of the autopsy itself. But starting with the purpose of

12 the autopsy. You said in your witness statement -- and

13 this perhaps is worth looking at, 247/1, page 4. It's

14 the answer to question 4:

15 "Describe the purpose of Claire's autopsy."

16 You say that the purpose of the autopsy was to

17 identify the cause of death.

18 A. Mm-hm.

19 Q. And then you go on to say in answer to 5(a):

20 "Dr Herron was part of the team carrying out the

21 autopsy and examined the brain in detail for the purpose

22 of identifying the cause of death and the subsequent

23 autopsy report."

24 A. Mm-hm.

25 Q. Dr Herron has a slightly different view of what the

1        purpose was. That's in his witness statement at 224/1,  
2        page 7. He says:

3                "The autopsy was done to address the presence or  
4        absence of status epilepticus and encephalitis."

5                So how does that compare? Because your statement  
6        seems to be quite straightforward and clear: we're  
7        trying to identify what the cause of death is.

8        Dr Herron has a slightly different view.

9    A. It's not such a different view. We're looking at the  
10       same points and the same disease process. What I mean  
11       by my statement is the cause of death was actually quite  
12       clearly established clinically, which was cerebral  
13       oedema. So what I was trying to explain in my statement  
14       was whether we could find a structural cause for the  
15       cerebral oedema because even with a CT scan and even  
16       during the clinical management. Sometimes it is not  
17       possible to actually say what was the cause of cerebral  
18       oedema. And to make sure that there's no other  
19       structural cause other than infection, like a tumour or  
20       a haemorrhage or stroke or whatever. So I think that's  
21       what I mean by saying to identify the cause of death  
22       means the cause of death was clear-cut here, cerebral  
23       oedema. So could we identify a cause other than  
24       infection or inflammation, such as a tumour or something  
25       like that.

1 Q. So you have a broader based enquiry. You know what the  
2 end result is; the end result was this cerebral oedema  
3 and you're looking at the brain to see if you can find  
4 some explanation for how that --  
5 A. -- how that cerebral oedema developed --  
6 Q. -- cerebral oedema developed in that way?  
7 A. Yes.  
8 Q. And it might be something to do with encephalitis or it  
9 might be something to do with something else?  
10 A. That's correct.  
11 Q. In relation to Dr Herron's view that the autopsy was  
12 done to address the presence or absence of  
13 status epilepticus, from what I understood you to say  
14 earlier, it couldn't do that because it was never going  
15 to assist with establishing status epilepticus.  
16 A. No, because there are no specific changes related to  
17 status epilepticus that you can look at under the  
18 microscope and you can actually say that it is  
19 status epilepticus. But what you could actually look at  
20 in the thing -- whether if the status epilepticus is  
21 related to another cause which you can actually identify  
22 in the brain, like a tumour or something else. So  
23 I think the pathologist is trying to find a cause for  
24 cerebral oedema.  
25 Q. I understand from what you said, that's very clear. The



1       other thing that I want to ask you is: in the autopsy  
2       request form there's reference to the child having  
3       a mental handicap.

4    A.   Yes.

5    Q.   When the evidence from Dr Steen -- although it's not  
6       accepted by the parents. Her evidence is that one of  
7       the things that she had told them when she was  
8       explaining about the brain-only autopsy is a benefit to  
9       that would be that they might gain some understanding of  
10      the reasons for their daughter's developmental delay.  
11      Nobody in particular had suggested that her  
12      developmental delay had given rise in a causal way to  
13      her cerebral oedema, but it was being said as something  
14      that might be discovered and that might be of some  
15      assistance for them to know. When you are looking for  
16      the cause of the cerebral oedema, which is your target,  
17      to what extent are you also looking for something like  
18      that, or would you have to be told, "We also want you to  
19      see if you can explain that"?

20   A.   No, I think as a pathologist, when you're looking at the  
21      brain, you're looking at the brain as a whole, as to  
22      what other things may be present apart from the cause of  
23      the cerebral oedema. And as you say very correctly, the  
24      learning disability may not produce a lesion in the  
25      brain which is evident on the naked-eye examination or

1       macroscopically or the changes could be so subtle. The  
2       reason we say that is because there are some  
3       malformations -- and I'm talking about real obvious  
4       malformations -- in the brain, which may have a genetic  
5       implication. So the purpose of looking at the  
6       brain: can you identify a cause or a -- see the  
7       malformation in the brain, which may have caused  
8       learning disability, which may caused -- have a genetic  
9       implication, which means there might be implication for  
10      other family members.

11             So when the pathologist is looking at it, the  
12      pathologist is looking at it as a whole not just holding  
13      on to the cerebral oedema.

14   THE CHAIRMAN: Did you look at that?

15   A. Yes, I did.

16   THE CHAIRMAN: Right. Is that referred to in the report at  
17      all?

18   A. Um ... I think it is referred to in the histology.

19   MS ANYADIKE-DANES: Why don't we pull up the two pages side  
20      by side? 090-003-004, 090-003-005.

21   A. Yes.

22   Q. If we can have a look at that and see if there's  
23      anything that identifies that kind of evidence.

24   A. I think I've said that under two headings in the  
25      histology, "Cortex and white matter":

1            "In the deep white matter, focal collections of  
2            neurones are present, arranged in a rather haphazard  
3            manner."

4            And then we have also said under "Periventricular  
5            grey matter, hypothalamus and mammillary body":

6            "There are focal collections of neuroblasts in the  
7            subependymal zone, suggestive of a migration problem."

8        Q.    If I'm right in understanding you, that's your evidence  
9            that leads you under the commentary section to where you  
10           say "neuronal migrational defect"?

11       A.    I think what I have said in the commentary sections may  
12           be that that -- that may be one of the causes, but --

13       Q.    But to the extent that there's evidence for it, that's  
14           where you're expressing it?

15       A.    Yes.

16       Q.    And the effect of that would be?

17       A.    Sorry?

18       Q.    What would be the effect of that?

19       A.    Effect of what?

20       Q.    Well, one of the things that you were looking at is  
21           because you've been told on the autopsy request form  
22           that this child had a mental handicap, as you understand  
23           it. And you said you were looking at the brain in the  
24           round to see what explanation you could provide and also  
25           whether any of that could, in any way, have predisposed

1           her or led to the cerebral oedema.

2    A.   Yes.

3    Q.   So where is the connection between your end point, which

4           is the cerebral oedema or an explanation of the mental

5           handicap, and this evidence that you have described

6           here?

7    A.   Cerebral oedema is not related to the neuronal

8           migrational disorder because that doesn't cause cerebral

9           oedema per se. And also, we were looking for whether

10          there was a very obvious malformation, and in the

11          absence of that, what we are relating is that the subtle

12          change which we found -- abnormally placed neuroblasts

13          in the deep white matter -- whether that was related, to

14          some extent, to the learning disability, which the child

15          had.

16   Q.   Are you able to do that or is that something that you

17          would actually -- would have prompted some discussion

18          between you and the clinicians?

19   A.   Well, I think the reason we have said that ... I'm not

20          able to say that -- the changes which were present were

21          so subtle, whether they definitely caused learning

22          disability or not. But that is something, a finding

23          which we had observed under the microscope, so we

24          recorded it in the autopsy report, and we wondered how

25          much of that was related to actual learning disability.

1 Q. I understand that. I'm just trying to see where it is  
2 the clinician would be able to interpret that. If the  
3 clinician says, "One of the things I wanted you to look  
4 at is to see whether there was any evidence that could  
5 help explain the child's developmental delay," and back  
6 comes your report, which refers to a neuronal  
7 migrational defect, how does the paediatric clinician  
8 understand that so that they're then in a position to  
9 say anything to the family?

10 A. I think they should have some indication of that if  
11 there is a neuronal migrational disorder, even though  
12 it is very subtle, but it is abnormal and it is there,  
13 could this in some way be related to the learning  
14 disability that the child had? So they should be able  
15 to connect that with the --

16 Q. Or is that -- that's why I was asking you whether that's  
17 the sort of thing that there might be a discussion  
18 about. The end product of that discussion might  
19 be: actually we probably need to take that to  
20 a specialist, if you really want to assist the family in  
21 understanding that, to know whether that level of  
22 neurone migrational defect could account for the child's  
23 presentation.

24 A. Yes because the case was discussed in one of the grand  
25 rounds so those points would have been brought up at

1           that time.

2   Q.   Yes, we are going to come to that.

3   MR FORTUNE:   Can I assist?  Dr Steen in fact would accept

4           that on reading the paragraphs under "Histology" and

5           "Comment" that what Dr Steen would understand is that

6           the pathologist, the neuropathologist, had found

7           a possible defect in the development of Claire.

8   THE CHAIRMAN:  That's what she wrote to the GP about, isn't

9           it?

10  MR FORTUNE:   Sir, I was merely going on the line of

11           questioning that my learned friend is pursuing now.

12  THE CHAIRMAN:  But that explains why it is in the letter to

13           the GP.

14  MR FORTUNE:   Yes, but to assist this line of questioning,

15           I make that concession.

16  THE CHAIRMAN:  Yes.

17  MS ANYADIKE-DANES:  Thank you.  I was going to go on to

18           another point.  I'm wondering about the time.

19  THE CHAIRMAN:  Doctor, we'll give the stenographer a break

20           for ten minutes.  Thank you.

21  (11.05 am)

22   (A short break)

23  (11.17 am)

24  MS ANYADIKE-DANES:  Dr Mirakhur, before I ask you about the

25           stages in the autopsy and how it was actually conducted,

1 I wonder if I could ask you about who did what, so the  
2 respective roles of yourself and Dr Herron. You have in  
3 your witness statement, 247/1, page 6 -- and I think  
4 it's in answer to question 8(a) and (e). You refer to  
5 it as being a team effort.

6 A. Mm-hm.

7 Q. If you see, certainly in relation to (e) -- if you see  
8 the findings ... When you're asked specifically which  
9 findings in the autopsy are either yours or Dr Herron's  
10 or anyone else's, you say:

11 "Dr Herron and I reported jointly."

12 Then in relation to (a), when you're asked about  
13 being the author of the report, you say that:

14 "It wasn't usual to put the consultant's name if the  
15 autopsy was carried out by a person with the status of  
16 a senior registrar. I supervised Dr Herron as part of  
17 the team."

18 So given that you're working as a team, who does  
19 what part of the work?

20 A. I think -- well, the consultant is supervising  
21 throughout the case, but is actually technically doing  
22 the autopsy, which is usually done by a senior registrar  
23 if it is of a sufficient senior status. Then the  
24 autopsy findings are then discussed with the clinicians.  
25 Sorry, with the supervising consultant, the naked-eye

1 examination. And the histology, when we block the  
2 organ -- at the organ review time, when we're blocking  
3 the brain and looking at the brain in detailed  
4 examination internally, both the senior registrar and  
5 consultant are present at that time. And then when  
6 we are doing the histology -- and this is part of the  
7 training thing as well -- that a histology and the  
8 histology is being supervised and being looked at by the  
9 consultant and the senior registrar jointly together.  
10 It's a double-headed microscope and both of them are  
11 sitting and looking at the histology together.

12 Q. Just so that we're clear about that, Dr Herron says in  
13 his witness statement at 224/4, page 10:

14 "There's no evidence that I had any involvement in  
15 the interpretation of the histology ..."

16 Which I think is what you were just talking about as  
17 part of the training exercise:

18 "... the drafting of the post-mortem report or  
19 in the conclusions made within the report in 1997."

20 Then he goes on to say:

21 "The brain description is mine, but there is no  
22 evidence that any of the rest of the report is mine."

23 So given that he puts it in that way, can you help  
24 us with actually who was doing what? Do you accept that  
25 that's how it worked?



1 A. I think it's not ... In my mind -- and I appreciate  
2 Dr Herron may have his own interpretation to it.

3 Q. Of course.

4 A. But in my mind, the way it actually works is that  
5 there's a case which comes for autopsy, the clinical  
6 notes and the initial point is when the registrar goes  
7 down and looks at the clinical notes, at the clinical  
8 summary, discusses with the supervising consultants, the  
9 consultant then comes down and looks at the notes and  
10 looks at the case. Then the consultant is toing and  
11 froing in between the department. If the senior  
12 registrar is of such senior status, the consultant leads  
13 for the senior registrar to do the autopsy and with the  
14 statement that if any point of the autopsy, when he's  
15 doing it, he feels that he has to consult the consultant  
16 again, the consultant will come down again and look  
17 at the case again with him.

18 Then the case goes -- the autopsy is completed, the  
19 brain fixes, and the case goes for organ review where  
20 the brain is looked at in detailed examination and the  
21 further tissue blocks are taken for histology. Both the  
22 senior registrar and the consultant are present there.  
23 Then the case comes for histology to reporting and then  
24 the senior registrar and the consultant are looking at  
25 the histology together. The final report obviously has

1           to be the interpretation of the consultant because he's  
2           the supervising consultant. The senior registrar is  
3           still under training, so the final commentary has to be  
4           the consultant's.

5   Q.   Okay.

6   A.   But both are involved in the process.

7   Q.   Throughout the process?

8   A.   Throughout the process.

9   Q.   So if I understand you, actually the removal of the  
10          brain, that is something that a pathologist of  
11          sufficient seniority might do all by themselves without  
12          the consultant being there?

13  A.   That's correct.

14  Q.   And that initial examination of what's there and the  
15          cavity and so forth?

16  A.   Yes.

17  Q.   And that is then put in for fixing?

18  A.   Yes.

19  Q.   It may carry on being the senior pathologist if the  
20          registrar is senior enough to look from time to time and  
21          to see whether the brain has reached a stage --

22  A.   Yes.

23  Q.   -- where it can be cut, if I can put it that way?

24  A.   Yes.

25  Q.   And then if that pathologist forms that view and the

1           brain is going to be cut, that's a point where the two  
2           of you might be there?

3    A.   Yes.

4    Q.   Because you might want to discuss where you're going --

5    A.   I think it's not just might be there.

6    Q.   Will be there?

7    A.   Because the senior registrar does not look at -- or  
8           doesn't do, conduct the internal detailed examination  
9           when he or she may still be under training, without the  
10          consultant being present there.

11   Q.   So you would have to be there?

12   A.   Yes.

13   Q.   When the decision is being made as to where the tissue  
14          is going to be taken from and when that actually  
15          happens?

16   A.   That's correct.

17   Q.   And then that tissue goes off, it gets made into slides?

18   A.   Yes.

19   Q.   And those come back and then there's another opportunity  
20          when you will be there or the consultant will be there  
21          with the senior registrar to actually look at those  
22          slides under the microscope. That's the histology part?

23   A.   That's correct.

24   Q.   And to discuss what you are both seeing?

25   A.   Yes.

1 Q. And then there's the actual writing up and although it's  
2 the report over which the consultant stands, it is  
3 informed by the discussion and the work to which the  
4 senior registrar has contributed?

5 A. That's correct. I think the final interpretation of the  
6 report has to be the consultant's --

7 Q. Yes.

8 A. -- in discussion with the senior registrar.

9 Q. Okay. Then if you are there when the routine blocks are  
10 going to be taken -- sorry, can I ask you: do you recall  
11 being there?

12 A. Yes, I do.

13 Q. Was there a discussion as to where you wanted the tissue  
14 to be taken from?

15 A. Yes.

16 Q. Is it something that's fairly standard or does it rather  
17 depend on the details of Claire's case where you decided  
18 you wanted that tissue to be taken from?

19 A. No, it is fairly standard that the consultant was there.

20 Q. Fairly standard?

21 A. Yes.

22 Q. So that happens and the tissue blocks are taken. Then  
23 the slides are made up and they come back. Is it you or  
24 in discussion with the registrar what stains are going  
25 to be applied to those slides?

1 A. Yes. We discuss it together as to what stains are going  
2 to be applied. Well, the initial staining is always the  
3 H&E, which is what the pathologist calls the screening  
4 staining. If we pick up any abnormalities with the  
5 initial H&E staining, then we would request for further  
6 additional stains to be carried out.

7 Q. Yes. And at that time, when you're discussing the  
8 blocks that you're going to take and deciding what  
9 stains subsequently you might apply thereafter, is that  
10 when photographs are taken of the brain?

11 A. The photographs can be taken at the stage when we are  
12 actually doing the organ review, when we are dissecting  
13 the brain, or the photographs can be taken at the time  
14 of the discussion or looking at the histology. So they  
15 can happen in both places.

16 Q. The only photographs we've actually seen is a photograph  
17 of a sort of slice through of which there are two --

18 A. The coronal sections?

19 Q. Yes. And then there are photographs of the slides --

20 A. -- of the histology --

21 Q. -- of the histology, so I think there's nine of those  
22 and one of the section.

23 A. Yes.

24 Q. There are no photographs of the whole brain; is that  
25 usual?

1 A. No, because there was nothing probably to see on the  
2 whole brain.

3 Q. I understand.

4 A. So there was no point in photographing if there was  
5 nothing to see.

6 Q. Not even to demonstrate pictorially the level of oedema,  
7 to see the extent to which there was effacement and so  
8 forth? Would that not have been worth recording?

9 A. With due respect, you will not see the effacement of the  
10 ventricles by looking at the whole brain. It is only  
11 when you dissect it and you look at the internal  
12 cavities and you assess the effacement.

13 Q. It may be I'm using the terminology incorrectly.

14 A. You look at the herniations, yes, on the -- looking  
15 at the whole brain.

16 Q. I recall that when Dr Armour was carrying out the  
17 examination of Adam's brain, for example, she took  
18 a number of photographs of the whole brain to  
19 demonstrate the extent to which there was, I would call  
20 it a lack of grooving, if I can call it that way, and  
21 that was part of her way of explaining how oedematous  
22 the brain was before she got into the internal  
23 examination at all. Is that something that you would  
24 do?

25 A. Yes, we would do, but it's not usual that we'll always

1 do because I think the coronal sections -- and if there  
2 are herniations and if there's oedema and if there's  
3 effacement of the ventricles, you can assess that or you  
4 can photograph that by slicing the brain and looking at  
5 it.

6 Q. I understand.

7 A. So it's not that you cannot assess the herniations in  
8 a coronally-sliced brain; you could still do it.

9 Q. When you say that you're taking the tissue to make  
10 blocks up and ultimately there will be -- or taking  
11 tissue blocks which will be made into slides, is there  
12 any consideration to whether tissue can be sent off for  
13 other testing? The reason I ask you that is because  
14 there was a concern about whether a virus had been  
15 responsible for the swelling in Claire's brain. Was  
16 there any thought that you might send that off for some  
17 sort of culture to see what could be developed out of  
18 that?

19 A. The tissues -- if they are sent off for culture or for  
20 viral studies ... There are two sets you can do. One,  
21 you can send it to virology for that, and for that you  
22 usually require fresh tissue, not fixed tissue. But if  
23 you want to do stains for looking for certain type of  
24 organisms, then you can actually look at it in histology  
25 under the microscope. You can assess in the same

1 histology you're assessing the -- you don't actually  
2 have to take separate tissues for assessing the -- for  
3 organisms in a fixed brain. But you have to send -- for  
4 viral culture or viral studies, then you take fresh  
5 tissues rather than the fixed tissues.

6 Q. If you're going to do that and think there might be  
7 a benefit, since nobody actually knows whether there was  
8 any kind of viral infection or, if there was, what sort  
9 it was -- they knew what the white cell count was at one  
10 stage, and it was slightly elevated -- is there any  
11 discussion between you and the trainee that maybe we'll  
12 take a section of that fresh tissue before or maybe you  
13 should do that since you won't be there at the time  
14 before the brain is fixed?

15 A. I can't remember that.

16 Q. Is that something that is done?

17 A. It is something done, yes. Something that can be done,  
18 and I'm not sure whether ... It's not actually in the  
19 report, but ... But that is something which can be done  
20 in the fresh tissue at the time of the autopsy.

21 Q. Yes. I recognise there are some things that if you  
22 don't do them at that time, you can't do them  
23 thereafter. Is that something that in retrospect that  
24 might have been a help?

25 A. Not necessarily. I mean, the viral studies could be



1 negative. In my mind, the more clear-cut evidence of  
2 a viral inflammation in the brain is the histology,  
3 because the viral studies, the culture studies may be  
4 negative, and yet the signs of the -- what we call  
5 in the pathology the footprints of the virus may still  
6 be looked at in the histology because the cellular  
7 reaction will still be there. Virus may or may not be  
8 there. So yes, in cases where you could actually find  
9 virus in the culture studies, that is helpful, but there  
10 are cases in which there is viral infection and you may  
11 not find anything, even with the fresh tissue and the  
12 culture studies.

13 Q. Can it be the other way round, that you can see it  
14 in the fresh tissue, but you can't actually see the  
15 evidence of in the stains on the slides?

16 A. That will depend upon the -- how long the illness has  
17 been present.

18 Q. Yes. In Claire's case, is it something that might have  
19 been done?

20 A. I don't remember that.

21 Q. I don't mean "was it actually done". In Claire's case,  
22 would it have been something that would have been useful  
23 to do?

24 A. The tissue for culture? I'm not sure because the  
25 histology was clear-cut, saying that there is a viral

1 infection, but the virus was not identified.

2 Q. The reason I'm asking is, at the time you're making your  
3 decision whether you're going to do that or not,  
4 of course you don't know what the histology is going to  
5 say because you haven't reached that stage yet. That's  
6 the whole point: that you need to make that sort of  
7 decision before you get to the stage of having the brain  
8 fixed and therefore producing your slides.

9 A. Yes.

10 Q. So at that stage, I'm simply asking you, is that  
11 something that would have been appropriate to do?

12 A. Yes.

13 Q. Then could I just ask you very briefly about other  
14 experts? Did it occur to you that it might be useful to  
15 seek a view from any other experts? For example,  
16 Dr Squier has referred to the possibility, once you  
17 reached the evidence that you thought you had for the  
18 neuronal migration defect, that might have been worth  
19 sending to somebody specialist to be able to help with  
20 that since it was quite a subtle change, even on your  
21 own description of it.

22 A. We are neuropathologists at the end of the day, so  
23 I think the specialist -- I don't know what Dr Squier  
24 means by "specialist". I mean neuropathology is  
25 a specialism in itself, so I'm not sure -- a

1        neuropathologist is not a general pathologist; he is a  
2        specifically-trained specialist neuropathologist.

3    Q.   Even within that, I assume there are some people who  
4        specialise even yet further, and she referred to --  
5        I will give you the reference in her report,  
6        236-007-004. She talks about a "paediatric  
7        neuropathologist" or a "neuropathologist specialising in  
8        neurogenics". That was actually her thought that that  
9        might have been appropriate.

10   A.   I think you can show it to as many people as you wish or  
11        you can show it to as many people as you may not wish,  
12        but at the end of the day we are all neuropathologists  
13        and we're all specialised, so if we are able to pick up  
14        that there were subtle abnormalities in the brain which  
15        were suggestive of a neuronal migration disorder, that  
16        was fairly sufficient in my mind.

17   Q.   Then if we go to the staining of the slides, both  
18        Dr Squier and Professor Lucas have expressed views about  
19        the staining of the slides. Professor Lucas' views are  
20        to be found in his report at 239-002-011 and on into  
21        012. It's there at the bottom. It says:  
22        "I am a little surprised that no one, even in  
23        retrospect, has performed specific immunohistochemical  
24        stains on the tissue slides to determine for sure the  
25        presence/absence of inflammatory T-cells or reactive

1 astrocytes. In my book, infiltrating CD8+ T-cells are  
2 necessary to diagnose encephalitis in most cases."

3 Do you have a comment on that view of his?

4 A. I think again with due respect I have to add, here,  
5 Professor Lucas is not a neuropathologist and I'm aware  
6 of that, and I think when we felt in the H&E examination  
7 that there was lymphocytes around blood vessels and  
8 there was -- we didn't see any evidence of gliosis or  
9 astrocytic proliferation to call gliosis in the H&E  
10 stains. We did not feel at the time the need of doing  
11 additional stains. At the time, we felt it was  
12 sufficient for us to call it a low-grade encephalitis.

13 Q. Yes. Professor Lucas is a histopathologist.

14 A. Yes.

15 Q. Is this not in his area, histopathology?

16 A. Histopathology is an area, yes, but he's not  
17 a neuropathologist, so I think he's -- the inflammation  
18 in the brain, which we saw, there were lymphocytes  
19 around the blood vessels in the brain, and we felt that  
20 they were, yes, lymphocytes and lymphocytes around blood  
21 vessels are suggestive of a viral infection. And we  
22 felt that he was sufficient. What Professor Lucas is  
23 describing is sub-typing those lymphocytes. CD8+, this  
24 is a sub-type of lymphocytes. But it still doesn't  
25 change the fact that there were lymphocytes. What he's

1       doing is he's sub-typing them, but we have already said  
2       in our original report that there were lymphocytes  
3       around blood vessels. So we felt that that was  
4       sufficient evidence to call it a low-grade inflammation.

5   Q. Well, when Dr Herron was giving evidence he regarded it  
6       as really quite marginal, the evidence. In fact, I will  
7       take you to it shortly, but there's a reference to it in  
8       one of his witness statements where, on balance, he's  
9       not sure whether he could necessarily characterise it as  
10      encephalitis. But in any event, Professor Harding  
11      looked at the slides and Dr Squier looked at the slides,  
12      and they were not of the view that what was being shown  
13      there could properly be categorised as an inflammatory  
14      response and therefore a low-grade meningoencephalitis.

15         If it was low grade in the way that Dr Herron has  
16      said, would it not have been better to have applied  
17      further staining to see if you could enhance it and get  
18      a better appreciation of what's there?

19   A. But the sub-typing of the lymphocytes would not have  
20      changed the grading of the inflammation; it would have  
21      just told you that these cells are present or not, and  
22      we are saying right throughout consistently, yes, that  
23      there were lymphocytes, but sub-typing them was not  
24      going to change the grade of the inflammation, which  
25      these people are doing.

1 Q. If we leave aside the sub-typing aspect of it, is it not  
2 possible that the application of other stains show up  
3 better the result so that you can get a better sense of  
4 what is happening, irrespective of whether they assist  
5 you in sub-typing?

6 A. Well, I think -- again, I say that we had already  
7 established that there were lymphocytes. We interpreted  
8 those as evidence of low-grade inflammation in the  
9 brain. What the special stains would have done is  
10 sub-type the lymphocytes, but still that doesn't change  
11 the point that there was low-grade inflammation in the  
12 brain.

13 Q. I understand.

14 A. Even after sub-typing, the fact would be established,  
15 yes, it would be in keeping with the low-grade  
16 inflammation, which we are already stating right  
17 throughout. So I'm not sure how it would have actually  
18 substantiated what we were already saying.

19 Q. I will take you to the part of Dr Squier's most recent  
20 evidence, but let me give you Dr Herron's reference that  
21 I mentioned. It's 224/1, page 10. If you see in the  
22 answer just above question 16:

23 "As a neuropathologist, I can only address  
24 neuropathological issues in the case. It is possible  
25 that Claire did not have encephalitis in all the

1       circumstances, but I cannot comment on the specifics of  
2       her cause of death."

3       Leaving aside that latter part, the reference to  
4       "it's possible that she didn't have an encephalitis in  
5       all the circumstances" -- well, the only evidence that  
6       the pathologist can provide on the encephalitis is this  
7       inflammatory response, isn't that right?

8   A. That's correct.

9   Q. So if he's saying it's possible that she didn't, is that  
10     calling into question whether it's possible that that  
11     inflammatory response or what was considered to be an  
12     inflammatory response should not actually be interpreted  
13     in that way?

14  A. I think that is his interpretation, but my  
15     interpretation was that if there were lymphocytes around  
16     blood vessels in the meninges, that was very much in  
17     keeping with the low-grade inflammation in the brain.

18  Q. Have you seen Dr Squier's most recent report?

19  A. Yes.

20  Q. And she produced some slides to try and assist with  
21     whether that's in fact what's being shown. I think they  
22     start at 236-007-015. If we go on to the next page.  
23     She is contrasting -- she says that these slides are of  
24     similar magnification. She's contrasting the one on the  
25     left, which is Claire's, and one where she says there is

1 an encephalitis to show the different formation that one  
2 can see.

3 Her view is that what you were seeing was not  
4 actually an inflammatory response. Can you --

5 A. Well, I think she's correct in the sense that what she's  
6 describing is a case of a very acute fulminant  
7 encephalitis, whereas what we had was a very low-grade  
8 inflammation in the brain. So the two extremes -- one  
9 is a low grade and the other one is a very fulminant  
10 encephalitis. We have said all along that in Claire's  
11 case there was no evidence of a fulminant encephalitis.

12 Q. If you leave aside the fulminant encephalitis point,  
13 I think the point that she and Professor Harding are  
14 making is that the pattern that you have discerned here  
15 isn't necessarily one of an inflammatory response:  
16 there's no infiltrates, neither of them see any  
17 infiltrate, which is what they claim they would be  
18 seeing if you have a true inflammatory response.

19 A. I think it's not a different pattern, it's a different  
20 degree of inflammatory cells or number of inflammatory  
21 cells. In the case they are showing, of course there  
22 are a large number of inflammatory cells, whereas in our  
23 case there was a sparse number or small number of  
24 lymphocytes. So on the basis of that, we are calling it  
25 that this was -- our case was a low-grade inflammation



1           as against the case which we are showing, which was  
2           a very fulminant encephalitis.

3   Q.   In fairness, it's not a case that they're showing; this  
4           is a case that Dr Squier has produced --

5   A.   That is what I mean [OVERSPEAKING] --

6   Q.   -- to show you by comparison.  It's not one that  
7           Professor Harding has produced.  Professor Harding's  
8           view in his report for the PSNI is really quite clear.  
9           In his view, he simply didn't see the evidence that you  
10          refer to as indicating any kind of inflammatory  
11          response.

12  A.   Well, that is his view, but my view is that there was  
13          inflammation and it was low grade.

14  Q.   And if there is -- if you look at Claire's slide there,  
15          what is it, just because obviously Dr Squier is going to  
16          address that, that you see there that indicates  
17          inflammation?

18  A.   Well, there's those small dark cells which are present  
19          around the blood vessels, dark blue cells.  Do you want  
20          me to point those out?

21  Q.   I can see them.  They're sort of like a ring round --

22  A.   Like a ring round the blood vessel.

23  Q.   And that to you indicates infiltration and an  
24          inflammatory response?

25  A.   That's correct.

1 Q. Thank you. Just so that we have it, as far as you're  
2 concerned, the standard H&E stain was enough to produce  
3 that and it wouldn't have been of any assistance to have  
4 applied any other stains, unless of course you wanted to  
5 see what kind of virus you're talking about?

6 A. I think the standard H&E stain was sufficient at that  
7 stage to regard that as an inflammatory response,  
8 without --

9 Q. If you had done a further stain -- or a different kind  
10 of stain, I should say -- would that have helped to  
11 determine what kind of virus was producing that  
12 inflammatory response?

13 A. No.

14 Q. So what would the further stains have done?

15 A. Further stains would have highlighted the sub-types of  
16 lymphocytes, which may be present. I think we are  
17 fine-tuning here in the sense that we have said from the  
18 very outset that there were lymphocytes around the blood  
19 vessels in the brain, which in our mind -- or we  
20 interpreted them as evidence of inflammation in the  
21 brain. What they're describing is the sub-typing of the  
22 lymphocyte, but the fact remains that there were  
23 lymphocytes. So if there are lymphocytes and you would  
24 not get normally lymphocytes around blood vessels in the  
25 brain, so the fact that there were lymphocytes around

1           the blood vessels in the brain, in our mind, was  
2           evidence of inflammatory response in the brain.

3    Q.   You said you wouldn't normally get it.  Could anything  
4           to do with the process of Claire's deterioration and  
5           manner of death have -- leaving aside the viral aspect  
6           of it, if I can put it that way -- have produced that  
7           kind of response?

8    A.   I am not aware of that.  I don't think so, according to  
9           my experience.

10   Q.   So according to you, once you've identified this, this  
11           is some sort of inflammatory response which you  
12           associate with encephalitis and that's the only  
13           explanation you can think of?

14   A.   Yes.

15   Q.   Thank you.

16           Then in terms of the status epilepticus, as you've  
17           already said, there's no real help that you could  
18           produce on that because it's not going to leave any kind  
19           of lesion or scarring in your view.

20   A.   That's correct.

21   Q.   Would it make any difference if you had been told that  
22           it was non-fitting status epilepticus that might  
23           actually have been going on for some time?  Would that  
24           make any difference to whether you would have expected  
25           to see anything?

1 A. Not necessarily.

2 Q. It's just not that sort of thing?

3 A. No.

4 Q. Thank you. If one thinks about epilepsy, though -- part  
5 of the information that you have been given in the  
6 autopsy request form was that Claire had had epilepsy at  
7 some stage in the earlier part of your life. As you  
8 said, you look at the brain as a whole, you were looking  
9 for it to see if there was anything that might explain,  
10 as it was described to you, her mental handicap.  
11 Presumably you'd be looking to see there was any  
12 footprint from the epilepsy, any scarring maybe.

13 A. Mm-hm.

14 Q. Did you do that?

15 A. We looked at the areas which are specific -- where  
16 you will actually see scarring for epilepsy. But it's  
17 not always the case that you will see scarring with  
18 epilepsy. You may or you may not see it, and again  
19 it is not specific to epilepsy. You can see scarring  
20 in the same region due to other causes.

21 Q. Yes. All I'm asking you is: were you looking for it?

22 A. Yes, we did.

23 Q. And would you be looking for that in the hippocampus,  
24 for example?

25 A. That's correct.

1 Q. Are there any particular stains that would assist you in  
2 highlighting any scarring that might be there?

3 A. Well, you can see the scarring very easily in the H&E,  
4 in the original screening, haematoxylin and eosin, and  
5 therefore we didn't find any evidence of scarring, so  
6 therefore we did not go ahead and do any special further  
7 stains.

8 Q. Dr Squier thought you might have -- well, she did --  
9 stained with GFAP and there are other stains that you  
10 might have applied could have highlighted subtle  
11 changes.

12 A. Dr Harding didn't think that there was scarring either.

13 Q. No, I'm just asking you in relation to what she said.  
14 In addition, she made her own slides, to which she  
15 applied other stains and her view, as I understand it,  
16 is that those stains would assist in highlighting subtle  
17 changes. I'm putting to you: did it occur to you that  
18 you might have applied other stains apart from the  
19 standard H&E?

20 A. No, because we did not find any evidence of scarring, so  
21 therefore we did not consider that there was need for  
22 doing further additional stains.

23 Q. And will H&E show sufficiently clearly very subtle  
24 changes?

25 A. Yes, it would.

1 Q. Then why do people use the other stains?

2 A. I think the other stains which they're using, which --

3 clearly, scarring in the brain is astrocytosis or a

4 proliferation of astrocytes which you will see, but the

5 difficulty with the staining which is done for

6 astrocytes, which is GFAP, is not actually specific to

7 astrocytes because it stains up other cells as well.

8 A lot of the people -- different pathologists will have

9 different views on the specificity of the further

10 additional staining, which is the GFAP because it is not

11 specific to astrocytes. So just the fact that there are

12 GFAP-positive cells present does not always equal that

13 there is astrocytosis or scarring.

14 Q. Well, do you ever use any other stains other than H&E?

15 A. Yes, we do. It depends on what the nature of the case

16 may well be. We use a variety of --

17 Q. What sort of thing leads you to do that?

18 A. If we find any evidence or if we see any abnormal cells

19 or if we find any excess of cells of a certain type. So

20 we would like to see whether this excess of cells which

21 is present, is it just one type of cell or more than one

22 type of cell or, if there are abnormal cells present,

23 then we will assess whether they are neoplastic or

24 whether they are reactive astrocytes. So we do for a

25 variety of reasons, but the H&E is a very good indicator

1       in the beginning as we are screening stains to give us  
2       that information.

3   Q.   Do you think for the neurone migration disorder, which  
4       was subtle, do you think that you might have applied  
5       further stains for that?

6   A.   You could have, but we felt that was sufficient, what we  
7       looked at it at the time, that there was these cells  
8       present where they should -- I think in the kind of  
9       subtle neuronal migrational disorder which we talked  
10      about in the report, should not be confused with the  
11      classic or with the severe end of the neuronal  
12      migrational disorder. In subtle neuronal migrational  
13      disorder, it is actually the anatomical place where the  
14      cells are present, which should not -- rather than the  
15      cells themselves.

16        So what we did was in the histology is we found  
17      these cells, which were in the deep white matter, and by  
18      that stage those cells should not be present in the  
19      white matter. It's not that the cell type -- it's the  
20      anatomical compartment of the brain where the cells are  
21      present that makes it into -- takes you to think that  
22      these are -- and that's why it is called "migration  
23      disorder". Because by that stage these cells should  
24      have migrated to the cortex. The cells all start,  
25      neurones, close to the midline, to the cavities of the

1       brain, and as the brain matures and develops, these  
2       cells migrate to the cortex and hence we see these gyri  
3       or foldings of the cortex, they form the constitute --  
4       so the fact that the cells were abnormally placed in the  
5       white matter, that's what prompted us to make  
6       a diagnosis of a subtle migration disorder rather than  
7       the cell type itself.

8   Q.   Finally on that quote, Dr Squier will say that it's  
9       quite possible to find still some cells there in that  
10       place without that necessarily meaning that there is any  
11       neuronal migrational disorder. That's just a facet.

12   A.   That is again Dr Squier's view and I fully respect her  
13       view, but I think we felt that, even for her age, it was  
14       slightly abnormal to find those cells at that age at  
15       that point. I would expect in younger children or maybe  
16       newborns, but we felt at that time in that age group it  
17       was abnormal, and we felt that it was important for us  
18       to record that if we felt that it was abnormally placed.

19   Q.   Then can I ask you about the inappropriate ADH, which  
20       was the third of those four clinical problems on the  
21       autopsy request form. It's actually given more  
22       importance than the viral encephalitis, which is the  
23       fourth, and which is a query anyway. Do I understand  
24       you to say that there wasn't very much that you thought  
25       that you could assist with in relation to that?



1 A. That's correct.

2 Q. Thank you. Did you think that you ought to be  
3 considering it all, even if it's something that you  
4 wouldn't be able to see any evidence of on the  
5 histology? Was it nonetheless something, together with  
6 the hyponatraemia, anything that you should have been  
7 thinking about?

8 A. Well, this is one of the things with hyponatraemia or  
9 with the inappropriate ADH disorder that you don't see  
10 anything structurally in the brain. So therefore, for  
11 a pathologist to put a slide under the microscope to say  
12 that this is or this isn't hyponatraemia, I think it's  
13 not possible. For instance, if you have a tumour, you  
14 can say very categorically, yes, the patient had  
15 seizures, the patient had epilepsy and we found a tumour  
16 in the brain and this relates directly to the presence  
17 of the seizures or epilepsy. But that is not the case  
18 in hyponatraemia or SIADH because of the lack of  
19 specific structural lesion in the brain.

20 Q. Thank you. Once you had got to that stage where you had  
21 looked at your slides and formed those sorts of views,  
22 which is that your contribution, if I can put it that  
23 way, is that there was some low-grade inflammatory  
24 response which may or may not be associated with some  
25 form of encephalitis and there was a neuronal

1        migrational disorder, a subtle one, which you thought  
2        you saw there. So that's -- you have reached that  
3        stage.

4    A. Yes.

5    Q. You haven't yet at that stage actually written your  
6        report yet, though. Is that a time when you might have  
7        a discussion with the clinicians?

8    A. We don't actually necessarily have a discussion with the  
9        clinicians at the time when we are still formulating the  
10       report and we are completing the histology. But once  
11       we have completed this histology and we have done the  
12       report, then we would -- the case would then be  
13       discussed in the ward rounds or mortality meetings or  
14       whatever to put to the clinicians or the clinicians who  
15       are actually present that these were our findings, and  
16       then the discussion goes on from there.

17   Q. All right. Then if we turn to the report proper, the  
18       report has an anatomical -- well, firstly, before the  
19       report goes out there's a provisional anatomical summary  
20       that goes, isn't there?

21   A. Yes.

22   Q. And Dr Herron has said that he produced that.

23   A. Yes.

24   Q. Sorry, I'll just give the reference for it.  
25       090-005-007. Do you see that or is that something just

1           that the registrar does and it's nothing you need to  
2           look at?

3    A.  No, the -- well, the report is done by the -- after the  
4           registrar has completed the autopsy, the provisional  
5           anatomical summary, which is a interim report to inform  
6           the clinician what has transpired.  Very often in cases  
7           of neuropathology, because there may not be anything to  
8           look at microscopically until you dissect the brain  
9           first, this is really an interim report and the  
10          registrar does it.  Obviously, after he has completed  
11          the autopsy, he will have discussed the autopsy findings  
12          with the consultant.

13   Q.  Let's pull it up then, 090-005-007.  I didn't hear you  
14          properly, did you say that was an internal report?

15   A.  No, an interim report pending histology.

16   Q.  Does that go to the clinician?

17   A.  That goes to the ward, yes, to the clinician.

18   Q.  Do you see there:

19                "A history of acute encephalopathy.  Brain to be  
20                examined after fixation."

21   A.  Yes.

22   Q.  Where does that come from, the history of acute  
23          encephalopathy?

24   A.  That must be from the clinical notes or the autopsy  
25          request form.  I can't remember where.

1 Q. Let me pull up the clinical history on the autopsy  
2 request form, 090-054-183, alongside this. Maybe if we  
3 could enlarge the "History of present illness" section  
4 to make it easier. Can you see how --

5 A. It's very difficult to see anything in there.

6 Q. Yes, I accept that. Would you regard that description  
7 as giving rise to a history of acute encephalopathy?

8 A. I think there's -- although it doesn't mention acute  
9 encephalopathy in the obvious way, but what it says here  
10 is:

11 "Started to vomit, speech becomes slurred and she  
12 became increasingly drowsy."

13 I think that is suggestive that one of the reasons  
14 may well be that there is an acute encephalopathy  
15 developing.

16 Q. So it's really a query then?

17 A. It is a query at that stage, yes.

18 Q. When you say that you discussed this, would you discuss  
19 what went into that anatomical summary given that it's  
20 going out to the clinicians?

21 A. Yes.

22 Q. Might it have been better phrased as "a possible  
23 encephalopathy"?

24 A. I think at some point in time -- I can't remember  
25 exactly, but at some point in time either in the

1 clinical notes or in discussion with the clinicians, it  
2 must have transpired that this was one of the things  
3 which they had considered clinically, that the patient  
4 was developing an acute encephalopathy and hence this  
5 history of -- it's included in the anatomical summary.

6 Q. Can I ask what the purpose is of sending this out to the  
7 clinicians if it's essentially going to recite something  
8 that they might have provided to you?

9 A. The purpose is to say -- to describe that there was no  
10 obvious external lesion on the brain --

11 Q. Okay.

12 A. -- to which the pathologist, at this preliminary stage,  
13 can say that that is what caused acute encephalopathy.  
14 And again, I go back to the very good illustration of  
15 a large brain tumour. If it is present, it will be  
16 apparent on the whole brain, looking at it with the  
17 naked eye, and it's just to indicate to the clinicians  
18 that there was no obvious external lesion on the brain  
19 to account for the presenting illness.

20 Q. So as far as it can go, this is simply going to describe  
21 or at least exclude anything from what you have seen?

22 A. I think it is more for the negative findings rather than  
23 the obvious positive findings.

24 Q. Yes. Then can I ask you about the purpose of the  
25 autopsy report?

1           Dr Carson who was the medical director at that time,  
2           his view is that the purpose of the report is to inform  
3           the clinician, who may have requested the autopsy, and  
4           the family, in regard to questions about the person's  
5           illness or the cause of death. We don't need to pull it  
6           up, but that comes from his witness statement, 270/1,  
7           page 7. You had already said that the purpose of the  
8           autopsy itself is to investigate the cause of death;  
9           do you accept that as the purpose of the report?

10    A.   Yes.

11    Q.   Thank you. And then if I ask you about the timing of  
12           the report. You had said that you had a role in audit  
13           and one of the things that you were auditing was  
14           response times, if I can put it that way.

15    A.   Mm-hm.

16    Q.   The actual report is nearly three months after the brain  
17           was cut, which is 28 November 1996, it's about three and  
18           a half months after Claire has died. Dr Herron gave an  
19           explanation for why it's so long and he's got a pie  
20           chart. But from your point of view, is that a typical  
21           sort of time?

22    A.   Well --

23    Q.   On a brain-only, I should say, because I know there are  
24           extra matters that have taken into consideration like  
25           fixation.

1 A. I think it is a typical sort of time for a complex  
2 neuropathology case. It's not unusual for  
3 neuropathology cases to have a long period of fixation,  
4 along period of review and a long period of additional  
5 work carried out in the lab. And the neuropathologist  
6 component of the whole turnaround time is a very limited  
7 one. The bulk of the time is with the lab, so when the  
8 case either for -- after the blocking or the staining is  
9 being done or additional work is being done, so it is  
10 a process rather than just a one point --

11 Q. In fairness to Dr Herron let's put up his chart very  
12 briefly. Witness statement 224/3 at page 74. If one  
13 enlarges that a little bit for ease. There we are.

14 So the purple stage is what you were just talking  
15 about, which is the lab preparation and the review.  
16 That khaki colour, the greeny colour; is that fixation  
17 time?

18 A. That's fixation time, yes.

19 Q. And that's about four weeks or so?

20 A. Well, it could be four weeks, it could be six weeks and  
21 it could be longer [OVERSPEAKING].

22 Q. Yes, but in terms of the time that it actually requires  
23 the brain to get to the stage where it can be cut,  
24 that's about four weeks.

25 A. It's approximately four weeks, but it could be longer.

1 Q. Yes. Then that time that's covered by the purple is the  
2 sending off the blocks to get them made into slides and  
3 that whole processing of that; is that right?

4 A. That's correct.

5 Q. So if there's pressure on the lab, that's what impacts  
6 on that time?

7 A. That's correct, quite correct.

8 Q. Is that part of the issue because if one looks at it  
9 in the way that Dr Herron was explaining it, the actual  
10 time that you spend with the product of all that,  
11 assessing it and determining what your conclusions are,  
12 is actually relatively short?

13 A. That's correct.

14 Q. Nobody can do anything about the fixation time, that's  
15 just how long it takes, but the lengthy time in between  
16 is the lab time. And when you're dealing with your  
17 audit issue, if I can put it that way, is that one of  
18 the things that you're discussing, the extent to which  
19 laboratory resources are impacting on turnaround times?

20 A. Well, I think it's -- yes, laboratory resources are one  
21 aspect of the stages of laboratory preparation and  
22 review. But there could be other factors like the  
23 nature of the tissues themselves because the brain  
24 tissue is just so delicate and you have to proceed with  
25 a lot of caution. You're not dealing with an organ like



1 a liver or a kidney, which are very firm organs with  
2 good structure, nice scaffolding. The brain doesn't  
3 have that sort of thing, so very often you have to  
4 actually deal with these tissues in a very slow manner.  
5 So there might be legitimate reasons for taking longer  
6 periods of time to deal with these tissues, so that the  
7 end result is appropriate for assessment for histology.

8 So yes, there are resource issues and there is  
9 pressure on time, and there are a number of technical  
10 people present at one point in time in the laboratory.  
11 But there could be genuine reasons for giving the margin  
12 for the nature of the brain tissue itself.

13 Q. As to those general issues, which would affect  
14 everybody, all neuropathology labs --

15 A. Yes.

16 Q. -- is that something that you have -- any contribution  
17 about that that you have made to the guidance that comes  
18 out of the Royal Colleges, which I think Dr Squier  
19 queries whether some of the guidance in terms of  
20 turnaround times could be adhered to even today. And  
21 I think what she is thinking of and certainly I think  
22 Dr Herron was of the view that they're rather  
23 unrealistic for the sort of work you're doing.

24 A. I must say, I will agree with Dr Herron because I know  
25 that it is -- although the College guidelines say -- and

1       this is the difficulty I have with Dr Squier describing  
2       adhering to the guidelines. Because the turnaround time  
3       will depend -- which is actually quite clear from this  
4       pie chart -- will actually depend upon the initial  
5       period of fixation for the brain. So if the brain is  
6       not appropriately fixed, it would be very difficult to  
7       actually do any detailed examination after that. So  
8       therefore, everything will actually depend on the  
9       initial stages of processing of a particular case.

10    Q. In fairness to you, doctor, Dr Squier is with you on  
11       that. She says in relation to the 1993 guidance, which  
12       is the guidance which would have been relevant at this  
13       time, that the -- it refers to the final report being  
14       issued in four to six weeks and she says:

15               "I doubt that standard is often met, even today."

16       That was her view, that that was effectively an  
17       unrealistic standard and what I'm wondering is, given  
18       the work that you have in audit, whether that point has  
19       been passed on, that it's unhelpful to have unrealistic  
20       audit turn around times?

21    A. We discuss this when we do the audit. We discuss it  
22       from time to time with our clinicians and we explain to  
23       them why a particular case may or may not be within the  
24       guidelines -- because the guidelines are always flexible  
25       and the period of fixation of brain itself is that, if

1       you take the minimum period of fixation, that is four to  
2       six weeks, so there's no way you can produce a final  
3       report in four to six weeks because that is in itself --  
4       that's why we find it very difficult even within the  
5       guidelines. When the period of fixation is even beyond  
6       the guidelines, stated guidelines, it is very difficult  
7       to -- because then the case comes back after histology  
8       and if you're doing additional work or taking more  
9       blocks or doing additional stains, that would again then  
10      add on to the time factor itself.

11    THE CHAIRMAN: Okay.

12    MS ANYADIKE-DANES: The significance of that for  
13      Professor Lucas is that, given that ultimately you are  
14      looking towards having some sort of meeting with the  
15      clinicians to see if you can correlate, if I can put it  
16      that way, what the clinicians have seen during the life  
17      and what you see under your microscope, his view is that  
18      an overlong time can have a detrimental effect on that  
19      discussion as they move on and deal with other things  
20      and I suppose it is just an issue as to how that is  
21      managed so that the case remains to the forefront so  
22      that you can get your best discussion.

23    A. Well, yes, and no. Because the clinician -- when you're  
24      dealing with a case and you're discussing with the case,  
25      the information goes to the clinician that the case is

1 coming up for discussion. So I think even if there has  
2 been a longer time interval between the time of the  
3 autopsy and the issuing of the final report, the  
4 clinician is aware of what the issues clinically were,  
5 so when you're actually discussing the case with the  
6 clinicians, the issues are all raised, so it's not that  
7 anything is forgotten just because there was a longer  
8 period of time.

9 Q. Well, it shouldn't be --

10 A. No, it shouldn't be. They're not.

11 Q. Then if I also deal quickly with attribution. I think  
12 both Professor Lucas and Dr Squier were of the view that  
13 the consultant should, if not actually sign the report,  
14 their name should be referred to in the report. I think  
15 you said earlier that ultimately you're taking  
16 responsibility for the report.

17 A. Yes.

18 Q. We have no way of knowing if the report that we have all  
19 been looking at and treating as a final whether that was  
20 the final since it's not signed. But from your point of  
21 view, would you expect, if you were the consultant, to  
22 in some way -- that that is evident from the report?

23 A. Very much so now, but it didn't happen in that time  
24 because if the person who was actually conducting the  
25 autopsy -- and if they were of sufficient seniority, you

1 know, it was the practice that the name of the senior  
2 registrar would go on the report. But I think now --  
3 and I think I agree with you -- that that is actually  
4 a better practice to have the consultant's name on the  
5 report.

6 Q. Thank you. In the version that we've been treating as  
7 the final version, if I can put it that way, the SNOMED  
8 codes are removed. Is there a reason for that?

9 A. I cannot ... I don't know why they were removed.

10 Q. Can you recall whether that was something that was done  
11 routinely in 1996?

12 A. Well, all the final reports have the SNOMED codes on  
13 them, so I can't explain why they are not there.

14 Q. They do on all the drafts, you're right, on all the  
15 drafts that we've seen they're on there.

16 A. Yes.

17 Q. Okay. The anatomical summary -- there are some  
18 differences between the anatomical summary and the  
19 autopsy request form. Do you know what gives rise to  
20 those? I'll give you -- let's pull that up. It's  
21 easier if you see it. 090-003-003. Then if we have the  
22 first page of the request form, which is 090-054-183  
23 alongside it.

24 You can see there it says there's a history of  
25 recent diarrhoea and vomiting and I think Dr Herron's

1 view is, although he didn't write it, that that came  
2 from the reference to a few loose stools and --  
3 A. Probably.  
4 Q. -- and the reference to vomiting. Is that how you would  
5 interpret that?  
6 A. Probably.  
7 Q. Then it goes on to talk about a history of epileptic  
8 seizures since 10 months of age. And if you look on the  
9 right-hand side, under "Past medical history", it says:  
10 "Seizures from six months to four years."  
11 Are you aware of where that came in?  
12 A. No. Either it was picked up from the medical notes  
13 or ... I'm not sure.  
14 Q. Yes. Then if one looks right at the bottom, you see in  
15 her past history:  
16 "She had an iatrogenic epilepsy since 10 months."  
17 What is an iatrogenic epilepsy?  
18 A. I think that might be a typo, typing error. It probably  
19 means "idiopathic" rather than "iatrogenic".  
20 Q. Your view was that that came from the clinicians, that's  
21 in your witness statement, 247/1, page 9 in the answer  
22 to question 1 4(d). So you were specifically asked  
23 about that. Maybe we will pull it up so we can see it.  
24 247/1, page 9. 14 (d):  
25 "State what you mean by 'iatrogenic epilepsy'."

1           And your answer to that is:

2           "This is a clinician's statement."

3   A.   Yes.   Iatrogenic epilepsy is a clinical statement, it's

4           not a pathological term.   That's what I mean to say.

5           But whether in this particular case what they meant was

6           idiopathic or iatrogenic --

7   Q.   No, but where did you get it from?   That's what I meant.

8           Where did you get the term from?

9   A.   Either from the clinical notes or from the autopsy

10          request form.   I'm not sure.   I don't remember.

11   Q.   It's not on the autopsy request form.

12   A.   It's either on one of the notes somewhere or it is

13          simply just a typing error.

14   Q.   So it might have been your typing error?

15   A.   Well, not mine.

16   Q.   A typist's error?

17   A.   Yes.

18   Q.   Then if we pull up the comments section of your report,

19          090-003-005.   One of the things that the 1993 guidelines

20          for post-mortem reports require is a commentary section,

21          which is to be written in the light of all the

22          information available, and the purpose of it is to

23          reconcile, as far as possible, the major clinical

24          problems with the pathological findings and to present

25          any inconsistencies in the findings and suggest any

1 steps to be taken such as further opinions, audit  
2 meetings, et cetera. That's to be found at 236-007-054,  
3 though we don't need to pull it up.

4 So the only place where one sees an attempt at  
5 that is in this commentary section. Can you help us  
6 with how that provides the clinicopathological  
7 correlation that is required in the guidance?

8 A. Well, it summarises the findings that the features here  
9 are those of cerebral oedema, which was clinically felt  
10 as well, and in association with that it was felt that  
11 there was neuronal migrational defect and a low-grade  
12 sub-acute meningoencephalitis, and the  
13 clinicopathological correlation is that there was no  
14 discrete lesion or a structural lesion, which we found  
15 to explain the cause of the epileptic seizures.

16 The probable clinical diagnosis of viral  
17 encephalitis or viral meningoencephalitis was  
18 substantiated by the fact that we saw -- the reaction  
19 in the meninges and cortex is suggestive of a viral  
20 aetiology. And this is a clinicopathological  
21 correlation in the sense that what we thought  
22 clinically, we found structurally the evidence of that  
23 in the brain.

24 There is a clinicopathological correlation in the  
25 sense (a) explaining there is cerebral oedema and there



1 is no other cause for cerebral oedema which we found  
2 structurally, and (b), the presence of inflammation was  
3 confirmed at the time of the autopsy, which was  
4 clinically suspected.

5 Q. If we go through what the 2002 guidance, which was  
6 looking back to 1993 and dealing with practice that has  
7 developed since then says, it starts at 206-004-090. So  
8 you can see it there at 8.1:

9 "The Royal College of Pathologists issued their  
10 guidance in 1993, and these new guidelines are to  
11 replace those and incorporate those that have emerged in  
12 the intervening period."

13 These are guidelines that you said you were familiar  
14 with.

15 A. Yes.

16 Q. If you look down at 8.4, it says the things that the  
17 report will normally include, an autopsy report. Then  
18 if we go over the page on to 091, you see:

19 "The following must be written in the autopsy  
20 report; optional items are listed separately."

21 If you look down those bullet items, there's "the  
22 name of the pathologist responsible for the autopsy".  
23 That's one. And I think you have now said the practice  
24 would be that that is what would happen now.

25 A. Yes.

1 Q. And by "responsible for the autopsy", that would mean  
2 the consultant?

3 A. Yes.

4 Q. And then a little bit below that, "the persons present  
5 during the autopsy". Is that meaning the persons  
6 present when the brain is taken out?

7 A. That's correct. During the autopsy.

8 Q. Yes.

9 A. Yes.

10 Q. When you were giving your evidence, you said that that  
11 would actually be something that a sufficiently senior  
12 registrar would do by themselves.

13 A. Yes.

14 Q. Is that something which, at that stage, you thought of  
15 identifying the person or the persons there in the  
16 report?

17 A. I think it's usually the medical persons would be  
18 identified, like Dr Herron or myself, or whoever is  
19 actually conducting the autopsy. But obviously,  
20 of course, there will be mortuary technicians and other  
21 people helping with the autopsy.

22 Q. I meant the medical people. As it happens, it has  
23 Dr Herron's name in and it has it in throughout, even  
24 though he only did certain sorts of things. Nowadays,  
25 would you distinguish that?

1 A. Nowadays the supervising consultant's name will also be  
2 present --

3 Q. Along with the --

4 A. -- along with the registrar's.

5 Q. -- along with the registrar's. I understand.

6 If then one goes over the page to 092 and one sees  
7 about the clinical history here and contrasts that with  
8 what's shown in the one that you provided, it says:

9 "All autopsy reports must include a clinical history  
10 to make clear the context of the autopsy. It comprises  
11 a summary of the present illness in chronological order  
12 and the circumstances of death. The past history often  
13 explains the findings and it is the pathologist's  
14 responsibility to be satisfied that a reasonable account  
15 had been obtained and mere references to notes or  
16 letters is not an adequate substitute. Absence of or  
17 difficulty in obtaining clinical information should be  
18 recorded. The source of the information, whether it is  
19 the medical notes and records ..."

20 And then it goes on to deal with a point that  
21 Dr Herron had made yesterday, which is:

22 "Many coroners specifically do not want a history or  
23 detailed history incorporated into the main body of an  
24 autopsy report. This is not best practice, but it is  
25 acceptable for the received clinical history in coronial

1 cases."

2 So they seem to be making a distinction and saying

3 that fuller history is something that ought to be

4 provided in a non-coronial autopsy.

5 A. Mm-hm.

6 Q. Is that the standard that you were striving to achieve

7 with whatever would have been your constraints and

8 restraints in 1996?

9 A. Yes, because the clinical history which went on the

10 autopsy report was actually directly taken from the

11 history on the autopsy request form.

12 Q. That's the point, isn't it? If it's your

13 responsibility, maybe you should not be necessarily

14 accepting that that is accurate.

15 A. Well, it is not for the pathologist to say that the

16 clinical history which has been provided in the summary

17 is -- how accurate that is because we have not been

18 involved with the care of the patient.

19 Q. I think that's why under that bullet on clinical history

20 it refers to you identifying your source, like medical

21 records.

22 A. Well, at that time the source of the clinical history

23 was not identified, whether it was ... I mean

24 identified on the autopsy report.

25 Q. But what it suggests to you is that you have available

1           to you the medical notes and records and that is  
2           therefore something that you should be consulting when  
3           you are taking responsibility for providing the clinical  
4           history.

5    A.   But it's usual practice when the autopsy request form  
6           comes down to the mortuary that medical records also  
7           come down, usually. That's the usual practice. And  
8           very often they are available for the pathologist to  
9           consult.

10   Q.   Exactly.

11   A.   So the pathologist would have consulted the medical  
12           records. But I point out that in all the cases, that  
13           may not be the case, that medical records have not come  
14           down, so what the pathologist has is only the summary  
15           which has been provided to the pathologist.

16   Q.   I understand. But if the pathologist has access to the  
17           medical notes and records, then they can be used to  
18           furnish the clinical summary.

19   A.   Yes.

20   Q.   Thank you. Finally, over the page, very quickly at 093,  
21           that's where it deals with the clinicopathological  
22           correlation:

23           "This is probably the most important part of the  
24           autopsy report for the clinician and often the coroner  
25           and the section that is read first.

1 A clinicopathological commentary must be written in the  
2 light of all the information available and the length  
3 will depend on the type and complexity of the case. The  
4 major clinical problems must be correlated with the  
5 pathological findings and, where possible, a brief  
6 narrative given of the sequence of events that led to  
7 death. New pathological lesions are indicated. Any  
8 inconsistencies in the findings or still uncertain  
9 pathogenesis of the final events are presented and steps  
10 to be taken such as further opinions, mortality and  
11 audit meetings are indicated. Discussion with the  
12 responsible clinicians will yield optimal  
13 clinicopathological correlation, but frank discrepancies  
14 or disagreements must be noted."

15 That is easier to put in your report if you've  
16 already had, effectively, your grand round. So you've  
17 sent out your best report pending any information that  
18 comes out of that grand round that might lead you to  
19 refine your view and that's how you might be able to  
20 indicate the frank discrepancies or disagreements.

21 A. Mm-hm.

22 Q. But if you produce your final report first and have your  
23 grand round, then at least it suggests that somewhere  
24 should be recorded any discrepancies or disagreements  
25 between the pathologist and the clinicians. Would that

1       be a fair interpretation of what's being suggested  
2       there?

3    A.  These are guidelines, but I think we must remember that  
4       there is an element of flexibility in all these things.  
5       There was very good reasons why, when the discussions  
6       were being had at the clinicopathological rounds and so  
7       on, those discussions are actually very vigorous and  
8       very intense, and they're not recorded for very  
9       specific, good reasons.  But that doesn't mean that the  
10      clinicians in charge of the case were not there to take  
11      home with them the points if there were any points which  
12      were raised at the time -- and I actually don't remember  
13      what discussion we had at the time -- but this much  
14      I know, that the case was definitely put up for  
15      a neurosciences grand round and the information was sent  
16      for the clinicians to be present there.

17   Q.  Let's come to that so that we understand what happens at  
18      one of these things.

19   THE CHAIRMAN:  Just before you do, is there a significant  
20      change between these guidelines from 2002, which didn't  
21      apply in 1996/1997, and the earlier 1993 guidelines?  
22      Does this section that we're looking at represent  
23      a significant change in guidelines from the College  
24      about how autopsy reports are completed or is it  
25      a repetition of the same thing?

1     A. I think it is very much a repetition of the same thing.  
2         The only difference may be that the attendance at these  
3         grand rounds is recorded now, which were not recorded at  
4         that time. The names of the people who were actually  
5         present at the grand rounds, that is usually recorded  
6         now, so you can say on a certain specific date who was  
7         present and who was not present.

8     THE CHAIRMAN: The trouble that we discussed yesterday, and  
9         I'm not sure if you're aware of it, is that there might  
10        be a very interesting and vigorous debate between the  
11        clinicians and the pathologists, but Mr and Mrs Roberts  
12        have no identified way of being advised of this  
13        discussion or if there were different views. It's  
14        genuinely interesting, I am sure for the doctors, but  
15        how does it help the family?

16    A. This is why, when the case is coming up for discussion,  
17        the list is sent or the information is sent to the  
18        clinician in charge that the case is coming up for  
19        discussion and it is -- after the discussion, if there  
20        has been any certain issues or points which have been  
21        raised, one would hope or expect that the clinicians  
22        would, if there were any differences than what was on  
23        the original report, that these will be then brought up  
24        by the clinician concerned with the family. Because the  
25        pathologists do not actually meet or discuss the issues



1           with the family.

2   THE CHAIRMAN:  Yes.  Have you ever known a report to be

3           changed as a result of this grand round?

4   A.  I can't remember.

5   THE CHAIRMAN:  There must surely, at some point, be

6           circumstances in which, when there is a vigorous debate,

7           that something emerges which -- well, maybe doesn't lead

8           to the report being changed, but leads to it being

9           reconsidered.

10  A.  Put it this way, it may be recorded if there was

11          a difference of opinion, and if it is recorded, which is

12          now practice -- that if there is a difference of opinion

13          it may be recorded and the family may be informed about

14          the difference of opinion.  But in a consented autopsy,

15          unless there is a major issue, I'm not sure how far down

16          the line it actually goes.

17  THE CHAIRMAN:  Mr Fortune?

18  MR FORTUNE:  Dr Mirakhur indicated that at the time with

19          which we are concerned there were good reasons for not

20          recording what was discussed at these grand rounds.  Can

21          we hear from Dr Mirakhur what these good reasons were,

22          bearing in mind Dr Herron's evidence yesterday?

23  A.  One of the reasons which probably is that the -- these

24          discussions are actually very frank.  They're very

25          vigorous and the clinicians, among themselves, discuss

1           very vigorously with each other and agree or disagree if  
2           they wish. And that is one of the reasons why they are  
3           not recorded, so that it doesn't inhibit anybody to come  
4           up with very vigorous opinions, which he or she may have  
5           during the discussion.

6   THE CHAIRMAN: Would that discussion include a consultant  
7           blaming another consultant for what happened to a child?

8   A. It ... It may or may not.

9   THE CHAIRMAN: Is that what you mean by "very vigorous"?

10   A. Yes, it may or may not.

11   THE CHAIRMAN: So if there's a discussion or debate along  
12           these lines, then there will be knowledge within the  
13           hospital, for instance, that Dr A and Dr B say to Dr X,  
14           "I'm sorry, you have to face up to it, you let this  
15           child down. This child died or would have had a better  
16           chance of survival but for the way you treated that  
17           child". But if Dr X is the consultant who is in contact  
18           with the family, is Dr X really going to go to the  
19           family and say, "I have to tell you Dr A and Dr B have  
20           said this"?

21   A. If there's ... I think if it alters the cause of death  
22           or if it alters what originally was said in the report  
23           in a major way, it is up to the clinician caring for the  
24           patient to discuss it with the family.

25   THE CHAIRMAN: Okay.

1 A. But I cannot remember how much that happened in this  
2 particular case.

3 THE CHAIRMAN: I'm not talking about this particular case,  
4 I'm broadening it out, doctor, because it seems to me  
5 that it would be -- although maybe it should be done, it  
6 would seem it's putting a significant obligation on  
7 a doctor who's being blamed by other doctors for letting  
8 down a patient to say that "You have to go to that  
9 family and you tell them that". Particularly, for  
10 instance, if the doctor doesn't agree. Let's say I'm  
11 the doctor and at that grand round I'm being blamed by  
12 other doctors for the death of a child and I don't  
13 agree. In fact, whether I agree or not, that  
14 information isn't going to reach the family, sure it  
15 isn't.

16 A. I don't know.

17 THE CHAIRMAN: Okay.

18 MS ANYADIKE-DANES: That's just where I was going to come  
19 to, the aftermath. In what typically happened in 1996,  
20 as I understand you, you finalise your report, you and  
21 the senior registrar had your discussion, reached  
22 a common view as to what the evidence showed, the report  
23 was drafted up, finalised and sent out to the clinician;  
24 is that right?

25 A. That's correct.

1 Q. And then what would happen is that there would be a note  
2 that the report is done, we're going to have the grand  
3 round whenever it is on the Tuesday, you say typically,  
4 and then that -- does it only go to the clinicians who  
5 are named on the autopsy request form? Who, other than  
6 the neurological community, if I can put it that way,  
7 gets notice of the grand round?

8 A. I think there's what I would call the core neurosciences  
9 clinicians -- which will comprise neurologists,  
10 neurosurgeons, paediatric neurologists,  
11 neuroradiologists -- and then any clinician who is what  
12 we would call a relevant clinician outside this core,  
13 and because the clinician is relevant to the discussion,  
14 the list will actually usually go to them, informing  
15 them that the case is coming up for discussion.

16 Q. So in this case, Dr Steen, who was the paediatric  
17 consultant for Claire, she's the person who signed and  
18 sent the autopsy request form. A notification would go  
19 to her?

20 A. Yes, and also the clinicians who are actually mentioned  
21 on the autopsy at the top of the autopsy report: Dr Webb  
22 and Dr Steen [OVERSPEAKING]. So the -- sorry, the  
23 information or the list will actually go to the  
24 clinicians who are mentioned on the --

25 Q. Dr Webb would be there anyway, typically.

1 A. Dr Webb would usually be there.

2 Q. But it might be worth telling him specifically because

3 it would indicate that a case in which he had been

4 directly involved in as opposed to one which was just a

5 professional interest.

6 A. What happens is that -- I think I'm not explaining

7 myself maybe clearly. What happens when a particular

8 case is coming up for discussion for a grand round, the

9 information about the case or the list of the cases

10 coming up for discussion goes to the core neurosciences

11 group.

12 Q. I understand.

13 A. That is A. B, it goes to the relevant clinician who

14 will be outside the core of the neurosciences group to

15 inform them that the case is coming up.

16 THE CHAIRMAN: Sorry, doctor, if you pause there. Is it the

17 list of names goes or is there information about each of

18 the cases?

19 A. No, information about the -- there's a list which we

20 prepare, "The following cases will be discussed at the

21 neurosciences grand round on Tuesday morning".

22 THE CHAIRMAN: Right.

23 A. And it is a list of cases. So the list of cases goes to

24 the clinicians.

25 THE CHAIRMAN: When you say a list of cases, does that mean

1           it's a list of names?

2   A.   List of names.   Just a list of names, yes.

3   THE CHAIRMAN:   No more detail than the names?

4   A.   Obviously the hospital number for them to locate the

5        medical records and things like that or any records

6        which they have.   So it goes to the core and, outside

7        the core, it goes to the relevant clinician.   And within

8        the core, the neurologists will look at the list and

9        say, "Right, that is a case in which I was involved", so

10       they would want to be present for the case, even though

11       their involvement may be relatively small or major,

12       depending on what their involvement is.   But once they

13       associate themselves with the case or they're aware of

14       the fact that, yes, I was involved at some point in time

15       in the management of the case, I would be there.

16   MS ANYADIKE-DANES:   So now apart from the sort of person,

17       the core as you say, who just routinely goes to these

18       things for professional development purposes, if I can

19       put it that way, the only other way you would know what

20       the aspects of that case were to know whether you'd be

21       interested to hear it discussed is if you'd been

22       involved in it.

23   A.   Yes.

24   Q.   And if that was the case, you would get notification of

25       it and there's no other way that -- am I right in

1       saying -- that anybody in the Children's Hospital other  
2       than those whose name, for example, was on the autopsy  
3       request form, would actually know that a case of  
4       potential interest was going to be discussed?

5   A.  No.

6   Q.  So for example, if you'd been a registrar and had been  
7       involved in the treatment of that child, unless your  
8       consultant, who provided the autopsy request form,  
9       specifically told you, "They're discussing that child  
10      at the next grand round", you wouldn't actually know  
11      that?

12  A.  Well, that is not for me to say.  It is up to the  
13      consultant whose case it may be.

14  Q.  Yes, that --

15  A.  They might actually mention it, they may discuss it with  
16      the registrar, "By the way, certain such-and-such a case  
17      is coming up, so I'm hoping to be at it", and very often  
18      the registrars will accompany the consultant to hear the  
19      discussion, what transpires.

20  Q.  I understand that.  The point I'm making it is it's not  
21      a list that goes up anywhere so that if you were a  
22      registrar and noticed, "That's a case I was involved  
23      in", you could independently make a decision to go.  If  
24      you're outside the core, as you described it, you will  
25      only know that if somebody tells you about it.

1 A. That's correct.

2 Q. Thank you. So the core turns up as well as those who  
3 were directly involved in the case, who want to be part  
4 of the discussion --

5 A. Yes.

6 Q. -- or who can be. They might want to, but just can't be  
7 available on the Tuesday. Although I know you say you  
8 were not entirely sure what was discussed in Claire's  
9 case, but can you describe what form it takes? What  
10 happens at a grand round?

11 A. What happens at the grand round is that the clinician or  
12 clinicians who had been involved in the care of the case  
13 would be present with the clinical findings or they will  
14 describe the clinical history or how the patient  
15 presented, what transpired and all that.

16 Q. Do they do that from the basis of the medical notes and  
17 records, does it go to that level of detail?

18 A. I think they have their own notes. Whether they bring  
19 the entire bulk of the entire records or whether they  
20 make a summary of it, or whichever, but they do it from  
21 their own notes.

22 Q. Do you recall in Claire's case who actually did that?

23 A. No, I don't.

24 Q. Even whether it was a female or a male doctor?

25 A. No, I don't remember that.



1 Q. Sorry, okay.

2 A. So the clinicians will actually present the clinical  
3 findings. Then the radiologist would discuss the  
4 relevant radiology.

5 Q. Yes.

6 A. Then there will be -- after that, after the clinical  
7 findings, the radiology is discussed, then there will be  
8 a clinical discussion in which everybody or anybody can  
9 take part. And then the pathology will be discussed.  
10 At the end, there will be another discussion to relate  
11 the pathology and the clinical findings.

12 Q. When you say "the pathology is discussed", does that  
13 mean that a presentation is actually made on the --

14 A. That's correct.

15 Q. -- pathological findings?

16 A. Yes, we will discuss the naked-eye findings and the  
17 histology findings. We'll do a presentation of the  
18 naked-eye findings and the histology findings.

19 Q. And those slides that we see pictures of --

20 A. And those 35-millimetre slides.

21 Q. -- you'd be showing those?

22 A. Yes.

23 Q. And can you recall if it was you, even though you might  
24 not actually remember the details, did you actually make  
25 that presentation yourself?

1 A. I was involved in preparing those slides, so I must have  
2 done those.

3 Q. Yes.

4 A. I probably did that, most probably, and I'm sure with  
5 Dr Herron as well.

6 Q. If you pause there a minute because somebody had asked  
7 me a point that I hadn't put to you. As you talk about  
8 how you were involved in preparing the slides, there  
9 were some extra blocks made for you in relation to that  
10 presentation.

11 A. Yes.

12 Q. Can you help with why you were having that done?

13 A. I think this is just for the completeness of the case  
14 because when we are presenting it -- well, extra blocks  
15 means that if we have looked at a certain area of the  
16 brain, we want to make sure that we have looked at it,  
17 at the same area. It's not that when the report is  
18 done, the case is incomplete. That's not the case  
19 because the case is only completed when all the blocks  
20 have been examined and the case ... when it comes up for  
21 the neurosciences grand rounds. By that stage, all the  
22 histology has been looked at. By "extra blocks", we  
23 mean that when we initially block the brain after the  
24 brain has been fixing for a certain period of time and  
25 we look at the histology, then we want to sometimes go

1 back and say, "Right, okay, we want to look at a couple  
2 more areas to make sure that there isn't a relevant  
3 pathology in that particular area". But that is all  
4 done before the autopsy report is completed.

5 Q. Thank you. Can I just ask, do you happen to know which  
6 are the slides that relate to those extra blocks you  
7 requested?

8 A. I can't remember.

9 Q. Or even the area as to what you were looking for?

10 A. No.

11 Q. Okay. So you present and then there's another  
12 discussion?

13 A. There is discussion, yes, after the pathology has been  
14 presented.

15 Q. And about how long does the grand round take?

16 A. Well --

17 Q. Roughly.

18 A. The total grand round takes about a couple of hours, but  
19 there are a number of cases in it.

20 Q. I understand.

21 A. So an individual case doesn't take a couple of hours.  
22 There may be, you know, other autopsy cases or other  
23 biopsy cases, depending on the nature of the case.

24 Q. What is the expectation of what the grand round can  
25 achieve? Because it's been categorised as part of your

1            clinicopathological correlation.

2    A.    Yes.

3    Q.    One part is the commentary section of your report, the

4            other part is what happens at these grand rounds.    So

5            what's the expectation of what you will achieve during

6            that grand round for Claire, say?

7    A.    Well, it is a clinicopathological correlation and it

8            also sort of -- because there are trainees present in

9            there as well, so it's a learning, training exercise as

10           well.    It informs the trainees and informs the other

11           clinicians who may not be directly involved with the

12           care of the patient, but who can take part in the

13           discussion and propose their views if they have any.

14    Q.    Claire's case would have been a particularly good one to

15           discuss, wouldn't it, because from your point of view it

16           was inconclusive?

17    A.    Yes, because also -- and we felt that it showed a number

18           of features in the brain, which were worth discussing.

19    Q.    And some of those things that had started off as

20           clinical problems which were listed on the autopsy

21           report are not things that you could assist with, so

22           that was necessarily going to have to generate further

23           discussion.

24    A.    Yes.

25    Q.    Can you recall at all what the sense was in relation to

1 Claire's case?

2 A. No, I don't recall.

3 THE CHAIRMAN: Let me ask you this: you have said sometimes

4 there is a vigorous debate. Was there a vigorous debate

5 about Claire?

6 A. I'm sure there was because that is the norm for all the

7 cases, not just in Claire's case. That is for all the

8 cases. There's a vigorous debate. So it's not that

9 there was ... Just for one case. And there's

10 a vigorous debate for all the number of cases which are

11 being presented that particular day.

12 MS ANYADIKE-DANES: Yes. And just to follow on something

13 that the chairman had been asking you, if one or two

14 consultants were blaming another. If we leave that

15 aspect out of it and one got into a discussion about

16 Claire, there might be, might there not, a discussion

17 about the SIADH or hyponatraemia more generally?

18 A. There might have been, yes.

19 Q. And if you're having that kind of discussion, that could

20 go the way of talking about her fluid management regime

21 and, if you're into the fluid management regime

22 territory, then you're into actually how her care was

23 managed.

24 A. Well, I ... You could discuss all aspects of

25 a patient's care or all aspects of the clinical history

1           and the patient's illness and so on and so forth. It is  
2           included with the rest of the discussion. It's not that  
3           there is one specific point picked up and discussed more  
4           vigorously than the other.

5   Q. I understand that.

6   A. So there's a generic discussion of the whole disease  
7           process and how the patient presented and what  
8           transpired at autopsy.

9   Q. What I'm trying to get at from a sort of care management  
10          or governance point of view is: if it's a valuable forum  
11          to have people debating vigorously a child's case, but  
12          if that leads to concerns about a child's care, where  
13          does one go with that if one is thinking about the  
14          interests of the child and care management and  
15          governance? Where is that supposed to lead to?

16  A. Well, I'm not sure that that is for the pathologist to  
17          answer because the pathologist's job is to complete the  
18          autopsy, do the case and then present it as the findings  
19          as --

20  Q. No, Dr Mirakhur, I'm not suggesting that for some reason  
21          the pathologists have the responsibility for doing  
22          things. I'm talking about ... A forum has been  
23          created --

24  A. Yes.

25  Q. -- where this kind of debate happens.

1 A. Yes.

2 Q. And both you and Dr Herron have described it as very  
3 vigorous debate and you have acknowledged to  
4 the chairman that that can involve some clinicians,  
5 consultants, taking the view that others may be  
6 responsible for what happened to a child or, at least,  
7 some aspect of their deterioration.

8 A. Yes.

9 Q. And that's something that could happen. What I'm asking  
10 is, since you are a senior person there in your own  
11 department and have subsequently become head of that  
12 department, what is thought to be the appropriate way of  
13 dealing with that once that emerges?

14 A. I think it is up to the clinician how they take --  
15 whether they see, whether there's any requirement to  
16 take it further or how they discuss it among themselves  
17 or what they put in and how they do actually deal with  
18 the particular problem.

19 THE CHAIRMAN: Doctor, can I ask you, who's the most senior  
20 person present at these meetings? In the terms of the  
21 hospital hierarchy, you've got a medical director.

22 A. The medical director is not present.

23 THE CHAIRMAN: Who would be the most senior person there in  
24 terms of the hierarchy?

25 A. I think it is a forum, it's not that there is a senior

1 person. They're all senior people of seniority and  
2 they're all consultants.

3 THE CHAIRMAN: But in terms of -- the point that  
4 Ms Anyadike-Danes was asking you about, if there are  
5 points which come out of this, which may or may not be  
6 issues about level of care, but which raise other issues  
7 about -- for instance, this emphasises yet again that  
8 there just aren't enough doctors on at night, which was  
9 clearly a problem when Claire was in for two nights.

10 A. That's right.

11 THE CHAIRMAN: If that emerges yet again at one of these  
12 grand rounds, is there anybody present who can take that  
13 on somewhere or does it involve the -- because there are  
14 people within the -- there were people in 1996 and are  
15 people now within the Trust who are responsible for  
16 trying to organise the Trust in a way which maximises  
17 patient care.

18 A. I think, if I can understand you correctly, you're  
19 meaning that there is -- whether there is senior admin  
20 kind of person present --

21 THE CHAIRMAN: It doesn't have to be an admin person, but  
22 there are consultants who also have managerial roles --

23 A. Which would be a medical director or a clinical  
24 director. The clinical director would be the person  
25 within the -- usually within the senior consultants who



1           are actually present.

2   THE CHAIRMAN:   Okay.

3   A.   So he may or may not be present in the forum, depending

4           on who the clinical director is at the time.

5   THE CHAIRMAN:   Mr Fortune?

6   MR FORTUNE:   Sir, can we try a different tack?  Although

7           there is a presentation and we've got the pathway set

8           out by Dr Mirakhur, is there actually a chairman who

9           controls the debate and then sums up and then takes from

10          the debate important points so that the hospital can act

11          upon those points?  Because I think that's what the

12          chairman is aiming to elicit from you.

13  A.   There's usually not a chairman.  There are individual

14          consultants who will stand up and discuss their own

15          case.

16  MR FORTUNE:   But isn't there somebody actually controlling

17          the procedure so that it's not a free-for-all that gets

18          out of hand?

19  THE CHAIRMAN:   I actually get the impression it's supposed

20          to be a free-for-all.  There's why no minutes are kept,

21          that's why there's no determined outcome and why there

22          doesn't appear to be any defined action taken.  We'll

23          pick up this up in governance over the next week or two,

24          Mr Fortune.

25  MR FORTUNE:   Yes, but Dr Mirakhur of course was a prime

1           witness to this type of discussion.

2   THE CHAIRMAN:  Am I right in understanding that when

3           Mr Fortune used the term free-for-all, perhaps in

4           a rather more polite and genteel way, it is a bit of

5           a free-for-all?

6   A.  All the senior medical consultants who are present and

7           they're discussing and they are presenting their own

8           case -- so it is not that there is one person who is

9           actually responsible for the entire cases which are

10          being presented in that particular meeting.

11  THE CHAIRMAN:  Okay.

12  MS ANYADIKE-DANES:  There is one more question I want to ask

13          just in relation to that and then, Mr Chairman, I think

14          I will have asked all my questions subject to what

15          anybody else might want to ask.

16                Dr Hicks, her discipline was in neurology; is that

17          right?

18  A.  Paediatric neurology.

19  Q.  Is she somebody that would be within the core, if I can

20          put it that way?

21  A.  Yes.

22  Q.  And she also had a position -- I think at some stage she

23          was clinical lead.

24  THE CHAIRMAN:  At the time of Claire's death, she had just

25          taken over as clinical lead.

1 MS ANYADIKE-DANES: As you were saying, there might be  
2 people there with managerial positions. She, for  
3 example, would be one?

4 A. I do not know whether she was the clinical lead at that  
5 time. I'm not sure.

6 Q. But in any event, she would be there because she is part  
7 of the core?

8 A. Well, she's one of the core people. The core people are  
9 usually there, depending upon their other commitments,  
10 whether they're doing a clinic or something like that.

11 Q. Could the end result of all of this be an uneasy feeling  
12 and a suggestion that maybe we should refer a particular  
13 case to the coroner; is that possible?

14 A. That may be possible, but I don't recall any uneasy  
15 feeling at that particular time.

16 Q. I don't mean in relation to this one, but that's  
17 a possible outcome of the grand round?

18 A. Possible, yes.

19 THE CHAIRMAN: Have you ever known it to happen?

20 A. I have not known it to happen.

21 MS ANYADIKE-DANES: Mr Chairman, if I might have a few  
22 minutes?

23 THE CHAIRMAN: Doctor, if you bear with us for a few  
24 minutes. Ms Anyadike-Danes is going to check around the  
25 chamber to see if there are any more questions, but

1           you're almost finished. Thank you very much.

2   (12.56 pm)

3                               (A short break)

4   (1.10 pm)

5   MS ANYADIKE-DANES: Dr Mirakhur, the description that was

6           given of the grand rounds as "a bit of a free for all",

7           that's not your description, I know, but people were

8           trying to characterise the dynamic in those grand

9           rounds. Are they like that still?

10   A. Yes.

11   Q. And are they recorded in any way now?

12   A. The attendance is recorded, who's present at the ward

13           rounds.

14   Q. Is the outcome in any way recorded?

15   A. I don't know what is happening presently.

16   Q. Who is recording the attendance?

17   A. I don't know. Well, the attendance is recorded by

18           the -- it's not recorded by the pathology department.

19           It is usually recorded by one of the clinicians, who may

20           decide on that particular day that they're going to

21           record this.

22   Q. So that's at somebody's discretion?

23   A. Well, I think they decide probably among themselves on

24           that specific day. It's not somebody's discretion in

25           the sense that I might decide: I'm going to record it

1           today. I think there's a decision made in the group  
2           who's going to be recording that.

3   Q. But they are definitely recorded irrespective of who for  
4           that day --

5   A. I think the names are recorded.

6   THE CHAIRMAN: You retired two years ago, was it?

7   A. Yes.

8   THE CHAIRMAN: So you're describing now the position in the  
9           period immediately before your retirement?

10   A. That's correct.

11   THE CHAIRMAN: And what was different was that the names of  
12           the people who were present were being recorded whereas  
13           in earlier years they had not been?

14   A. Yes.

15   THE CHAIRMAN: Do you know why that came about?

16   A. That came about because one of the requirements was for  
17           the CPD, I think, the clinicopathological things.  
18           I think the clinicians still felt that it was for  
19           various vigorous and frank discussions.

20   THE CHAIRMAN: So in essence it's a deliberate decision not  
21           to have a minute or a record of what's said, isn't it?

22   A. Before the ...

23   THE CHAIRMAN: After. Correct me if I'm wrong, but it seems  
24           to me that a conscious decision has been taken not to  
25           record or minute what is said at these meetings on the

1           theory that that will allow or promote vigorous debate.

2    A.   I'm not sure whether it was a conscious decision in that

3           sense, but I think it was just felt that it might

4           inhibit a very vigorous discussion if everything was

5           just recorded at the time the discussion was taking

6           place.

7    MS ANYADIKE-DANES:   The other place where the inquiry was

8           informed that a clinicopathological correlation happens

9           is at the audit or mortality meetings --

10   A.   Yes.

11   Q.   -- that the paediatricians have.   And Dr Herron said

12           yesterday that he has, from time to time, actually

13           attended some of those meetings and presented a case.

14   A.   Yes.

15   Q.   Have you done that?

16   A.   Yes.

17   Q.   Dr McKaigue said in his witness statement at 156/2,

18           page 6, in answer to question 22, that Dr Steen

19           presented Claire's death at the audit meeting at the

20           Children's Hospital and that he was present at that.

21           Did you attend any other meeting in relation to Claire?

22   A.   Well, I remember attending the neurosciences ward round

23           meeting, but I do not remember whether it was myself or

24           Dr Herron who attended that -- the mortality meeting.

25   Q.   Do you think that somebody from your department did

1 attend that mortality meeting?

2 A. That is the norm. That's the usual case, unless both  
3 people were involved in doing something else so they  
4 were not able to go.

5 Q. What happens at the meeting like that that is different  
6 from what happens at your grand round?

7 A. The grand round meeting is more for discussion and it's  
8 a learning and a teaching and a training exercise.  
9 Whereas the mortality meeting discusses probably the  
10 cause of the disease and the outcome of the disease and  
11 then the pathology, and the clinicians who are actually  
12 present in the mortality meeting are not the core  
13 neurosciences people. It is usually the paediatricians  
14 and anybody else who might have been involved in the  
15 care of the patient, but the paediatricians.

16 Q. Are those meetings, so far as you're aware, recorded in  
17 any way?

18 A. I think there's a record kept on those meetings. But  
19 I can't remember whether that was in 1996, that happened  
20 or not, I'm not sure.

21 Q. And do you know what the outcome of those meetings is to  
22 be?

23 A. The outcome of the meetings is usually to inform the  
24 clinicians of all aspects of the case, including the  
25 presentation, the clinical presentation, the disease

1 process and what has transpired during the stay of the  
2 patient in the hospital.

3 Q. When you were describing the grand round, you said the  
4 clinician came and would make a presentation, if not  
5 literally from the clinical notes, but from their own  
6 notes so there would be some detail in terms of the  
7 clinical aspects of the case, which generated  
8 a discussion before even the pathologists made their  
9 contribution. Is this mortality meeting another  
10 opportunity to discuss the case in detail?

11 A. Yes.

12 Q. Is --

13 A. Well, the clinicians present it. The format is very  
14 similar in that the clinician will present the case and  
15 then the pathology will be discussed and the findings  
16 will be discussed and all aspects of the case will be  
17 discussed. The only difference is that the core  
18 neurosciences people or the neurologists/neurosurgeons  
19 may not be present. If they're not involved in the care  
20 of the patient, they might not be there.

21 Q. So is it the reverse way round? In the grand round, the  
22 clinicians who are directly involved, who are not part  
23 of the core and who are directly involved in the case,  
24 are invited to that. When it's the mortality meeting,  
25 the pathologists who worked on the autopsy, they're



1 invited to that.

2 A. Yes.

3 Q. It's the other way round really.

4 A. Yes, that's right.

5 Q. Thank you.

6 MR FORTUNE: Before my learned friend moves off that topic,  
7 is there normally an order in which one takes place  
8 first? For instance, the grand round. So that the  
9 learning at the grand round is then taken to the  
10 mortality meeting or vice versa?

11 THE CHAIRMAN: Can you help us with that, doctor?

12 A. The mortality meeting usually happens before the grand  
13 round. The mortality meeting usually happens as soon as  
14 possible when the autopsy report is completed, but the  
15 grand round may not happen soon after the autopsy report  
16 is completed. But it's usually the mortality meeting  
17 happens -- usually happens -- and I say that usually  
18 happens before the grand round.

19 THE CHAIRMAN: Why?

20 A. Because I think it's a practice generally in paediatrics  
21 and also to some extent other areas as well to discuss  
22 the pathological findings of the autopsy at the time of  
23 these meetings.

24 MS ANYADIKE-DANES: If you've had your mortality meeting  
25 first and so you've had your discussion there, informed

1 by the notes and so forth, what is the sort of thing  
2 therefore that's generating such active discussion  
3 amongst the clinicians or robust discussion amongst the  
4 clinicians at the grand round? Have they not dealt with  
5 that at the mortality meeting?

6 A. The findings will be dealt with, but all the clinicians  
7 and all the trainees, relevant trainees, may not be  
8 present, including the pathology trainees, because for  
9 the grand round the pathology trainees go as well. They  
10 all may not attend the mortality meetings. In the  
11 mortality meetings, it's usually the relevant  
12 pathologist who will go.

13 Q. It's a much broader audience?

14 A. It's a much broader audience and it is more for the  
15 teaching and the training exercise than the mortality  
16 meeting is.

17 Q. Thank you.

18 Dr Herron yesterday -- I think I mentioned this to  
19 you -- when he was dealing with how low the low-grade  
20 sub-acute meningoencephalitis was, he scored it on  
21 a range of zero to ten, and he said he thought it was  
22 one or two. Are you able to do that?

23 A. Yes. I would think it would be nearly the same, one to  
24 two. I would maybe call it more two than one, but it's  
25 a matter of opinion.

1 Q. How high does it have to be before you can start to say  
2 that the inflammation or infection is a cause of death?

3 A. Well, it has to be at least above five, I would think.

4 Q. Thank you. Then I have a couple of other questions for  
5 you. One relates to a change between your draft autopsy  
6 report and the final one. We can pull up the two pages  
7 so that you can see -- I'm going to pull up the draft  
8 first, 090-054-187. Then next to it, if we can have  
9 090-003-004.

10 You can see in your draft, I'm not saying it's the  
11 original because I'm not sure it is the original draft,  
12 but it is a draft anyway. And under that section on  
13 "Cortex and white matter", you had had:

14 "The thickening and cellular reaction in the  
15 meninges and perivascular space and the underlying  
16 cortex is present in places."

17 A. Mm-hm.

18 Q. That's been removed so that in the final version it says  
19 that:

20 "The thickening and cellular reaction is in the  
21 meninges and perivascular space in the underlying  
22 cortex."

23 As opposed to indicating that it might only be in  
24 a few places, if I can put it that way. Is there  
25 a particular reason for that change?

1 A. No, it is simply because it's a repetition. Because it  
2 says:  
3 "Cortex and white matter. The sections show that  
4 there is focal meningeal thickening and a cellular  
5 reaction in the meninges and perivascular space."  
6 When we describe "focal", it means "in places".  
7 Q. Yes. So focused?  
8 A. Yes.  
9 Q. Thank you. The other point relates to your witness  
10 statement. If we take your witness statement 247/1 at  
11 page 20. If we can pull up alongside it 090-054-178.  
12 This is the day book, the record of material in and out.  
13 A. Yes.  
14 Q. You can see "cord times 2". Spinal cord, one might  
15 think, alongside 1 May 1997. Then there's a query about  
16 that under question (f).  
17 A. Yes.  
18 Q. And you are being asked to explain that. You say:  
19 "'Cord times 2', which is spinal cord, is most  
20 probably an incorrect entry as this was a brain-only  
21 autopsy."  
22 A. Yes.  
23 Q. How the query arises is if we can now pull up instead of  
24 the 090-054-178, if we can pull up 247/2, page 8.  
25 THE CHAIRMAN: Dr Mirakhur's next statement?

1 MS ANYADIKE-DANES: Yes. You can see under "Spinal cord":  
2 "This is normally formed. The tissue is  
3 oedematous."  
4 Then the underlined part:  
5 "Dr Harding describes no major downward shift of  
6 brain or cerebellum. He also states that the sections  
7 from spinal cord are unremarkable."  
8 That sounds very much as if he has seen material  
9 from the spinal cord.  
10 A. It is quite likely because when you remove the brain,  
11 the upper end of the cervical cord usually comes away  
12 with the brainstem, so what we went was incorrect entry,  
13 that the full spinal cord was not removed. It was only  
14 the bit which is attached, the upper bit which is  
15 attached to the brainstem.  
16 Q. Sorry, where is that referred to?  
17 A. Well ...  
18 THE CHAIRMAN: The witness is explaining, I think -- the  
19 doctor is answering your query about how it could be  
20 that Dr Harding has said that the sections from the  
21 spinal cord are unremarkable and you're suggesting that  
22 they would actually have become part of the original --  
23 A. I think what I'm saying is that the entry on the day  
24 book say it is, "spinal cord times 2", which is an  
25 incorrect entry because the entire spinal cord was not

1 present. It was not removed because it was a consented  
2 brain-only autopsy. But when you are removing the brain  
3 from the top, a bit of the upper -- very, very upper --  
4 cord, which is in junction with the brainstem, comes  
5 away with the brain. It is actually because part of it  
6 is actually above the thing and the rest of it is in the  
7 neck and way down in the back. So very often that  
8 happens. So what Dr Harding may be describing was the  
9 upper end or the bit of the upper end of the cervical  
10 cord which is attached to the brainstem. But it's not  
11 the rest of the cord. The full spinal cord was not  
12 removed.

13 THE CHAIRMAN: So that doesn't help us explain what the  
14 wrong entry was about because --

15 A. The wrong entry was about that it was not the full cord.  
16 What they should have said is: junction of brainstem and  
17 spinal cord times 2.

18 THE CHAIRMAN: Sorry, that's a mistake?

19 A. Rather than the "spinal cord 2".

20 MS ANYADIKE-DANES: Sorry, can you repeat again what they  
21 should have said?

22 A. They should have said "junction of brainstem and spinal  
23 cord" rather than "spinal cord 2" because I think that  
24 suggests that the entire spinal cord was there.

25 Q. And do you know how much of the spinal cord is likely to

1           have been there to allow him to make those sorts of  
2           comments? Obviously we can ask him that.

3   A.   It could be a very tiny portion, but you could say that  
4           it is spinal cord.

5   Q.   But it would not be intended that any part of the spinal  
6           cord had been --

7   A.   It's not a question of intended, it happens naturally.

8   Q.   Other than would happen in the natural way. I'm not  
9           trying to take --

10   A.   If you're removing the brain, the brainstem and the cord  
11           are connected to each other; it's not that they're lying  
12           separately. So you remove one and you don't remove the  
13           other. The bit of the cervical cord which is attached  
14           to the brainstem invariably comes out with the brain  
15           when you're removing the brain. But you're not removing  
16           the entire spinal cord, which has to be done from the  
17           back, whereas this can come out while you're removing  
18           the brain from the skull.

19   Q.   Even the small part that you have, is it a relevant  
20           thing to describe?

21   A.   Well, you can either describe it or you can describe it  
22           together with the brainstem.

23   Q.   That's what I'm getting at. Is it something that should  
24           have been described in the section of your report on  
25           brain description?

1 A. I think we described it with the brainstem. We  
2 described the entire thing, which we probably saw with  
3 the brainstem.

4 MS ANYADIKE-DANES: Thank you.

5 THE CHAIRMAN: Okay.

6 MR FORTUNE: Sir, can I follow on with one matter? Because  
7 it's just occurred to me. You've expressed a real  
8 interest in the absence of notes at these grand round  
9 meetings and indeed at the mortality meetings at the  
10 time. Perhaps the question needs to be asked of  
11 Dr Mirakhur -- or more particularly in governance -- as  
12 to whether a possible reason for there being an absence  
13 of notes was based on advice from the Trust within the  
14 Trust, perhaps from managers, or indeed from the Trust  
15 solicitors on medico-legal grounds, so there could be no  
16 disclosure of such notes in any civil action or any  
17 other reference to a statutory body like the General  
18 Medical Council.

19 THE CHAIRMAN: Okay. Can you help us on that, doctor?

20 A. I don't know. I can't answer.

21 THE CHAIRMAN: Were there always grand rounds during your  
22 career?

23 A. Yes.

24 THE CHAIRMAN: And they were never recorded or minuted?

25 A. As far as I can remember, and certainly the pathology --



1           well, as far as I can remember, yes, they were not  
2           recorded.

3   THE CHAIRMAN:   Okay.   We'll come back to it in governance,  
4           Mr Fortune.

5           Doctor, that concludes your evidence.   Thank you  
6           very much again for your time.

7   A.   I would like to take this opportunity to express my  
8           sympathy to the family and the distress which may have  
9           been caused as a result of the details of the  
10          pathological findings.

11                               (The witness withdrew)

12   THE CHAIRMAN:   Thank you very much indeed.

13           Ladies and gentlemen, we'll sit again at 2.15 and  
14          start Dr Webb.

15   (1.30 pm)

16                               (The Short Adjournment)

17   (2.15 pm)

18                               DR DAVID WEBB (called)

19                               Questions from MS ANYADIKE-DANES

20   MS ANYADIKE-DANES:   Good afternoon.   Can I call, please,  
21          Dr Webb?

22   THE CHAIRMAN:   Doctor, I'll say this to you now -- and  
23          I should have said it to Dr Steen when she first came to  
24          give evidence -- that whatever else the inquiry throws  
25          at you, I'm very glad that you're well enough to attend

1           and that Dr Steen was well enough to come back to us.

2   MS ANYADIKE-DANES:   Good afternoon, Dr Webb.

3   A.   Good afternoon.

4   Q.   Do you have a copy of your CV handy there?

5   A.   I do.

6   Q.   We'll come to it in a moment.   You have made three

7           statements for the inquiry.   The series number, for the

8           record, is 138.   The first one was dated 14 March 2012,

9           the second is dated 18 September 2012.   The third is

10          dated October 2012, but no specific day.   That's

11          in relation to Claire's case.

12   A.   That's correct.

13   Q.   So do you wish to adopt those statements as your

14          evidence, subject to anything that you say now in this

15          oral hearing?

16   A.   I do.

17   Q.   You were also due to give evidence in an earlier case,

18          Adam's case, but you were unable to do that.   So we are

19          going to try and inconvenience you as little as possible

20          by trying to take all your evidence together, so there

21          will be some matters that relate to Adam, some that

22          relate to Claire, both from the clinical point of view

23          and also the governance point of view.   I'm afraid it's

24          a bit of a tall order and we'll try to do what we can to

25          minimise the inconvenience of it.   But that's the

1 compass, if I can put it that way.

2 For those who are trying to follow their way through  
3 the lines, there's an area that we wanted to explore  
4 with you in Adam's case, which relates to the  
5 brainstem-death test and the completion of that form.  
6 There is a similar area to be addressed in relation to  
7 Claire's case and we are going to deal with those two  
8 things together at the end, just to avoid repetition.

9 A. Okay.

10 Q. So the fact that I haven't mentioned it doesn't mean  
11 that we are not going to ask you about it; it's just  
12 probably easier to do it in that way. If you have your  
13 CV there, the reference is 306-043-001. I will take you  
14 to page 003 of that. You were appointed a consultant  
15 paediatric neurologist in August 1995; is that right?

16 A. That's correct.

17 Q. You have come up through the Royal, you were in the  
18 Royal immediately preceding that, I think.

19 A. No, this is --

20 Q. Not literally. Immediately preceding that you were in  
21 British Columbia.

22 A. That's correct. This was my first appointment in the  
23 Royal.

24 Q. This was your first appointment in the Royal, I beg your  
25 pardon. If we deal with that British Columbia period,

1           that's almost exactly a year. And there has been some  
2           reference in Claire's case to a certain anticonvulsant  
3           therapy that you prescribed, midazolam.

4    A.   That's correct.

5    Q.   And you refer to going to check your notes because it  
6           was a therapy that you had used or had some experience  
7           of when you were in Canada. Is that the time that  
8           you're referring to?

9    A.   That's correct.

10   Q.   And can I just ask you what exactly your work involved  
11          in that year?

12   A.   I was working as a fellow in paediatric neurology, so  
13          there were four fellows and we provided the care for the  
14          children with neurological problems in British Columbia  
15          Children's Hospital.

16   Q.   And what size of children's unit would that be?

17   A.   It's the main teaching hospital in British Columbia, so  
18          it's a very large unit. I can't recall how many beds,  
19          but close to 200 beds, and there would have been  
20          a paediatric ward of 12 beds.

21   Q.   Thank you. Then you came from there to take up your  
22          consultancy in the Children's Hospital in Belfast.

23   A.   That's correct.

24   Q.   At that time, how many consultants in paediatric  
25          neurology were there if you can remember?

1 A. In Northern Ireland?

2 Q. Well, at the Children's Hospital.

3 A. In British Columbia?

4 Q. Here in Belfast.

5 A. In Belfast, sorry. I joined one person, Dr Elaine

6 Hicks. Dr Hicks had been a consultant on her own here

7 for a period of time. So there were two of us. That's

8 two paediatric neurologists for the Province.

9 Q. At the time you joined, which is August 1995 -- and if

10 you can't recall that's fine -- can you give us some

11 idea of how many registrars there might be in that

12 department?

13 A. There was one registrar and one SHO. It was a very busy

14 post because you're essentially providing neurological

15 cover for the entire province. So we regularly received

16 calls from other paediatricians round the Province. You

17 were also dealing with the neurosurgical cases over

18 in the main hospital, the Royal, the adult hospital,

19 rather, and the neonatal intensive care unit and

20 post-natal wards -- we were also consulted on.

21 Q. That's your the four of you?

22 A. There were two of us.

23 Q. Four people in --

24 A. Yes, that's correct. In fact, the registrar and SHO

25 would not have gone to the neonatal unit or to the

1           neurosurgical ward; it was really myself and Dr Hicks  
2           that would have done that.

3   Q.   I understand.

4   THE CHAIRMAN:  Sorry, just to get it clear, doctor: when you  
5           say you were also dealing with the neurosurgical cases  
6           in the main hospital, those are adult patients?

7   A.   No, they're children with head injury who are moved  
8           over.

9   THE CHAIRMAN:  For surgery?

10  A.   Yes, exactly, or observation.

11  MS ANYADIKE-DANES:  Just following on from what the chairman  
12           has asked you, was your neurological unit within the  
13           Children's Hospital?

14  A.   Yes.  There was a ward on the Children's Hospital.

15  Q.   And who was your clinical lead at that time?

16  A.   There were two of us.  Dr Hicks was the clinical lead,  
17           I guess.

18  Q.   I'm just trying to see how it fits -- that was  
19           a specialism within the whole Children's Hospital?

20  A.   Yes.  It was a new specialism at the time in a sense.  
21           Paediatric neurology has evolved from general  
22           paediatrics like most of the specialties have and it was  
23           quite a young specialty, really.

24  Q.   The reason I ask is when we were asking about just that  
25           sort of line of responsibility in relation, for example,

1 to the paediatric anaesthetists, it wasn't entirely  
2 clear -- well, their reporting lines seemed to be both  
3 within the Children's Hospital and -- in terms of  
4 anaesthesia -- and perhaps also outside the Children's  
5 Hospital because they straddled two areas. I'm just  
6 trying to see whether it worked that way for your  
7 department.

8 A. No, it was very much within the Children's Hospital, so  
9 our line would have been to the clinical director.

10 Q. Thank you. So by the time you became aware of Adam, you  
11 had been a consultant for about three months?

12 A. That's correct.

13 Q. By the time you became aware of Claire, you'd been  
14 a consultant for about 14 months?

15 A. I can't remember when the Adam Strain case was, but yes.  
16 14 months --

17 Q. That was November 1995, Claire is October 1996.

18 A. Okay, yes. That's correct.

19 Q. You've now left and you're now in the south?

20 A. That's correct.

21 Q. In fact, I think you left in September 1997; is that  
22 right?

23 A. That's correct.

24 Q. Just very briefly, in terms of your other  
25 responsibilities, we can see that at 004. All this

1        seems to post-date Claire's admission, so your teaching  
2        starts in 1997, both undergraduate and postgraduate.  
3        And you were a member of the ethics committee in 1998.  
4        Can I ask you briefly what that involved?  
5    A.   The ethics committee in Our Lady's hospital in Crumlin  
6        would meet on a monthly basis to review research  
7        projects that were proposed. So that was the basis of  
8        it.  
9    Q.   It's specifically in relation to your research?  
10   A.   It was in relation to research being done in the  
11        hospital, so other physicians would present their  
12        material to the ethics committee for approval.  
13   Q.   Not the conduct of clinicians?  
14   A.   No.  
15   Q.   And then your research really starts in 1997 as well?  
16   A.   I had done research actually during my training period,  
17        so I did a thesis during my time in Bath, back in  
18        1993/94.  
19   Q.   And then if we look at point 6 under your research, "The  
20        value of sleep EEG record in predicting seizure  
21        recurrence after a first afebrile seizure in childhood".  
22        Your research period spans from 1997, at least on this  
23        CV, until 2012. When were you carrying out that kind of  
24        research?  
25   A.   Well, I've always been interested in research. As



1 I said, I did some research during my training.

2 Q. I meant that specific issue.

3 A. Sorry. That's been going on over the last 12 months.

4 Q. So that's fairly recent?

5 A. Yes.

6 Q. And then if we just deal with audit. "Hospital chart  
7 audit"; is that something that you created?

8 A. Yes.

9 Q. What is that that you have created?

10 A. I wasn't terribly happy with the chart in Crumlin and  
11 I made -- we formed a committee and designed a new  
12 chart.

13 Q. So what do you mean by that?

14 A. Well, literally that. We took the existing chart,  
15 reviewed it, made some suggestions as to how we could  
16 improve it.

17 Q. Which chart did you take?

18 A. The hospital chart in Crumlin hospital where I was  
19 working at the time.

20 Q. There are a number of different sorts of charts. Is it  
21 the fluid balance chart, for example?

22 A. The clinical notes.

23 Q. Just the clinical notes.

24 A. So I -- the clinical notes, which are referred to as the  
25 hospital chart, we redesigned a chart essentially. We

1 sought opinion from various -- from the physicians  
2 working in the hospital and we produced a new chart and  
3 then audited before and afterwards. And there was  
4 a clear improvement in how the chart was used and --  
5 Q. And how did those charts compare with the charts that  
6 you had been used to at the Children's Hospital? Before  
7 you --  
8 A. Well, the main adjustment that we made was to divide the  
9 chart into six different sections and that was being  
10 very useful in terms of just -- the ease of finding  
11 material in the chart and locating material. I think  
12 the chart that I came to when I went to Crumlin was very  
13 similar to the ones that were actually in Belfast.  
14 Q. Does that mean from your point of view the charts in the  
15 Children's Hospital might have benefited from some  
16 redesigning?  
17 A. Perhaps. Yes.  
18 Q. And that was so in 1995 and 1996?  
19 A. Yes.  
20 Q. And when you left, so far as you're aware, they hadn't  
21 been redesigned in any way?  
22 A. I don't know. I haven't --  
23 Q. So far as you're aware.  
24 A. Not as far as I'm aware.  
25 Q. In terms of the connections, what was the connection

1           between paediatric neurology and adult neurology. Did  
2           you meet your adult counterparts?

3    A. Yes, we met on a weekly basis at a clinical meeting on  
4           a Friday morning where we would present children or  
5           adults to the full neurology group, which would include  
6           neurosurgery, adult neurologists, neurophysiology, and  
7           ourselves.

8    Q. I want to ask you a bit about meetings. I think in one  
9           of your witness statements -- I think it's 138/1,  
10          page 2 -- you talk about holding weekly  
11          multidisciplinary rounds and neuroradiology conferences  
12          at the Children's Hospital. Dr Mirakhur and Dr Herron  
13          have given evidence about grand rounds and, for example,  
14          they say that there was a grand round in relation to  
15          Claire. Can you describe what a grand round was and how  
16          it operated?

17   A. A grand round, as I recall it, would be usually  
18          a clinical round at which we would present a child's  
19          clinical history and the child's investigations and  
20          management. And it's usually a learning point for  
21          undergraduates or indeed postgraduates. Occasionally,  
22          there would be a grand round that would involve a death,  
23          but I don't recall that occurring in Claire's death, and  
24          if it did, I don't recall being asked of it.

25   Q. Well, would you typically go to grand rounds?

1 Dr Mirakhur said these grand rounds would occur on  
2 a Tuesday typically.

3 A. Yes. I can't recall my schedule for the week, to be  
4 honest, but I would have -- if it was a choice, I would  
5 have attended a neurology grand round on a Friday  
6 morning rather than the paediatric grand rounds.

7 Q. Is there a reason for that?

8 A. It may have been that there was a clinic. I don't know.  
9 My preference would have been to go to the neurology  
10 grand rounds. I'm sure I did attend the paediatric  
11 rounds on occasions. I just can't recall.

12 Q. I want to make sure we're not talking about two  
13 different sorts of things. In the way that Dr Mirakhur  
14 has described it, this is a grand round where all those  
15 involved across the neurological services, if I can put  
16 it that way --

17 THE CHAIRMAN: She described it as the core neurosciences  
18 group.

19 A. That would be the Friday morning meeting.

20 MS ANYADIKE-DANES: Is that what you're talking about?

21 A. Yes.

22 Q. And you're saying that you --

23 A. I certainly would attend that.

24 Q. That's exactly what I am asking you. And she, in her  
25 view, prepared slides for that in relation to Claire and

1       both she and Dr Herron think that there was one  
2       in relation to Claire and typically what would happen  
3       is that the core group across the neurosciences would  
4       attend as a matter of course, unless they couldn't for  
5       some reason, and then they would invite any of the  
6       clinicians who were relevant to the children's cases  
7       that were going to be discussed. So for example, in  
8       Claire's case the referring clinician or her consultant  
9       is the sort of person who might be invited to attend.

10       She doesn't particularly remember whether you were  
11       there, but she was of the view that you would be the  
12       sort of person who would be considered part of the core.

13   A. Absolutely, yes, and I don't recall that.

14   Q. You don't recall attending something in relation to  
15       Claire?

16   A. No, no, and I would have thought it would be very  
17       strange for it to go ahead without me attending, if you  
18       like.

19   Q. She also said that those grand rounds formed part of the  
20       clinicopathological correlations and they were  
21       an important part of trying to understand in that  
22       multidisciplinary way what had happened to a child.  
23       Would that --

24   A. Yes, that's right.

25   Q. -- accord with your view?

1 A. Yes.

2 Q. Whether or not you can remember going to one in relation  
3 to Claire, is it something that you would have  
4 considered appropriate to have in relation to Claire?

5 A. Yes.

6 Q. And would you have wanted to go to it?

7 A. Yes.

8 Q. She also said there were other meetings, which are the  
9 mortality meetings. And Dr McKaigue has referred to  
10 that and he said there was one in relation to Claire  
11 because he remembers Dr Steen presenting at it. Would  
12 you attend those sorts of meetings?

13 A. That meeting would have been in the paediatric  
14 hospital --

15 Q. Yes.

16 A. -- and again, that would depend on whether it clashed  
17 with my schedule. I'm just not certain what time that  
18 was or --

19 Q. So not necessarily?

20 A. So I may not have made that one routinely.

21 Q. Yes. I just want to ask you one or two brief questions  
22 about Adam's case and then the other matter, we'll leave  
23 until it can be dealt with together with the related  
24 matters in Claire's.

25 The reference is 058-035-140. You had a diagnosis

1 of "osmotic disequilibrium syndrome" in relation to  
2 Adam. What does that mean?

3 A. In relation to Adam, I was asked to see Adam while I was  
4 at a clinic in Derry. The conversation included the  
5 description of his care and the fact that he was found  
6 during surgery to have fixed and dilated pupils. And  
7 I was given to understand that the reason for this was  
8 unexplained. So when I saw Adam that evening and  
9 I returned to the Royal, I spoke to the staff, the  
10 nursing staff, and I think a member of the anaesthetic  
11 staff, I'm not certain. My understanding was that it  
12 was still unexplained why he had deteriorated in the way  
13 he had.

14 So I went to -- there was a room in the Children's  
15 Hospital where they had a computer with a CD-ROM. This  
16 CD-ROM included PubMed, so each year the publications  
17 for each year were included on a disc. I tried to see  
18 was there any other explanation that might explain the  
19 situation in somebody who had renal impairment. And  
20 osmotic disequilibrium is a syndrome that's associated  
21 with abnormal management of urea, if you like, and has  
22 been described following dialysis. So I speculated it  
23 might be one explanation for Adam's presentation, which  
24 to me, as I understood, was unexplained.

25 Q. Let me pull up the right reference for you.

1           058-035-140, I think. That seems to be wrongly entered  
2           because it's showing "12" on the bottom, so there's  
3           a problem there. Never mind. We'll come back to it.

4           In any event, that's how you described it. You say  
5           the reason you got to that analysis or at least that  
6           description of what might have happened to Adam was on  
7           the information that you received and you were trying to  
8           seek some sort of explanation?

9   A. Yes.

10 Q. Can you remember who actually contacted you?

11 A. I can't. I don't know.

12 Q. I think in fairness to you, I think in your witness  
13       statement of -- let's hope this is right -- 107/2,  
14       page 4, you were unaware of his sodium levels and  
15       therefore you were unaware that he actually was  
16       hyponatraemic.

17 A. That's correct.

18 Q. So do I understand you to say that you were --

19 THE CHAIRMAN: Sorry. The witness statement -- was it 107?

20 MS ANYADIKE-DANES: 107/2, page 4.

21           If you look under (a) about five or six lines up  
22       from the bottom:

23           "I do not think I was aware of the low sodium level  
24       recorded in the notes ... I am fairly sure no one  
25       informed me that the sodium level was so low because if



1 I had been aware of the low sodium, I would have  
2 considered hyponatraemia to be the likely cause of the  
3 fluid shift and I would not have had to go and conduct  
4 research to find an explanation."

5 So you were trying to find that explanation in the  
6 absence of knowing that he was so hyponatraemic?

7 A. That's correct.

8 Q. And if you had realised his sodium level was at that  
9 level, then you wouldn't have been trying to look at  
10 things like osmotic disequilibrium syndrome?

11 A. Absolutely.

12 Q. And would that have been a perfectly straightforward,  
13 "He's hyponatraemic"?

14 A. It would be a perfectly reasonable explanation for  
15 cerebral oedema --

16 Q. Yes.

17 A. -- in the context of surgery and --

18 Q. Were you aware at the time that dilutional hyponatraemia  
19 could lead to cerebral oedema?

20 A. I was aware that hyponatraemia could lead to cerebral  
21 oedema. I wasn't aware of the concern about the  
22 particular fluids that were being used.

23 Q. No, I don't mean the particular fluids. Let me put it  
24 in a different way.

25 Were you aware that the administration of

1       considerable quantities of low-sodium fluid over  
2       a relatively short period of time could lower the serum  
3       sodium levels and could result in cerebral oedema?

4   A.   Well, in somebody who was normal, that shouldn't happen.  
5       If the person has SIADH, then it will happen.  So you  
6       can tolerate low-sodium fluids as long as you have  
7       normal renal function.  But if you have SIADH at the  
8       same time, then you get into trouble.

9   Q.   Does it make any difference if you also have no proper  
10       renal function?

11  A.   Absolutely.

12  Q.   If you're polyuric, does that make a difference?

13  A.   That's the important point.  Renal function is crucial.

14  Q.   If you've got a child who is polyuric and you administer  
15       considerable quantities of low-sodium fluids in a short  
16       period of time, would you have a concern that that could  
17       lead to dilutional hyponatraemia and could lead to  
18       cerebral oedema in that scenario?

19  A.   Yes, if the -- the polyuria would suggest that you're  
20       actually losing a lot of fluid, so if you're not losing  
21       sodium as well, it shouldn't cause a problem.  I think  
22       it's particularly in the context of renal impairment  
23       surgery and SIADH that I would expect that.

24  Q.   And why is it the surgical element?

25  A.   Surgery is one of the things that can cause SIADH.

1 Q. So from your point of view, it was your understanding  
2 that that particular sequence of events is what happens  
3 if you've got SIADH present for some reason?

4 A. It could occur, yes.

5 Q. So it doesn't necessarily happen in the absence of  
6 SIADH?

7 A. That's correct, unless you have renal impairment.

8 Q. Then I think you said that you had no knowledge of the  
9 inquest findings in the case of Adam Strain.

10 A. That's correct.

11 Q. The reference for that is 138/1, page 93. Do you know  
12 why you didn't hear what happened to Adam?

13 A. No.

14 Q. Would you have expected to?

15 A. Not necessarily.

16 THE CHAIRMAN: If Adam's case, death, had been discussed at  
17 a mortality meeting and --

18 A. That would be in the paediatric hospital?

19 THE CHAIRMAN: Yes -- and then there's an inquest which --  
20 our understanding of exactly what was being accepted or  
21 not accepted at the time of Adam's death is a little bit  
22 clouded. But at the time of the inquest the following  
23 spring, there was a verdict which was, at least on its  
24 face, accepted by the hospital even though there was  
25 some internal issue about whether it was accepted by

1           every individual. Is that not something that you would  
2           have preferred to know about, or would you?

3    A. I don't know that it would have come to my attention if  
4           it was a surgical case and it was a nephrology issue.  
5           If it had some neurological angle, then I think I would  
6           have, but really my role was to, I think, assist them in  
7           doing the brainstem testing. That's the principal  
8           reason I was there. So I wouldn't have expected to be  
9           informed of it. I would like to have known of course,  
10          but I ...

11   MS ANYADIKE-DANES: Ultimately, I suppose you might say it  
12          was a neurological issue; the reason he died was because  
13          he developed cerebral oedema.

14   A. Yes, but it was a complication of his surgery.

15   MR FORTUNE: Sir, following on from Dr Webb's involvement  
16          in the brainstem death test, would that in itself mean  
17          that Adam's case was discussed at the neurosciences  
18          grand round? What are the criteria for such  
19          a discussion or the inclusion of case for such a  
20          discussion?

21   THE CHAIRMAN: You're shaking your head, doctor.

22   A. It wouldn't have been discussed at the neuroscience  
23          meeting on the Friday morning.

24   MS ANYADIKE-DANES: We've heard about your neuroscience  
25          meeting on the Friday morning; we've heard about

1 Dr Mirakhur's grand rounds on a Tuesday. Is there  
2 a difference between the two?

3 A. I think she was referring to the Friday morning meeting.  
4 I could be wrong, but I thought that was what she was  
5 referring to because that's the meeting that the  
6 neuroscience people -- the neuropathology,  
7 neurophysiology, neurosurgery and neurology -- would all  
8 meet at, but I'm not certain.

9 THE CHAIRMAN: She did refer to her meeting as a Tuesday  
10 meeting.

11 A. I'm not sure what meeting she's referring to.

12 MS ANYADIKE-DANES: What is the criteria for -- let's call  
13 it a grand round because I think you understand what  
14 that means. What's the criteria for a case to be  
15 included there?

16 A. That it would have some teaching benefit. That's the  
17 principal criterion.

18 Q. Who determines that?

19 A. Usually the consultant involved in the team and care of  
20 the child.

21 Q. Was it not thought that Adam's case had some teaching  
22 value? It certainly led to Alison Armour, who carried  
23 out the autopsy for the coroner, producing a paper on  
24 it. It led to Professor Arief providing an editorial  
25 in relation to it. Was it not thought there might be

1           some teaching element to Adam's case?

2    A.   I can't speak for the nephrology team.

3    Q.   Oh, I see.   So it would have to be the consultant in

4           charge of the child's case who would consider that that

5           had the requisite teaching benefit to refer it to the

6           grand round?

7    A.   Yes.

8    Q.   And could anybody else who was involved in the case who

9           thought it was interesting refer it?

10   A.   I think so.   It could be recommended to the lead

11           consultant.

12   Q.   Well, was there anything of interest in Adam's case that

13           you thought might have warranted a discussion at a grand

14           round?

15   A.   I don't recall at the time that ...

16   Q.   You now know more about Adam's case than you did at the

17           time.   With the knowledge that you have now, is it

18           a case that you think would have warranted that kind of

19           discussion?

20   A.   I don't know.   Um ...   I think it's a case that could

21           have been presented at grand rounds, but I do not know

22           whether the team at the time would have felt that was --

23           would have been of benefit.

24   Q.   And if it was one that could have been presented, why do

25           you think that?

1 A. Sorry, I don't understand the question.

2 Q. You have said you thought it was a case that could have  
3 been presented at the grand round because I was asking  
4 your view. I'm simply asking you why do you think that.

5 A. Because there could have been educational benefit from  
6 it.

7 Q. And if that had happened, leaving aside any other means  
8 of disseminating the learning points from Adam's case,  
9 that in and of itself would have assisted?

10 A. Yes, looking back on it, yes.

11 Q. I'm going to move from Adam's case now because the next  
12 place to go with it is actually in relation to the  
13 brainstem issues which I want to cover later on.  
14 Somebody might want some to cover other points of  
15 Adam's, in which case they'll raise them with me over  
16 the weekend.

17 If I can go on to 22 October 1996. I think your  
18 evidence is that you were working in the hospital then  
19 and your hours will have been 9 am to 5 pm; is that  
20 right?

21 A. I was usually in around 8 o'clock.

22 Q. Sorry. Is that when you came in to prepare for the day  
23 or that's when you were supposed to be there?

24 A. That's when I prepared for the day.

25 Q. If you had a typical day, when would you typically

1           leave?

2    A.   I was usually home by about 7.

3    Q.   When does that mean you left the hospital?

4    A.   About half six, 6.40.

5    Q.   Okay. As I understand it, you were on call every other

6           week and that meant that you were on call every night of

7           the week of the 21st, 21 October being the Monday?

8    A.   Yes.

9    Q.   So you would have been on call the evening of Claire's

10          admission --

11   A.   That's correct.

12   Q.   -- and on the Tuesday, when she deteriorated and

13          ultimately suffered her respiratory collapse in the

14          early hours of Wednesday. That evening, you would have

15          been on call.

16   A.   All that week.

17   Q.   Is that part of the reason that you -- just so that

18          we're clear about what "on call" means. Is that part of

19          the reason you were contacted because you were actually

20          on call that evening?

21   A.   Yes.

22   Q.   How clear a recollection do you have of the events of 22

23          and 23 October 1996?

24   A.   I have some recollection of the events, talking to

25          Dr Sands, meeting Claire's grandmother and her mother.



1 Q. So you have some independent recollection?

2 A. Yes.

3 Q. And the rest is something that you've gathered from the

4 medical notes and records and perhaps discussions with

5 your colleagues?

6 A. Exactly.

7 Q. You say that you have some recollection of talking to

8 Dr Sands. Doing the best you can, can you remember when

9 you first spoke to him about Claire's case on the 22nd?

10 A. I have difficulty with when I first spoke to him. I

11 know that he says I spoke to him shortly after the grand

12 rounds -- sorry, just shortly before lunchtime. And

13 I don't recall that conversation, but I think it may

14 have happened. There was a meeting, as I recall, that

15 day, which I think I actually was speaking at. That was

16 a lunchtime meeting.

17 Q. When would that lunchtime meeting start?

18 A. I think it would have run from quarter to one until half

19 one. I have a recollection of coming out from that

20 meeting and having the relief of having given the talk,

21 it was over, and meeting Dr Sands and going into a room

22 to discuss a case with him.

23 Q. Yes. If I can ask you in this way: apart from going to

24 give your talk during the lunchtime, can you recall what

25 you typically do on a Tuesday when it's one of the weeks

1           in which you're at the hospital? Do you have a ward  
2           round, for example?

3    A. We would have had a ward round most days, unless you  
4           were doing clinic.

5    Q. When would your ward round start typically?

6    A. Typically, I can't recall exactly, but it would have  
7           been between 9 and 10.

8    Q. Is that fairly standard across the hospital?

9    A. Yes.

10   Q. That's typically when consultants start their ward  
11          rounds?

12   A. Yes.

13   Q. And your ward round would have involved your registrar,  
14          SHOs?

15   A. I think the registrar actually was away, but the SHO  
16          and, if there were students, they would join us.

17   Q. And again, doing the best you can, roughly when would  
18          you anticipate that you would finish a ward round?

19   A. Somewhere between 11 and 1, depending on the number of  
20          patients.

21   Q. So for this particular Tuesday, what might have happened  
22          is that most of your morning was taken up with your ward  
23          round and then presumably you would have gathered your  
24          papers or whatever it was and gone and presented your  
25          talk?

1 A. Yes.

2 Q. And if anybody wanted to reach you because they needed  
3 some guidance from you or for some other reason, prior  
4 to that lunchtime talk, how would they do that?

5 A. I believe I had a pager, so they would page me and  
6 I would then ring the number.

7 Q. And given that the paediatric neurological team was such  
8 a small team, was it quite common to be paged and to be  
9 asked to provide some expert opinion or guidance on some  
10 aspect or other of another child's case?

11 A. Absolutely. And it was from, as I said, from all over  
12 the Province. It could be phone calls from other  
13 paediatricians, from other physicians in the hospital  
14 and occasionally junior doctors.

15 Q. Is it at all possible that you had a call like that from  
16 Dr Sands at least in relation to the administration of  
17 diazepam?

18 A. Yes.

19 Q. And then that was followed up perhaps by a chance  
20 meeting or some arranged meeting in the corridor after  
21 you had finished your talk?

22 A. I think that is possible, yes.

23 Q. Because you'll probably appreciate the time when the  
24 diazepam was administered and one of Dr Sands' concerns  
25 was to actually seek your view as to whether that's what

1           he ought to administer at that stage.

2    A.   Yes.

3    Q.   So that would seem to fit with you, would it, that that

4           might have happened?

5    A.   Yes.

6    Q.   You've got no recollection of it?

7    A.   I don't, but it may have happened, yes.

8    Q.   Thank you. Then if we can -- because I think you do

9           seem to have a bit of a recollection of the meeting

10           in the corridor, if I can put it that way.

11   A.   Yes.

12   Q.   Can you help us with what exactly was happening then or

13           what he was seeking from you, what he was telling you?

14   A.   My recollection was that he asked me for advice on

15           management of a child who he thought had non-convulsive

16           seizures.

17   Q.   Did he tell you why he thought the child had that?

18   A.   It was his clinical impression.

19   Q.   I know that, but did he explain to you why he thought

20           that?

21   A.   He talked about her having fluctuating level of

22           consciousness.

23   Q.   Okay.

24   A.   And that she had a previous history of having had

25           seizures in infancy and having learning disability.

1 Q. What did he want your guidance on so far as you can  
2 recall?

3 A. On the appropriate treatment in that situation for that  
4 condition.

5 Q. What did you advise him?

6 A. Well, at the time I would have said to him that, on the  
7 first contact, that rectal diazepam was appropriate. On  
8 the second occasion, I wouldn't have given advice  
9 straightaway until I'd seen the child. But we discussed  
10 the differential, if you like.

11 Q. I'm going to ask you about that. How did the question  
12 of encephalitis/encephalopathy actually arise?

13 A. That would have been within the differential. I think  
14 the child's background history is very important.

15 Q. Yes.

16 A. And in Claire's care the top of your list, really, in  
17 somebody who's had previous seizures and epilepsy would  
18 be that this was a reoccurrence of her epilepsy. So  
19 that's -- and in the context of non-convulsive seizures,  
20 the child presents as encephalopathic, they're not  
21 behaving normally. So that's really where  
22 encephalopathy would have come from.

23 Q. What led you to the encephalitis aspect?

24 A. Encephalitis is implying that there's inflammation or  
25 infection in the brain and that certainly would be

1           a differential of that presentation.

2   Q.   Yes, but I imagine there's any number of differentials

3           that one might have. Why did you think that on the

4           basis of whatever it was that Dr Sands told you?

5   A.   He would have described to me that Claire had presented

6           with vomiting and I don't think he mentioned anything

7           in relation to her bowel motions, but he described her

8           having vomited the previous day prior to admission. So

9           that raised the issue for me that she had

10          a gastrointestinal illness, and that would be a common

11          trigger, if you like, for epileptic seizures, infection.

12   Q.   Did you ask anything about how she had been treated so

13          far or what tests and results had been carried out?

14   A.   Yes, and I have a good memory of this actually.

15   THE CHAIRMAN: Is this still at the point before you've

16          actually gone to see Claire?

17   A.   Yes.

18   THE CHAIRMAN: Are we working on the assumption that

19          you have spoken to him late morning, approved the

20          diazepam, and this is the meeting some time in --

21   A.   It's around 1.30.

22   THE CHAIRMAN: Thank you.

23   MS ANYADIKE-DANES: This is the corridor meeting?

24   A.   We stepped into a room, I'm fairly sure, actually.

25          Sorry, the question was?

1 Q. I had asked you whether he told you anything about her  
2 results or what investigations or such treatment she  
3 had --

4 A. I believe he told me that her white cell count was  
5 raised, which would have supported the suggestion of  
6 infection. I specifically asked in relation to her  
7 glucose and sodium.

8 Q. Her glucose and sodium?

9 A. Yes.

10 Q. And what did he tell you?

11 A. Her glucose was normal and her sodium was 132. And  
12 I remember saying to him, "Well, that would not explain  
13 Claire's presentation at the moment".

14 Q. Did he tell you when the tests that produced those  
15 results had been carried out?

16 A. No, he didn't.

17 Q. What did you understand about when they had been done?

18 A. My understanding was that they were done that day  
19 because my question related to her presentation today  
20 and he had just examined her.

21 Q. Before you go on to the other elements of testing and so  
22 forth, can I just ask you, in terms of blood results or  
23 blood tests that are done for the ward rounds, when do  
24 you understand the bloods are taken, the tests done and  
25 the results are made available typically?

1 A. In my experience in the hospitals that I worked in prior  
2 to the Royal, if a child was put on intravenous fluids  
3 on an evening, then the blood test was done the  
4 following morning. That would also have been my  
5 practice in the Royal. So my expectation would have  
6 been that there would have been a blood test done that  
7 morning.

8 Q. So therefore, if you were being told, "I've just seen  
9 the child, this is how she presents to me", you ask what  
10 her serum sodium level is and he tells you 132, you are  
11 thinking that that's come from tests done in the way  
12 that you have just described?

13 A. Yes.

14 Q. Would you have wanted to know that that test actually  
15 resulted from a sample taken the previous evening?

16 A. I should have raised that with him, but I didn't.

17 Q. Yes, but would you have wanted to have that information?

18 A. The timing of the test?

19 Q. Yes.

20 A. Yes.

21 THE CHAIRMAN: Sorry, doctor, are you saying that with the  
22 benefit of hindsight, you should have checked with  
23 Dr Sands when the blood test, which gave the reading of  
24 132, was carried out?

25 A. Yes, I'm not blaming Dr Sands.



1 THE CHAIRMAN: No, I understand that.

2 A. My understanding was it was done that morning, but

3 I made a mistake.

4 MS ANYADIKE-DANES: And I think you then went on to say that

5 you would have wanted to know; it's not just that you

6 should have asked him. That was information you would

7 have wanted to know.

8 A. It would have been unlikely that the test would have

9 been lower than that, than the 132. So it wouldn't have

10 concerned me greatly that the sodium was on admission

11 because if it was 132 that morning, it's unlikely that

12 it would have been very different.

13 Q. Yes, but if it had been actually 132 from the 9.30 of

14 the previous evening, you might have wanted to know: how

15 do we stand now at lunchtime the next day?

16 A. Yes.

17 Q. Because depending on what had happened to that sodium

18 level, given -- did you know she was on IV fluids?

19 A. Yes.

20 Q. Depending on what had happened to that sodium level, it

21 might have affected how you started to formulate your

22 thoughts as to what was wrong with her.

23 A. Yes, but a sodium of 132 would not have created great

24 concern.

25 Q. No, sorry, that wasn't the way I put it. 132 at 9.30

1           the previous evening, you might have therefore wanted to  
2           know, "What is it now?", or, "What was it this  
3           morning?", so after a number of hours --

4   A.   As I said, I understood that it was 132 that morning.

5   Q.   That's why I'm saying you might have wanted to know that  
6           because, had it been significantly lower, that might  
7           have made a difference to how you started to formulate  
8           your differential diagnoses.

9   A.   Absolutely.

10  Q.   And that's the significance of knowing that.

11  A.   Yes.

12  Q.   So you knew about the tests that had been done, you knew  
13           she was on fluids, you knew in those terms the results  
14           there were in relation to those tests. Was there  
15           anything else you wanted to know before you went to see  
16           the child?

17  A.   I think we went over her background history, her  
18           medication that she had been on, her presenting history  
19           and his examination and the investigations that had been  
20           done to date. I think that was probably it.

21  Q.   Did you want to know more specifically, apart from the  
22           serum sodium levels, what blood tests were actually  
23           taken, or what blood tests were carried out, I should  
24           say? You knew about the white cell count.

25  A.   I felt the important ones, acutely, were the glucose,

1           the white cell count and the electrolytes.

2   Q.   Would you have wanted to know if there was

3           a differential carried out in relation to the white cell

4           count?

5   A.   The differential would be occasionally of benefit, but

6           often not terribly helpful actually.

7   Q.   Would you have wanted to know if one was done?

8   A.   I wouldn't have gone chasing a differential.

9   THE CHAIRMAN:   So if you asked what the white cell count and

10          he told you, then you wouldn't follow it up unless he

11          raised a flag about it?

12   A.   No, I wouldn't because it's not terribly helpful ...

13   THE CHAIRMAN:   Okay.

14   MS ANYADIKE-DANES:   In the lab report that we've seen of

15          those blood tests, there doesn't appear to be a space,

16          if I can put it that way, to show the differential.  Was

17          that your experience that, in 1996, the reports just

18          didn't do that unless you asked specifically for that to

19          be shown?

20   A.   I don't recall that there was an issue around

21          differential white cell counts, but I may be incorrect.

22   Q.   No, do you recall if you had reports that routinely

23          showed that or did you have to specifically ask for it?

24   A.   No, I thought -- I would have expected that they would

25          routinely show the differential, yes.

1 Q. Thank you. He seems to have communicated quite a bit of  
2 information about Claire.

3 A. Yes.

4 Q. Perhaps as much as he had at the time.

5 A. Yes. That's right.

6 Q. At what point did you think, "I should see this child"?

7 A. I think I went to see her very quickly actually.

8 THE CHAIRMAN: Was he asking you to see her?

9 A. He was asking me for advice about the management of the  
10 seizures and he wanted my opinion on Claire. So I said  
11 yes, I would see her.

12 MS ANYADIKE-DANES: So was it you who decided this is  
13 a child I ought to see before I actually advance an  
14 opinion about her?

15 A. No, I think he wanted me to see her.

16 Q. And did you have a sense of how quickly perhaps you  
17 ought to be seeing her in the circumstances?

18 A. It would be a child, from that story, that I would want  
19 to see within the hour, really.

20 Q. Sorry?

21 A. Within the hour.

22 Q. Yes, but I don't know whether that's urgent. That might  
23 be extremely urgent for you, given your busy day.

24 A. It wasn't a situation where we were running down the  
25 corridor, but it was a situation where I was seeing the

1 child within a reasonable time frame and it would depend  
2 on what I had to do otherwise.

3 Q. Was that because, from the description that you'd  
4 received, you had concerns about her?

5 A. Yes.

6 Q. And were you able to form a view even at that remove as  
7 to how ill you thought she was?

8 A. I think even at that point I would have been thinking  
9 that this was probably a reoccurrence of an epileptic  
10 tendency in a child who was at risk of that. That's  
11 a reasonably common scenario. What was unusual here is  
12 it was manifesting in the way it was with these  
13 non-convulsive episodes.

14 Q. Did that aspect of it make it more or less concerning  
15 for you?

16 A. I think a little more.

17 Q. More? Did he tell you when she had last had any kind of  
18 episode, if I can put it that way?

19 A. I can't recall. I don't think he did.

20 Q. Did you know that in relation to those early, if they  
21 are epileptic seizures -- there may be some issue about  
22 that. I'm calling them that, but not necessarily saying  
23 that that's what they were. Did you know that she had  
24 been admitted and treated at the Royal by the senior  
25 consultant, Dr Hicks?

1 A. I think I did, yes.

2 THE CHAIRMAN: Sorry, at that point or later on in the  
3 sequence?

4 A. I don't know when, but I'm fairly certain that in the  
5 context of her presenting in infancy with seizures and  
6 going on treatment, we would have had a discussion about  
7 who was managing that and that she would have been seen.

8 THE CHAIRMAN: Sorry, let me interject. If you're there  
9 that day from roughly 8 to 6, or whatever the exact  
10 hours are, would Dr Hicks have been there too?

11 A. She could have been.

12 THE CHAIRMAN: If there's such a thing at that time as an  
13 ordinary Tuesday, would you and Dr Hicks both have  
14 been --

15 A. I don't know. She could have been.

16 THE CHAIRMAN: Right.

17 MS ANYADIKE-DANES: It wasn't a scenario where it was always  
18 one or the other of you there? Sometimes you were there  
19 together.

20 A. Exactly, yes.

21 Q. Did you at any point think you might just want to chat  
22 through this child's presentation with Dr Hicks?

23 A. No. Not at that time.

24 Q. And I think I had started that line of questioning by  
25 asking you whether you had appreciated the last time she

1           had had an episode. Had you?

2    A. I don't recall. I think I was aware that she had just  
3           come off treatment in the previous 18 months, but  
4           I don't recall when the last seizure was.

5    Q. You are starting to formulate the characterisation of  
6           what's happening. Would it have made any difference if  
7           you'd appreciated that she may not have had a seizure  
8           since she was 4? And in fact, that was one isolated  
9           one, and the main bulk of them were when she was few  
10          months old.

11   A. I know this is somewhere I differ from the experts. The  
12          risk of you developing seizures following infantile  
13          epilepsy is 60 to 70 per cent. That's a very high risk.  
14          The risk of a child next door who's never had a seizure  
15          coming in with a seizure is 1 in 200. So ...

16   Q. Do you think that just on the description that you were  
17          given perhaps -- well, hindsight is a wonderful thing  
18          and we all wish we had it -- you started to think in  
19          terms of recurrent epilepsy, maybe not keeping your  
20          range of possibilities as broad as it might be?

21   A. I haven't yet taken the history from the grandmother or  
22          examined the child, but I think I would have been  
23          mentally considering other conditions but, perhaps  
24          dismissing them.

25   Q. So of the ones that you had considered mentally and not

1 dismissed, you have encephalitis there? That's one of  
2 them?

3 A. Yes.

4 Q. Which would have a different origin, if I can put it  
5 that way. So did you give Dr Sands any indication as to  
6 when you thought you might be able to see Claire?

7 A. I can't recall that, whether I gave him a specific time  
8 or ...

9 Q. Did you get the impression he was rather anxious for you  
10 to do that?

11 A. No, I thought we had discussed it, he seemed happy  
12 enough with the plan, that I would go and see her.

13 Q. Did you know who Claire's paediatric consultant was?

14 A. Yes, I think I did know that it was Dr Steen.

15 Q. Did you know anything about Dr Steen's whereabouts?

16 A. No. I think he did say to me that he did the ward round  
17 himself.

18 Q. Did you have the impression or did you know whether  
19 he had been trying to reach her and he was now reaching  
20 you directly?

21 A. I can't recall whether he told me that, that he had  
22 tried to reach her.

23 Q. Did you think that before you saw her patient, you might  
24 see if you could give Dr Steen a call?

25 A. No. No, there was a specific question that I was being



1           asked and I was --

2   Q.   If you hadn't understood whether he had been trying to  
3       reach her or not, did you at least know whether she had  
4       been informed in some way or other that your advice was  
5       being sought?

6   A.   Well, I would have expected that.

7   Q.   But you didn't know that for sure?

8   A.   I didn't know for certain, no.

9   Q.   Would you have expected that because it's what one calls  
10      professional courtesies or because that was just the  
11      practice?

12  A.   Well, both.

13  Q.   So when you ultimately do see Claire, the note  
14      indicates -- the note is incorrect and you have  
15      explained that, but it indicates it was probably about  
16      2 o'clock. Well, the note is timed about 2 o'clock in  
17      the afternoon.

18  A.   Yes.

19  MR GREEN: Before my learned friend goes on to deal with the  
20      actual visitation by Dr Webb to Claire's bedside, she  
21      has put, if you like, the "two contacts between Dr Sands  
22      and Dr Webb" theory before Claire was seen by Dr Webb.  
23      In fairness to Dr Webb, perhaps the one-contact theory  
24      could be put. If we pull up the official evidence  
25      transcript of the inquiry for 19 October of this year,

1       sir, at page 32, line 18. If you forgive me and we go  
2       up to line 15 you, sir, asked the question:

3               "Question: Why do you think that it's not likely  
4       that Dr Webb is right that you spoke to him at about  
5       2 o'clock?

6               "Answer: My memory is that I left the ward round  
7       after we'd seen Claire and that I went to find Dr Webb  
8       at that point. I would have probably gone first to  
9       Paul Ward because that's where Dr Webb's ward base was.  
10       I don't think that's where I found him; I think I found  
11       him elsewhere in the hospital at that stage. So I think  
12       it took me a little time to find him, but not so very  
13       long. I think while there, my memory is that  
14       I described briefly Claire's findings to him and asked  
15       him if it was okay that we give a dose of rectal  
16       diazepam because that's what we had suggested on the  
17       ward round. But I think it wasn't actually given or  
18       prescribed until 12.15. So I believe I checked with him  
19       that he was comfortable with that before it was given  
20       and it was given around about or shortly after 12.15."

21               Sir, Dr Sands' recollection is there was one  
22       discussion between him and Dr Webb. He went to speak to  
23       Dr Webb straight after having seen Claire on the ward  
24       round.

25       THE CHAIRMAN: Because of his concern?

1 MR GREEN: Because of his concern. He found Dr Webb and  
2 there was one conversation, which also included checking  
3 with Dr Webb whether it was appropriate to administer  
4 rectal diazepam. The answer was yes, and during the  
5 course of that conversation the summary as to Claire's  
6 neurologically-concerning presentation was given to  
7 Dr Webb by Dr Sands.

8 THE CHAIRMAN: That's fine.

9 MR GREEN: I wonder if he could deal with that.

10 THE CHAIRMAN: I don't know to what extent you've been able  
11 to follow these transcripts over the last few weeks,  
12 doctor. I think you've had some chance. You have  
13 described in the last 40 minutes or so an involvement  
14 that comes about because you are contacted once, you  
15 approve the rectal diazepam, and then, at some later  
16 point around lunchtime, Dr Sands comes to you and,  
17 perhaps with a bit more urgency, asks you to come and  
18 see Claire, which you think is reasonably urgent, so you  
19 want to do it within the hour.

20 What Dr Sands thought was, from the best of his  
21 recollection, that he had contacted you once, that you  
22 had approved the diazepam, but that then, for whatever  
23 reason -- which is not necessarily a criticism of you  
24 because you may have been busy looking after other  
25 children -- you weren't able to come or didn't get to

1           the ward to see Claire until about 2 o'clock.

2    A.   I think I actually got to the ward about 25 to 2. My  
3           note is written at 2 and that's when I finished with the  
4           patient. If Dr Sands did speak to me before the talk  
5           that I gave, it would have been very brief because  
6           I would have been preparing for the talk. And he  
7           wouldn't have given me sufficient story, from what he's  
8           describing, to merit going to see the child. He's  
9           asking me could he give rectal diazepam and I would have  
10          approved it. But I don't recall him giving me any other  
11          information at that stage.

12   THE CHAIRMAN: Well, is this -- insofar as you were saying  
13          earlier that you could remember some things and not  
14          others, are you saying that you have a reasonably clear  
15          recollection of two contacts with Dr Sands?

16   A.   I have difficulty remembering the first one, but I have  
17          a good memory of the second one, coming out of the  
18          meeting, and as I said, getting that feeling of "I've  
19          finished that talk now", meeting Dr Sands, going into a  
20          room and discussing it with him.

21   THE CHAIRMAN: If he had contacted you, say around midday,  
22          and it had seemed reasonably urgent for you to see  
23          Claire sooner rather than later, what's the priority  
24          between going ahead and giving the presentation or talk  
25          over lunchtime or going to see the patient?

1     A.   Well, on the basis of what we had discussed, it was  
2           clear he was going to give some treatment, so I think  
3           it would have been reasonable to wait until after the  
4           talk.

5     THE CHAIRMAN:   Right.   But let's take the other scenario.  
6           Let's suppose he told you earlier about fluctuating  
7           level of consciousness, seizures, learning disability  
8           and so on, which you think was the 1.30-ish talk --

9     A.   Mm.

10    THE CHAIRMAN:   -- or conversation.   If you had been told  
11           that about 12, 12.15, something like that, in the sense  
12           that you thought there was some degree of urgency about  
13           that, does it take priority over the talk?

14    A.   Um ...   It may have done.   I find it very hard to answer  
15           that, actually.

16    THE CHAIRMAN:   Because it's recreating a level of urgency  
17           and --

18    A.   Yes.

19    THE CHAIRMAN:   But your point in answer to the question,  
20           which was raised by Dr Sands' counsel, is that you have  
21           a clear recollection of a meeting after your talk and  
22           then going into a room, discussing it with him --

23    A.   I do.

24    THE CHAIRMAN:   -- and then going reasonably soon after that  
25           to see Claire.

1 A. To see Claire.

2 MS ANYADIKE-DANES: Can I perhaps ask you a question

3 in relation to that point? The way it was being put to

4 you is that you had been contacted earlier than the

5 substantive contact that you remember clearly, which is

6 when you discussed matters in greater detail in a room.

7 That contact -- the timing of that is being reached

8 because Dr Sands wanted to discuss whether he should

9 administer rectal diazepam with you, and you certainly

10 remember the bit about the rectal diazepam.

11 A. Mm.

12 Q. So we have a timing because we know when the rectal

13 diazepam was actually administered. But you also say in

14 your witness statement, 138/1, page 6, at the top

15 at the (c) in answer to the question there. You are

16 being asked to state the nature of Dr Sands' discussion

17 with you and any direction or advice given by you. You

18 say that you can't recall the details and so on and that

19 you discussed a possible differential diagnosis. Then

20 you say:

21 "I would have recommended regular neurological

22 nursing assessments of her Glasgow Coma Scale."

23 Do you know if that's something you were

24 recommending to him or that's something he was asking

25 you about?

1 A. I would have recommended to him.

2 Q. Then if you were recommending it to him, the Glasgow  
3 Coma Scale observation chart, which for reference  
4 purposes is at 090-039-137 -- it may help you to see it  
5 pulled up, sorry. There we are. Right at the top,  
6 there's the 22nd. That actually starts at 1 o'clock.

7 A. I don't think you can assume that 1 o'clock means  
8 1 o'clock. It could be between 1 and 2.

9 Q. Ah. But it might mean 1 o'clock?

10 A. It might, yes.

11 Q. And, indeed, it might fit a little bit with an earlier  
12 conversation that related both to the rectal diazepam  
13 and also to the hourly observations.

14 A. Yes.

15 Q. And then that would leave your recollection, but not  
16 Dr Sands', of a more detailed discussion starting in the  
17 corridor and going off into a room.

18 A. Yes.

19 Q. But that's the one you say you have a clear recollection  
20 of?

21 A. Yes.

22 Q. And your explanation for that might be maybe you had two  
23 conversations.

24 A. Yes.

25 MR GREEN: Just before we leave this point, if we go back to

1       WS138/1, page 5, I would be very grateful if my learned  
2       friend could just nail down whether or not Dr Webb has  
3       a specific recollection of a discussion taking place  
4       after his talk because what he says at the bottom of  
5       that page is:

6                "I believe Dr Sands contacted me in person at  
7       lunchtime on 22 October 1996. This may have been after  
8       a hospital clinical meeting that we had both attended."

9                I wonder if it could be clarified as to whether  
10      Dr Webb is now saying that he has a definite  
11      recollection that it took place after that clinic  
12      meeting or whether that's a possibility.

13   MS ANYADIKE-DANES: Can you help?

14   A. When I read Dr Sands' transcript, he recalled that there  
15      was a meeting at Tuesday lunchtime, so that, if you  
16      like, strengthened my view that that's actually what  
17      happened. That was my personal recollection of the  
18      time, so I ... My recollection is strengthened by his  
19      memory that indeed there was a Tuesday meeting.

20   Q. Then if we round that off at your witness statement  
21      138/2, page 3, you deal with it in this way. You say:

22                "I have a recollection that there was an educational  
23      clinical meeting that day."

24                So there you've said that you have a recollection of  
25      that. Then you say:



1            "This may have been a lunchtime meeting and would  
2            have taken place in a lecture room at the Children's  
3            Hospital."

4            Can I ask you this: if there was going to be  
5            an educational clinical meeting, is that one that  
6            happens at lunchtime or could you have a meeting like  
7            that other than at lunchtime?

8    A.    I think it was a meeting that was held at a regular  
9            time.

10   Q.    No, is it possible for you to have had an educational  
11          clinical meeting other than at lunchtime?

12   A.    I think it's one that was held at a regular time between  
13          quarter to 1 and 1.30.

14   Q.    So the "may" that you say there is just you being  
15          cautious. If you had a recollection of one of those,  
16          then it would have been at lunchtime?

17   A.    Yes.

18   MR GREEN: There's absolutely no dispute that there was  
19          a lunchtime meeting from Dr Sands' point of view. The  
20          question that I would like to address through the  
21          inquiry -- and through you, sir -- to Dr Webb is whether  
22          or not he simply says it's possible that the  
23          conversation with Dr Sands took place after that meeting  
24          or that's his definite recollection now. Because what  
25          he says in the statement is that it may have been after

1           a hospital clinical meeting.

2    A.   What I'm saying is, having read Dr Sands' transcript,  
3           I feel stronger of the view that it was after a meeting.

4    MR GREEN:   Finally, this.   You will recall, sir, Dr Sands'  
5           evidence that the meeting was actually timed -- and even  
6           to this day is timed -- on a Tuesday at 1 to 2.

7    A.   I think the meeting doesn't always run until 2 o'clock.  
8           I think I was the only person giving the talk.

9    MS ANYADIKE-DANES:   Thank you.   Then I was going to ask you  
10           something about consultant responsibility because we had  
11           started to touch on that.

12   THE CHAIRMAN:   If we're trying to sort out Dr Stevenson and  
13           Mr Counsell, could we leave consultant responsibility  
14           until Monday?

15   MS ANYADIKE-DANES:   We can.

16   THE CHAIRMAN:   It'll be done, but -- okay?

17   MS ANYADIKE-DANES:   We can.   There was an issue, which I am  
18           perhaps going to take slightly out of turn with you,  
19           just because it assists if it's done that way, so I hope  
20           you'll bear with me.   That relates to the way in which  
21           the midazolam was prescribed.

22           The midazolam is actually administered at, I think  
23           it's 14.45.   Can you actually recall prescribing it?

24   A.   Giving the advice to prescribe it?

25   Q.   Yes.

1 A. Or writing the prescription?

2 Q. No, the advice to prescribe it.

3 A. I can ...

4 Q. Sorry?

5 A. I can recall discussing it with, I believe, a doctor,

6 but I can't recall who that doctor was.

7 THE CHAIRMAN: Sorry, I didn't mean to skip straight through

8 to Dr Stevenson's point. If you want to do the

9 2 o'clock examination --

10 MS ANYADIKE-DANES: That's where I was going to go.

11 THE CHAIRMAN: Yes.

12 MS ANYADIKE-DANES: Okay.

13 Let's go back to 2 o'clock, Dr Webb. When I started

14 to take you to that, there's an error in the notes,

15 which you have conceded. You have put "4 pm". It may

16 be 14.00 that you might have put, but in any event it's

17 2 pm and I don't think there's any issue about that.

18 Can you help us with this: we've spent quite a bit

19 of time trying to see what reliance can be placed on

20 actual times that are inserted in notes or prescription

21 sheets or whatever they are? When you look at the

22 notes -- and I'll just take you to it. Your note

23 appears at 090-022-053.

24 On the left-hand side, we see you've maybe got the

25 date wrong, but anyway that's the 22nd, and 4 pm, which

1       you have acknowledged should have been 2 pm. What does  
2       that mean? How are we to interpret that? Is it when  
3       you actually write up the note, is it when you are  
4       recording that you are seeing the child or when you have  
5       finished seeing the child? How is that to interpreted  
6       for those coming after you?

7   A. Can I just say the date is my bad writing? It is 22.  
8       I think that varies from person to person, and --

9   Q. Well, for you.

10  A. I tend to write the note at the end of the consultation  
11       and I would put the time that I'm writing the note as  
12       the time that I --

13  Q. So we are to understand that 2 pm, let's say that's what  
14       was written there, means that's when you had finished  
15       examining Claire, you formed your view and you're now  
16       writing up whatever you have to say about that?

17  A. Yes.

18  Q. If that's a practice that varies from person to person,  
19       how does anybody coming after you know that?

20  A. Well, they can't for certain, but I think it gives  
21       people some idea when the child was seen. It's either  
22       half an hour before, half an hour afterwards.

23  Q. It rather depends how long you spend with the child.

24  A. Yes. Most consultations are within that time frame.

25  Q. So do you actually recall roughly how long you spent?

1 A. I think it would have been 20, 25 minutes.

2 Q. And when you came to see her, who was there?

3 A. Her grandmother and a member of the nursing staff, who

4 I think was Nurse Field, is it?

5 Q. Mm-hm.

6 A. And I expect there was one of the -- Dr Steen's team on

7 the ward, but I don't recall interacting at that point

8 with a doctor on arrival.

9 Q. When you are examining her, do you have a quick look at

10 her notes before you do that or do you examine her first

11 and then have a look at her notes?

12 A. I would usually look at the notes first.

13 Q. What did you understand from the notes? In fact, we can

14 put the two pages together. 090-022-052 and 053. How

15 far back would you have gone? Would you have gone back

16 to her admission note?

17 A. I don't think I would have spent a lot of time looking

18 through the notes because she had been in for a short

19 period of time and I had got a good history from

20 Dr Sands. I might have focused on his examination

21 findings.

22 Q. So does that mean you would have started from 052 to see

23 what he had to say about his ward round examination?

24 A. Well, particularly -- the examination findings are

25 actually on the page that I wrote, which -- it's

1           page 53.

2   Q.   There's no point in looking just at page 53 because

3           that's not the start of his ward round note.

4   A.   As I said, the examination findings were the one bit

5           that I wouldn't have perhaps known about.

6   Q.   Sorry?

7   A.   His examination findings were the one thing that

8           I wouldn't have known about from the story.

9   Q.   Well, wouldn't it have made sense to just see his full

10          note?  It's not a very lengthy note.

11  A.   Yes, I may have looked at the other page.

12  Q.   If you'd looked at his full note, you'd have seen that

13          her serum sodium level was 132.

14  A.   Yes, and that's preceding the ward round note --

15  Q.   Yes.

16  A.   -- which is the figure that he told me.

17  Q.   Yes, but it's above some other SHO's signature and

18          slightly below 12 midnight.  How did you interpret that?

19  A.   Well, it's in a different handwriting to the person

20          above.

21  Q.   What did that mean to you?

22  A.   Well, that result could have been written in that

23          morning.

24  Q.   Would it not be timed?

25  A.   It's not timed.

1 Q. No. Would you not expect it to be timed if it's written  
2 on a different day? Would you not start off with the  
3 22nd as the first observations on the new day of the  
4 22nd?

5 A. No.

6 THE CHAIRMAN: But it has to be a new day because the  
7 previous entry's at midnight and it's signed off by  
8 Dr O'Hare. So what follows on from that, it might be  
9 12.05 or it might be 8 am or 10 am or 11 am. But it's  
10 going to be a new day, isn't it?

11 MS ANYADIKE-DANES: Yes.

12 So would you not want to know when that -- that's  
13 the result coming through at that stage. If the result  
14 is coming through at that stage, then what does that  
15 imply about when the blood test is taken to produce that  
16 result?

17 A. It could have been done at 8 o'clock.

18 Q. Was that typical?

19 A. As I said to you before, the electrolytes were done  
20 in the morning on some children who were on IV fluids  
21 overnight.

22 Q. I'm asking you whether it was typical to have the blood  
23 tests taken at 8 o'clock.

24 A. It wasn't atypical. I think Dr Volprecht in her witness  
25 statement said she would have done that and Dr Stewart

1           talked about bloods coming through to the ward round as  
2           they were having the ward round.

3   Q.   Did you --

4   A.   So it was perfectly possible --

5   Q.   You've got your SHO there -- not your SHO, you have the  
6           paediatric SHO there -- you have a nurse there; did you  
7           think just to ask to confirm that?

8   A.   No.

9   Q.   So you carry out your examination and that's what you  
10          describe. We can pull up the next page. Let's keep 053  
11          and put up 054. That's your complete record. Can you  
12          recall if that "encephalitis/encephalopathy" was there  
13          when you looked at his note?

14   A.   I can't.

15   Q.   And then you say under "IMP" -- that's "impression" for  
16          IMP --

17   A.   Yes.

18   Q.   -- that you don't have a clear picture of ...

19   A.   "Prodrome."

20   Q.   What does that mean?

21   A.   The lead into the presentation.

22   Q.   And "yesterday's episodes".

23   A.   So I must have received some history that gave me  
24          concern that there had been some events the previous  
25          day.



1 Q. And you suggest, having not got a clear picture, you  
2 formed the view it was probably longstanding and needed  
3 to be checked with her notes?

4 A. So this is the next sentence, which is relating to her  
5 motor findings.

6 Q. Which are the notes that you think it needs to be  
7 checked with?

8 A. Well, there was mention of notes from Dr Gaston, who  
9 I think had seen Claire most recently. I don't recall  
10 whether the full chart was available at the time.  
11 That's the other possibility. But I think it related  
12 more to Dr Gaston's notes.

13 Q. So you wanted to know about her most recent  
14 presentation?

15 A. Well, it was a long shot if you like, but if he had  
16 undertaken a neurological examination, that would be  
17 very helpful.

18 Q. And then you suggest -- and this is what you're  
19 suggesting:

20 "Start on IV phenytoin [which is a stat dose] to be  
21 followed by 2.5 milligrams per kilo, 12-hourly. Levels  
22 will need to be checked six hours after the loading  
23 dose."

24 If we start with that, what did that mean in terms  
25 of when you expected that medication to actually start

1 to be administered?

2 A. Well, I've written the word stat, so that usually

3 implies that it should be given straightaway.

4 Q. And what would that mean? Roughly what time are we --

5 15 minutes, half an hour, an hour?

6 A. Whatever it took to draw up the fluids and to prepare

7 the solution. So it could take 15 minutes or a little

8 bit longer perhaps.

9 Q. And then if it's administered then, then what do you

10 expect it means in terms of the next dose, which is

11 12 hours from then?

12 A. The next dose is six hours. The first thing to do would

13 be to check the levels first and then give the dose

14 after that level and then 12-hourly from then. So the

15 purpose of checking the levels is to make sure that

16 they're right.

17 Q. You check the levels six hours after you've given the

18 loading dose and in relation to that, then when do you

19 give the next amount?

20 A. As soon as you get the result back, you give the first

21 dose of 2.5 per kilo and then --

22 Q. -- 12 hours after that. Who is this being directed

23 towards? Is it being directed towards the SHO who's

24 there?

25 A. It's being directed towards the medical team.

1 Q. Yes, but in practical terms, if it is a stat dose and  
2 you want it done as soon as it can be done, then the  
3 person there to do it is an SHO.  
4 A. Yes, or the registrar.  
5 Q. But the registrar is not there.  
6 A. Yes. I don't think I knew that at the time.  
7 Q. Did you know where Dr Sands was at that time?  
8 A. No.  
9 Q. Did you ask?  
10 A. No.  
11 Q. Is it not something that your examination of Claire,  
12 given that he had sought your advice and guidance, that  
13 you would have thought he might have wanted to attend?  
14 A. Um ... I didn't know what his -- where he was at the  
15 time, but yes, I would have thought he would have wanted  
16 to attend.  
17 Q. That's why I was asking whether you asked where he was.  
18 A. No, I didn't.  
19 Q. Had you come with the kind of speed that you had  
20 communicated to him that you would come or were you  
21 conscious that you might have come a little later than  
22 he would anticipate?  
23 A. No, I didn't feel I was later than expected.  
24 Q. So in the absence of the registrar -- you knew Dr Sands  
25 by sight?

1 A. Yes.

2 Q. Well, you had met him in the corridor, apart from  
3 anything else. Did you know him before then?

4 A. No, he was highly thought of in the hospital and someone  
5 who was going to do well.

6 Q. So you knew of him?

7 A. I knew of him.

8 Q. So you know he's not there.

9 A. I couldn't see him, but yes.

10 Q. And you haven't asked where he is. So the person  
11 available to carry out --

12 A. Was the SHO.

13 Q. Was the SHO, yes. Was there any indication as to what  
14 the levels ought to be to enable the next amount of  
15 phenytoin to be given?

16 A. Well, that would be reported with the result, so there  
17 would be a treatment range, if you like --

18 Q. Yes.

19 A. -- reported with the result.

20 Q. And what is that range that you would consider was  
21 appropriate to enable the next amount of phenytoin to be  
22 given?

23 A. It's -- 10 to 20 is the typical range.

24 Q. So as long as it's within that range, then the next  
25 amount of phenytoin can be given?

1 A. Can be given.

2 Q. And then you say "hourly obs". That's point 2 of your  
3 suggestion. And then you say:  
4 "CT tomorrow if she doesn't wake up."  
5 We'll come to that precisely in a minute, but  
6 there's nothing in there that addresses the differential  
7 that you were formulating and which it seems that you  
8 raised with Dr Sands of encephalitis.

9 A. No. I have referred to the pictures of acute  
10 encephalopathy.

11 Q. Sorry?

12 A. I referred to -- you're right, there's no mention of  
13 encephalitis, that's correct.

14 Q. Is there a reason for that?

15 A. No. I think I ... I tend not to give a long list of  
16 differentials, I tend to focus on what I think the most  
17 likely explanation is and that's in my note.

18 Q. Well, how would that be addressed? Encephalitis was  
19 something that you thought was a sufficiently reasonable  
20 differential to have raised with Dr Sands.

21 A. Yes.

22 Q. So if that's something that, presumably at that stage,  
23 hadn't been excluded, so it could be something that was  
24 the reason for her presentation. How is that being  
25 addressed in that suggested plan?

1 A. I think having seen her and she had remained afebrile,  
2 I thought that was less likely at that stage.

3 Q. So at that stage you didn't think that the encephalitis  
4 was as credible a possibility as you might have thought  
5 earlier?

6 A. Yes. Earlier, I hadn't seen her, but it was in the  
7 differential, but at this point I didn't think it was as  
8 likely.

9 Q. Would it have been worth noting that?

10 A. Perhaps.

11 Q. That's something that you had raised with the registrar  
12 and so, according to him, he's included it in the notes.

13 A. Yes.

14 Q. He's not there for you to have that discussion, so  
15 actually I'm not sure that is such a strong possibility.  
16 So would it not have been appropriate to have recorded  
17 that?

18 A. I wouldn't be dismissing it.

19 Q. I didn't say you were. Would that not have been  
20 appropriate?

21 A. I don't know that it would have been terribly helpful  
22 because I think it was still a possibility, but I was  
23 less convinced, having seen Claire, that that was the  
24 diagnosis.

25 Q. Then if it's a possibility, don't you go about treating

1           it, with that sort of adage, you treat the treatable?

2   A.   She wasn't febrile and I think I subsequently did start

3           her on treatment, as you know, but at the time I --

4   Q.   That's why I'm asking you why you didn't do it here.

5           Either you think it is a differential diagnosis which

6           has some credibility to it, some possibility, or you

7           don't.  If you think it is, why don't you seek to treat

8           it?  If you think it's not, why don't you make a note to

9           that effect?

10  A.   I think you could make the case that I should have

11          started acyclovir there.

12  Q.   Do you think you should?

13  A.   It's difficult to know what I was thinking at the time.

14          But in retrospect, I think you could make that case,

15          yes.

16  Q.   And as for the status epilepticus -- in fact, what

17          Dr Sands has recorded as his impression is "non-fitting

18          status".  Was that something that you still considered

19          was likely at the time you were examining Claire?

20  A.   Yes, I thought that was the most likely explanation.

21  Q.   How do you confirm such a diagnosis?

22  A.   Most of the time it's a clinical diagnosis, so the

23          child's presentation and response to treatment.  In an

24          ideal world, you obtain an EEG.

25  Q.   Yes.  Did you think of doing that?

1 A. I did think of an EEG at the time, but I was conscious  
2 that that was going to be very difficult because the EEG  
3 service was very stretched.

4 Q. I understand. Was it even worth contacting the service  
5 just to see what the possibility was?

6 A. Well, I think if I had made contact knowing the person  
7 who was providing the service, that she would have  
8 almost certainly felt that she had to do it, and that  
9 was very likely to lead to her being there after hours.

10 Q. Let me understand you. If you'd contacted her, she  
11 would have formed the view that that meant you wanted it  
12 done and she really ought to comply with that?

13 A. Yes.

14 Q. And that might have inconvenienced her because she would  
15 have been doing longer hours?

16 A. She would almost certainly had had other patients she  
17 was dealing with. This service was the only service  
18 in the province, so it was providing EEG for all of the  
19 paediatric hospitals in Northern Ireland.

20 Q. That doesn't sound as if she wouldn't have done it; it  
21 sounds as if you were being considerate as to her  
22 workload and seeking to not burden her with it.

23 A. Well, my understanding was we didn't have an emergency  
24 service for EEG and this -- essentially what I would be  
25 requesting was an emergency service.



1 Q. Sorry, I just asked you whether you thought of doing it  
2 and you said you did and I think you ended up by  
3 saying: if you'd asked, she would have thought she had  
4 to, and that would have happened, and that would have  
5 meant her staying on later.

6 A. Effectively, yes.

7 Q. Yes. So it's not that she -- whether you call it an  
8 emergency service or an urgent service or whatever you  
9 call it, you haven't yet said it wouldn't happen; you've  
10 just said that it would have placed a burden on the  
11 person doing it.

12 A. That's correct.

13 THE CHAIRMAN: Doctor, if that was your thinking, then that  
14 perhaps leads on to the question of how urgently you  
15 thought an EEG was required.

16 A. Yes. This is an area where there's conflict between  
17 myself and the experts. I think the reality is if this  
18 was happening at 2 o'clock in the morning, I would have  
19 to treat it and I wouldn't have access to EEG. If EEG  
20 is a service that is required 24/7, it's not provided  
21 now, 16 years later.

22 THE CHAIRMAN: Yes, but how hard you push for an EEG to be  
23 carried out surely depends on how urgently you think  
24 an EEG is required.

25 A. Yes. But my clinical --

1 THE CHAIRMAN: In not pushing at this point, am I to infer  
2 something about the lack of urgency with which you  
3 thought an EEG was required?

4 A. No, my clinical judgment is that I can treat this and  
5 look for a response.

6 MS ANYADIKE-DANES: Treat it and look for a response. What  
7 is the response?

8 A. An improvement in awareness.

9 Q. And if there isn't that, then what do you do about the  
10 EEG?

11 A. Well, I would have almost certainly arranged an EEG for  
12 the following morning.

13 Q. That presupposes that the deterioration, if that's  
14 what's happening, the failure to respond, can carry on  
15 until that time without any great risk of harm or  
16 further harm to Claire; did you know that?

17 A. Well, I initiated a number of treatments, as you know.

18 Q. I'm just dealing at the moment with what you're doing at  
19 2 o'clock. That's where we are at the moment.

20 A. I wasn't to know what was going to happen after that.

21 Q. No. That's exactly the point. At 2 o'clock, you're  
22 prescribing something, you're looking down the number of  
23 hours that are left in the afternoon, so if you're not  
24 going to get your EEG done in the next few hours then,  
25 not so much inconveniencing somebody and staying

1       slightly later -- talking about something happening in  
2       the evening or the night. So in a way, you have to  
3       start making up your mind now or fairly shortly after  
4       this point of time as to how ill you think Claire is so  
5       that you can start, if that's what it is to be, certain  
6       treatment now that is easier to arrange now than it is  
7       in the evening when you have a more skeletal staff.

8   A. Yes, and I made the judgment that I should treat this  
9       now.

10   THE CHAIRMAN: And that ties in, does it, with the judgment  
11       that the third point under "Suggest", which is, "CT  
12       tomorrow if she doesn't wake up". Does that also give  
13       an indication of how severe you regarded her position at  
14       2 o'clock that afternoon?

15   A. I think what I was thinking there was that this -- if  
16       encephalitis was being entertained, that we were going  
17       to have to do a lumbar puncture and it was considered  
18       routine at the time to do a CT scan prior to lumbar  
19       puncture.

20   THE CHAIRMAN: Let me ask it this way: how ill did you think  
21       she was when you saw her at 2 o'clock?

22   A. She was not systemically unwell in the sense that she  
23       didn't have a fever or have any vital sign changes.  
24       I felt that she had developed seizures in the context of  
25       a viral illness and this was quite likely to be

1           a recurrence of her epilepsy.

2   MS ANYADIKE-DANES: Well, when you were describing the

3           discussion between you and Dr Sands, in what's been

4           referred to as the second meeting, you said that you

5           formed the view that she was quite ill, really --

6           I think that was your expression, or something like

7           that -- and that you would then be wanting to see her

8           sooner rather than later, and within about the hour.

9           Were you told whether she was afebrile at that stage?

10   A. Yes.

11   Q. So you knew she was, so that's never an issue. That

12           wasn't ever part of her presentation.

13   A. No.

14   Q. So you formed that view, even in the knowledge that she

15           was afebrile. So when you actually did come and see

16           her, which is a little bit after that, there's going to

17           be a dispute as to how long after that conversation --

18           depending on whether you're on one or two

19           conversations -- but a little bit after that you see

20           her. How does your examination of her compare with what

21           you have been told about her by Dr Sands?

22   A. It's very similar, really.

23   Q. So --

24   A. She has the signs that he referred to and she was

25           sitting up in bed, but was vacant in her expression and

1           that's as he described her, really.

2   Q.   So she was still ill?

3   A.   She was, yes.

4   Q.   And so if we can have some sort of sense of measurement

5           from you, how concerned were you about her?

6   A.   As I said, I think my assessment of her was that she had

7           a recurrence of seizures which I needed to try and

8           treat --

9   Q.   Well --

10  A.   -- and that was accounting for her presentation.

11  Q.   That doesn't connote quite the same thing.  How

12           concerned were you about her?

13  A.   Um ... I didn't think that she required admission to

14           intensive care. I felt that she could be managed on the

15           ward and I felt that she could be managed with the

16           treatment that I was suggesting.

17  Q.   From your position as a paediatric neurologist, is there

18           anything else other than non-fitting status -- because

19           you didn't actually witness any seizure activity, did

20           you?

21  A.   No, but the story was that she had a fluctuating pattern

22           of her behaviour. She had been quite bright that

23           morning at 7 o'clock. She had periods where she was

24           vacant and staring and she had responded to rectal

25           diazepam.

1 Q. Can I just pause and ask you about that? How did you  
2 know she had appeared to improve following rectal  
3 diazepam at 12.30?

4 A. From the nursing staff.

5 Q. They told you that?

6 A. Yes.

7 Q. So you had this fluctuating picture, but nonetheless  
8 there's no evident seizure activity, but there are these  
9 vacancies that you see?

10 A. That's correct.

11 Q. And that's part of what, you said earlier, concerned you  
12 because that didn't seem to quite fit the pattern?

13 A. No, it's part of the picture of non-convulsive status.

14 Q. No, didn't quite necessarily quite fit the pattern of  
15 recurring epileptic seizures.

16 A. Well, non-convulsive status is an electrical seizure; it  
17 doesn't manifest as jerking or stiffness. But it's  
18 nonetheless a seizure.

19 Q. That's why I was asking you: was there anything else  
20 that could have accounted for her presentation in terms  
21 of vacancy and so forth, reduced responsiveness, not  
22 speaking, although she was perfectly capable of  
23 speaking? Was there anything else in your mind as  
24 a paediatric neurologist that could account for that  
25 other than non-fitting status?

1 A. Um ... and encephalitis. They may be the two most  
2 likely differentials.

3 Q. If she had had a --

4 THE CHAIRMAN: Let's pause for the stenographer. We'll take  
5 a break for about ten minutes. We'll resume and finish  
6 at about 4.45.

7 (4.00 pm)

8 (A short break)

9 (4.10 pm)

10 MS ANYADIKE-DANES: Dr Webb, maybe we can bring up  
11 090-022-054. Let's have your whole note. Could you add  
12 053 ahead of that?

13 Just so that we've got the presentation that you're  
14 looking at, it's not just about the fact that she has  
15 these vacant episodes, if I can put it that way. But  
16 you're also noticing, if you looked at any of her other  
17 notes, that she is different down one side, if I can put  
18 it that way, and you note that; is that right?

19 "Reduced movement, right-hand side, query. Mildly  
20 increased tone, both arms."

21 So what is the significance of the fact that  
22 whatever is affecting her is not affecting her equally?

23 A. I think Claire had a history of having favoured  
24 movements on the left side.

25 Q. Where did you get that history from?

1 A. Well, I could certainly have got it from the  
2 grandmother. It's the kind of thing I would have asked.

3 Q. You think the grandmother told you that?

4 A. Well, I don't know, but I certainly know that she did  
5 have a tendency to favour her left arm.

6 Q. Okay. Then if you see on the right-hand side, you say  
7 she sits up, the eyes open, "looks vacantly, not obeying  
8 commands". But she's sat up and her eyes are open. And  
9 then just to go back to what the chairman had asked you  
10 about point 3 of your suggestion, "CT tomorrow if she  
11 doesn't wake up". It's the fact that she's sat up and  
12 opened her eyes -- what do you mean by "if she doesn't  
13 wake up"?

14 A. It's not a very good choice of words, but what I was  
15 implying was that she didn't come back to normal.

16 Q. Okay. Then if you look at, just under the impression  
17 part, where I had asked you to help us with your writing  
18 there, and you say -- what was the expression you gave,  
19 "the lead into"? Was that --

20 A. The lead into the presentation, yes.

21 Q. "Yesterday's episodes." What were "yesterday's  
22 episodes" so far as you were concerned?

23 A. Well, I can't recall exactly, but that would suggest to  
24 me that there was some events that had occurred the  
25 previous day that I had obtained that history from the



1        grandmother, but it wasn't clear at the time whether  
2        those were epileptic events that -- might have been  
3        epileptic events or some other event.

4    Q.   If you look at the top of the previous page, which is  
5        just above your first note, it says, "No seizure  
6        activity observed".

7    A.   Yes, and I think that's --

8    Q.   Can you see that, where I am?

9    A.   Sure, yes.

10   Q.   How does that compare with your view of "yesterday's  
11        episodes"?

12   A.   I think it is important to understand the spectrum of  
13        epileptic activity can be enormous. When you read a  
14        note that says "no seizure activity", that to me would  
15        imply there was no tonic-clonic convulsive activity.  
16        I would have been looking for more subtle --

17   Q.   It's not that you've looked for it; you are recording  
18        that it happened. You're not saying you noted the more  
19        subtle non-seizure-like episodes that are nonetheless  
20        called episodes; you are recording that those episodes  
21        happened the previous day. She was admitted some time  
22        around 8-ish or so on the 21st. So what are the  
23        episodes that you are talking about and where do you see  
24        the evidence of that or where do you get the evidence of  
25        that?

1 A. What I'm saying is that my impression of her at the time  
2 was she was in this non-convulsive status.

3 Q. Yes.

4 A. In my notes, it suggests to me that I had elicited some  
5 history that suggested there may have been some more  
6 convulsive activity the previous day. What I'm saying  
7 is that that convulsive activity can be quite subtle and  
8 it depends on how the story is taken.

9 Q. Yes. If the registrar himself is noting "no seizure  
10 activity" --

11 A. There was no frank -- if there had been obvious  
12 convulsive activity, with stiffening and jerking, that  
13 would have been recorded.

14 Q. If you bear with me, Dr Webb. If he has noted "no  
15 seizure activity" and you are saying that this is  
16 something which could be a little subtle, then  
17 presumably you would expect the clinician to note any  
18 such subtleties and, if it's not the clinician who's  
19 noting it, are you really expecting the unmedically  
20 trained grandparent to convey to you a subtle episode?

21 A. No, it's much more likely that I would have sought  
22 a description of events that she might have said: yes,  
23 something like that happened.

24 Q. Like what?

25 A. I would have said to her, did you notice any funny

1 movements yesterday?

2 Q. What would that mean, "funny movements"?

3 A. Well, I would often actually demonstrate it to the

4 person, the parent. So I would say: did you see any

5 movements that involved jerking or facial twitching

6 or --

7 Q. Are you saying you actually did this? You demonstrated

8 that to the grandmother and asked her --

9 A. I can't recall on that particular occasion, but it would

10 be something that I do regularly, that I would actually

11 demonstrate movements.

12 Q. The grandmother hadn't seen the child. The child had

13 gone to school on the Monday, she had come back from

14 school unwell, was vomiting, and the parents had brought

15 her to the Royal. If it's not in any of the notes that

16 any of the clinicians recorded, given that the parents

17 aren't there at that stage to give you their description

18 of her presentation, where do you get any subtle

19 jerkings or movements from yesterday's episodes?

20 A. I don't know, but what I'm saying is that clearly there

21 was something in the history from the grandmother that

22 suggested to me that there may have been episodes the

23 previous day.

24 Q. Well, we will be hearing your evidence again on Monday.

25 Maybe in the interim we and you can look at the medical

1 notes and you can help us identify if the sort of thing  
2 that you're talking about emerges from her notes.

3 A. Okay.

4 MS O'ROURKE: I wonder while my learned friend's on this  
5 point if she could perhaps ask Dr Webb to look at  
6 090-011-013, which I think is the note in respect of the  
7 GP's referral into hospital. And secondly, while we're  
8 on the same, my learned friend has put several times --  
9 I think she said "no seizure activity". In fact,  
10 I think the note says "no seizure activity observed".  
11 And I think there may be a quantitative or qualitative  
12 difference in respect of that.

13 MS ANYADIKE-DANES: Thank you.

14 Let's look at 090-011-013.

15 MS O'ROURKE: "Further fit."

16 MS ANYADIKE-DANES: Do you regard that as something the GP  
17 has actually seen or is that her differential diagnosis?  
18 How do you understand "query further fit" and "query  
19 underlying infection"?

20 MS O'ROURKE: Well, I don't think that's a question because  
21 the question isn't how Dr Webb interpreted that because  
22 he may not even have seen that. But the GP, in order to  
23 have written that, must have been told something by way  
24 of activity or event that caused him to raise that  
25 query, so the question then is -- and this is recorded

1            contemporaneously by the GP: was Dr Webb, the next day,  
2            again given also some sort of description of something  
3            that caused him to query it was a fit?

4    MS ANYADIKE-DANES:    Yes, thank you very much.

5            And that was the very reason why I was asking him  
6            whether he was saying that he got that from the  
7            grandparents because the evidence of the parents and the  
8            grandparents is that the grandparents did not see the  
9            child on the Monday, and certainly weren't there when  
10          the GP was there.    The people who were there are her  
11          parents and her parents, unfortunately, were not there  
12          when you came to examine Claire.

13    THE CHAIRMAN:    But it still leaves open the possibility  
14          that -- when Mr and Mrs Roberts went off at lunchtime  
15          shortly before Dr Webb arrived, the grandparents had  
16          come to relieve them and presumably there would have  
17          been some discussion between them about how Claire was  
18          and what they had seen or not see.    It would be  
19          perfectly natural for Mr and Mrs Roberts to have  
20          a discussion with the grandparents about that.

21    MS ANYADIKE-DANES:    Yes, Mr Chairman, you're absolutely  
22          right.    Maybe that is something we should pick up with  
23          Claire's parents as to what sort of discussion they did  
24          have.

25    THE CHAIRMAN:    Whether anybody remember any detail of that

1           is another matter.

2   MR QUINN:  Mr Chairman, the parents are clear: there were no  
3           seizures on the day before or that morning.  So how  
4           could they tell the grandparents that there were  
5           seizures?

6           And the other thing we must ask at this stage is if  
7           Dr Webb actually did have the GP referral form.  In my  
8           recollection of his evidence, he had the clinical notes  
9           and he didn't have all of them; he just had the notes of  
10          the day before -- and he didn't pay much attention to  
11          the admission notes either, he said.

12  THE CHAIRMAN:  What he has told us is that he focused on the  
13          note that had been written by Dr Stevenson of Dr Sands'  
14          ward round.

15  MR QUINN:  That's correct.  That's my recollection.

16  MS O'ROURKE:  And, sir, my point is that I'm not saying that  
17          he did.  However, I am saying --

18  THE CHAIRMAN:  You didn't say that.  You didn't say that he  
19          did, but you are saying that there is information being  
20          relayed through notes.

21  MS O'ROURKE:  Sir, even if he doesn't see it and it isn't  
22          relayed through the notes, somebody else the day before  
23          has obtained information that causes them to query a fit  
24          and it may well than Dr Webb gets the same sort of  
25          information about a jerky movement or favouring her left

1 side or something else -- medical people interpret it  
2 differently to laypeople -- and Dr Webb has been  
3 explaining that you've got to be very careful when you  
4 use the word "seizure" at to what it means to  
5 a layperson and what it means particularly to a  
6 neurologist.

7 THE CHAIRMAN: The admission examination refers to Claire  
8 favouring one side, doesn't it?

9 MS O'ROURKE: I think that's correct, sir, and Dr Webb's  
10 already given evidence this afternoon in respect of how  
11 she was favouring the left side.

12 THE CHAIRMAN: Yes.

13 MS ANYADIKE-DANES: Yes, it does, Mr Chairman. I don't  
14 think that it says anything about the sort of movements  
15 that Dr Webb has described, which would have allowed him  
16 to express a view that maybe there were these subtle  
17 episodes, but he's been good enough to say that he will  
18 look at the medical notes and records after the weekend  
19 perhaps and we can revisit the point on Monday and see  
20 whether we can advance the matter.

21 So then just to deal with that third point, the  
22 "CT scan tomorrow if she doesn't wake up". Was there  
23 any reason why you didn't think in terms of having  
24 a CT scan that day?

25 A. I thought the yield from a CT scan with the story that

1 I'd been given was going to be very low.

2 THE CHAIRMAN: So it didn't seem to you to be such  
3 an important resource to use at that point?

4 A. That's right, in somebody who has a learning disability  
5 and has had previous history of epilepsy, who has now  
6 come in with what we know think are seizures with an  
7 intercurrent illness, the yield from a CT scan in that  
8 situation would be very small.

9 MS ANYADIKE-DANES: But if it wasn't that and if it was your  
10 other differential and --

11 A. Well, if it was early encephalitis without fever,  
12 I think in that situation the yield would be very small.

13 Q. Sorry?

14 A. In that situation too, the yield would be very small and  
15 in the early stages.

16 Q. So then what about the encephalopathy?

17 A. The encephalopathy as --

18 Q. As a more generic description.

19 A. Um ... Perhaps you could give me some differentials  
20 that you --

21 THE CHAIRMAN: Sorry, can I ask you in a slightly different  
22 way? Dr Sands' evidence was that, by lunchtime on  
23 22 October, he thought that Claire was seriously  
24 neurologically unwell. You've been good enough to make  
25 yourself available, you come in, as you do, in response



1 to these calls on your time. You see Claire, you have  
2 a fairly detailed conversation with Dr Sands, at least  
3 one, maybe two, but it doesn't matter how many because  
4 you have at least one detailed one. You then come and  
5 see Claire, you have a grandparent there, you have the  
6 nurse there, a house officer there, you do an  
7 examination, you draw up a note, you consider what's  
8 before you. You opt against an EEG, you opt against  
9 a CT scan. You give me the impression -- which I'd like  
10 you to correct if I'm wrong -- that you didn't regard  
11 her as seriously neurologically unwell.

12 A. I wasn't expecting her to deteriorate quickly.  
13 I thought she had a problem and I thought that we needed  
14 to treat it. I didn't think the yield from a CT scan,  
15 which would involve her leaving the hospital and going  
16 over to the adult hospital, was likely to be high and  
17 that um ... I think while I understand experts have  
18 expressed a different view, in fact the differentials  
19 when you think about them, they're extremely unlikely.  
20 So for example, it's extremely unlikely that she would  
21 have had a subarachnoid haemorrhage or a bleed because  
22 that's a stroke, essentially, and it presents very  
23 acutely. It's very unlikely that she would have had  
24 hydrocephalus because that is not detectable with  
25 papilloedema. And she didn't have a neurosurgical

1 presentation, that hadn't been a history of trauma or  
2 definite focal weakness, she was moving all four limbs.  
3 So I felt the yield was going to be very small.

4 MS ANYADIKE-DANES: What about the SIADH, is that possible?

5 A. I wasn't expecting SIADH if her sodium was 132 that  
6 morning.

7 THE CHAIRMAN: In essence, she obviously wasn't well, but  
8 you didn't at that time think that she was seriously  
9 unwell?

10 A. I thought this was a situation that she could come out  
11 of.

12 MS ANYADIKE-DANES: And the way in which you were going to  
13 test and assess that was how she responded to the  
14 anticonvulsant therapy that you were about to commence.  
15 To some extent, it had already been commenced with the  
16 rectal diazepam, but you had further anticonvulsant  
17 medication that you were prescribing for her and there  
18 was a regime that would stretch on into the next day.  
19 Was one way of testing whether your diagnosis was  
20 accurate to see how she responded to that?

21 A. Yes.

22 Q. And how did you expect that she would respond to that if  
23 your diagnosis was accurate?

24 A. You might have seen an improvement in her awareness.

25 Q. And what do you think would be the effect on your

1 differential diagnoses if you didn't see that  
2 improvement? Where do you go there?

3 A. Are we at 2 o'clock now or ...

4 Q. We're still at 2 o'clock. You are still considering  
5 your options, if I can put it that way. So you're going  
6 to start something fairly shortly -- not you personally,  
7 but the SHO is going to start something fairly shortly,  
8 which you hope will lead to an improvement in her  
9 presentation and that will be one way, actually, of  
10 confirming that you're on the right track, if I can put  
11 it that way.

12 A. Mm.

13 Q. What's the plan B if she doesn't show any signs of  
14 improvement? What does that do to the range of things  
15 that you think might be causing her presentation?

16 A. Well, I think I subsequently started her on acyclovir.

17 Q. Not at 2 o'clock.

18 THE CHAIRMAN: Subsequently.

19 A. Yes. Sorry, could you repeat the question?

20 MS ANYADIKE-DANES: What I'm asking you is: you have got no  
21 actual confirmatory results in relation to your  
22 differential diagnosis of non-fitting status, nor have  
23 you set any in train. But as I understand it, what  
24 you're going to do is you're going to prescribe some  
25 medication and, if she responds in a certain way to

1           that, that will have two benefits. One, it'll confirm  
2           you're on the right track and secondly, of course, it'll  
3           be leading to her improvement. What I'm asking you  
4           is: if she's not responding to that, then what are your  
5           alternatives because you would have had those in mind?  
6           So she doesn't respond to the anticonvulsant therapy,  
7           does it now make more likely something that you had  
8           pushed a little lower down the scale, which is the  
9           encephalitis?

10       A. Yes.

11       Q. It would?

12       A. Well, it certainly pushed me to start treatment at  
13       5 o'clock for encephalitis.

14       Q. I'm just trying to think of your thought process at 2.

15       A. It's not quite true to say that I hadn't put  
16       investigations in train because I had planned for her to  
17       have a CT the following day and --

18       Q. But that would give an immediate result, if I can put it  
19       that way, then or a result that day, obviously, by  
20       definition.

21       A. Yes.

22       Q. And other than the encephalitis, if she wasn't  
23       improving, is there anything else on the radar, if I can  
24       put it that way, that might be the problem because those  
25       would be your range of things which you'd be thinking of

1           and which you'd be wanting to address, assuming that you  
2           continue to be involved in her care?

3    A.   I have mentioned some of the things that I thought were  
4           unlikely. I think the issue of cerebral oedema was  
5           unlikely, given that her sodium was 132 that morning.

6    Q.   So you then leave after that. What was your  
7           expectation? Was your expectation that you'd come and  
8           responded to a request for specialist guidance and  
9           opinion and you had provided that, or did you think that  
10          you were actually there to follow through the, if I can  
11          put it that way, the treatment plan that you had  
12          suggested?

13   A.   I think I intended to give advice and I was expecting  
14          that there would be further follow-up during the  
15          afternoon at some point.

16   Q.   Did you ask anybody to get in contact with you?

17   A.   I can't recall.

18   Q.   Is that a likely thing for you to have done in those  
19          circumstances?

20   A.   Um ... I may have done, but I can't recall.

21   Q.   Let me put it slightly differently. Although  
22          you haven't been able to exactly convey how seriously  
23          ill she was, I think you were still concerned about her.

24   A.   Mm-hm.

25   Q.   Did you leave any message that if certain things

1           happened or didn't happen, they were to contact you,  
2           that Dr Sands, since you didn't actually know where  
3           he was, could contact you and discuss the case further  
4           if he needed to? Anything of that sort?

5   A. I would have had an expectation that if there was any  
6           deterioration that I would have been contacted.

7   Q. Yes.

8   A. And I imagine that I would have planned to come back  
9           later in the afternoon at some point.

10   Q. Because there are some aspects that I want to deal with  
11           now to facilitate people. I'm not going to put to you  
12           what the experts have said about the various events that  
13           you've been recounting. I will do that, but I'll do  
14           that on Monday. I'm just letting you know that and  
15           we can move on and see if we can advance what you were  
16           actually doing.

17           At 2 o'clock, it's not recorded, but did you suggest  
18           that her serum sodium levels were tested?

19   A. No.

20   Q. Did you indicate that any further blood tests might be  
21           useful?

22   A. No.

23   Q. Is that because you didn't think that was part of what  
24           you were dealing with or because you thought about it  
25           and discounted it?

1 A. I can't recall, but I am likely to have thought about it  
2 and said further blood tests wouldn't have been terribly  
3 helpful.

4 Q. And you knew that she was on IV fluids. Did you know  
5 what she was on and what rate she was on?

6 A. No, and I would have left that part of her care to the  
7 general paediatric team.

8 Q. And why is that exactly?

9 A. Because it would be very unusual for a consultant coming  
10 in to consult like this to manage the fluids. That  
11 would not be what I would normally have done.

12 Q. Well, not manage them necessarily, but would it not be  
13 part of the full picture of what is being administered  
14 to Claire so that you take all that into consideration,  
15 offer some guidance on it?

16 A. I did raise the issue of the sodium on the very first  
17 contact, but I understood that the fluid management was  
18 being dealt with by the general paediatric team.

19 Q. Did you offer any advice about fluid management in  
20 circumstances where Claire seemed to have these  
21 neurological problems that were as yet unresolved?

22 A. No.

23 Q. Do you think that would have been appropriate?

24 A. I don't ... It wouldn't have been my normal practice to  
25 do that. And in the context of what I was dealing with,

1 I didn't think it was appropriate.

2 Q. Well, let me put it to you slightly differently. If

3 Claire was one of your patients, if I can put it that

4 way, is fluid management something that you pay any

5 attention to?

6 A. Of course, yes.

7 Q. Yes. And so you would be giving advice to your

8 registrar, for example, as you went through a ward round

9 and were looking at your own patients?

10 A. Yes, if there isn't another consultant involved, another

11 team involved, of course, yes. But actually, most of

12 the time, that management is done by the junior staff.

13 Q. Yes, but it's part of her picture, is it not, what she's

14 receiving, what's happening to her?

15 A. Yes.

16 Q. So that's why I'm asking you, in that context, when

17 you're trying to get a sense of where that child is and

18 you're at a very early stage in it and you don't really

19 know, you have some thoughts, but whatever it is, you

20 know it's neurological. Is it not appropriate in those

21 circumstances -- I'm not saying to prescribe -- to give

22 some advice and guidance on fluid management?

23 A. If I was requested for guidance and advice, I would have

24 given it. I had asked about the sodium only an hour or

25 two previously, or an hour previously, and as



1 I understood it, the sodium level that morning was not  
2 one that I would be concerned about.

3 Q. Well, the SHO might not be in a position to know that  
4 that's a relevant thing to be asking about in relation  
5 to a child who's got a neurological presentation. It  
6 might be a very junior SHO, early in their rotation,  
7 they might just know that that is relevant to ask.  
8 You're the consultant paediatric neurologist, you're in  
9 a position to know whether fluid management is something  
10 that needs careful attention when you have a child with  
11 an as yet unconfirmed neurological problem.

12 A. And if the SHO needed guidance and advice, he would have  
13 asked his registrar.

14 Q. I think you had just said then that you asked about the  
15 sodium. Who did you ask about the sodium?

16 A. Dr Sands.

17 THE CHAIRMAN: In the first meeting?

18 MS ANYADIKE-DANES: In fairness to you, I think you say that  
19 in your witness statement, 138/1 at page 22.

20 THE CHAIRMAN: He said it earlier this afternoon.

21 MS ANYADIKE-DANES: Yes, but in terms of consistency, that  
22 has been your position from the outset that you asked  
23 Dr Sands for Claire's biochemistry results. Just on  
24 that point, if we pull up 138/1, page 22. You say in  
25 there:

1            "A mildly reduced serum sodium is a common finding  
2            after vomiting in children. This note was a note to  
3            myself that hyponatraemia was a very unlikely cause of  
4            her admission symptoms and course in hospital."  
5            That note where you say, "I note no  
6            biochemistry ..."  
7    A. That's my bad writing again.  
8    Q. Yes. "Normal biochemistry profile", I beg your pardon.  
9            And you say that was a note to yourself?  
10    A. Effectively, yes. I considered the issue of sodium, but  
11            my understanding was that it was 132 that morning, and  
12            therefore it would not explain what I was seeing in  
13            front of me.  
14    Q. Would it not have been helpful for those coming after  
15            you, particularly as she's not your patient, for you to  
16            have expressed that a little more descriptively as to  
17            what that meant, that at this stage you see no  
18            indication of hyponatraemia or something of that sort?  
19    A. Well, I discussed it with Dr Sands and I've written it.  
20    Q. But you didn't think you would record it in that way in  
21            the notes?  
22    A. No.  
23    Q. Okay.  
24    THE CHAIRMAN: Let's move on to 3 o'clock.  
25    MS ANYADIKE-DANES: There are some other matters that I'm

1       going to come back to, but I'm going to move on to  
2       3 o'clock now.

3             If we pull up side-by-side 090-022-054 and  
4       090-022-055. There we are. If we concentrate for the  
5       moment just on the top right-hand side. "S/B", this is  
6       Dr Stevenson's recording:

7             "Seen by Dr Webb. Still in status."

8             And then there is a dosage there for midazolam. So  
9       far as you can recall, did you see Claire other than at  
10      that 2 o'clock recording again before you prescribed the  
11      midazolam?

12    A. I can't recall that. In my inquest statement, I said  
13      that I had seen her twice, and that's my recollection.  
14      But I have, in a sense, tried to put myself there  
15      because the notes seem to suggest I was there, but I'm  
16      increasingly not certain that I was there.

17    Q. So you're not certain that that note accurately records  
18      you being there?

19    A. That's correct.

20    MS O'ROURKE: Can I just get clarity on that because that  
21      note doesn't say he's there at that time and, sadly,  
22      once again it's an untimed note. "Seen by Dr Webb"  
23      could refer to "seen an hour ago" or "seen an hour and  
24      a half ago". One of the difficulties we've got is that  
25      nobody other than Dr Webb earlier has timed a note.

1 MR COUNSELL: I don't know whether the witness can be  
2 assisted if we bring up on the screen the third  
3 statement from Dr Stevenson. Because although,  
4 of course, Dr Stevenson has no recollection of these  
5 events, he is able to interpret that note, which is his.  
6 So if we have page 4 of the witness statement 139/3.

7 MS ANYADIKE-DANES: Just enlarge that a little bit.

8 MR COUNSELL: He's asked about what "S/B" means.  
9 Dr Stevenson's answer is:  
10 "As stated above, I would interpret this entry as  
11 indicating that Claire was reviewed by Dr Webb in person  
12 on Allen Ward."  
13 He goes on:  
14 "I note that there is an entry in the nursing  
15 records stating:  
16 "'Stat dose IV phenytoin at 2.45, to have BD. Seen  
17 by Dr Webb, still in status epilepticus. Given stat IV  
18 Hypnovel at 3.25.'  
19 "I also note that at page 3 of Dr Webb's third  
20 witness statement he makes reference to making three  
21 visits to the ward at 2 pm, after 3 pm, and at 5 pm."  
22 THE CHAIRMAN: I think there's a slight difficulty,  
23 Mr Counsell, because Dr Webb and Dr Stevenson aren't on  
24 their own in trying to, at least in part, reconstruct  
25 events from the notes. So that raises an issue about

1           how precise and reliable the notes are in the first  
2           place.

3   MR COUNSELL:   Absolutely.

4   THE CHAIRMAN:   Let's look at it this way: if you take down  
5           the right-hand page, which is Dr Stevenson's note,  
6           please, and give us 054.

7   MS O'ROURKE:   Sir, could I just throw into the mix while  
8           we're looking at it in asking Dr Webb? Of course,  
9           there's very clear evidence from Mrs Roberts that once  
10          she came back from lunch at 2.10, she did not leave  
11          Claire again until round about 4 o'clock, when she went  
12          for a tea break that lasted no more than 10 minutes. So  
13          if that's the case, then she was present at 3 o'clock  
14          and at 3.15 and 3.25, and you'll recall she says she  
15          wrote on the fit chart at 3.25 and she never met Dr Webb  
16          until 5 o'clock. So that may assist because that's  
17          someone's direct recollection as opposed to trying to  
18          interpret notes.

19   THE CHAIRMAN:   Okay. Let me ask you this way, doctor --  
20          whether we'll ever resolve this uncertainty, I just  
21          don't know -- but you were there and there is a note  
22          written at about 2 o'clock, which ends up with your  
23          three points of suggestion, okay? And it refers  
24          specifically to giving Claire phenytoin. The note below  
25          that on the bottom of page 54 is Dr Stevenson giving the

1       phenytoin. The top right on page 55 is then Claire  
2       being given midazolam. Okay? That wasn't part of your  
3       2 o'clock plan. So doing the best you can, what would  
4       have happened for you to prescribe midazolam at about  
5       3-ish if it didn't involve you coming back to see Claire  
6       again?

7   A. I think it's most likely that I was contacted and most  
8       likely that I was contacted after the seizure at 3.25.

9   THE CHAIRMAN: And on foot of that you would then -- well,  
10       one possibility is that you would then prescribe, by  
11       phone, midazolam.

12   A. Certainly recommended by phone, that's possible.

13   THE CHAIRMAN: If you were advised of the seizure at 3.25,  
14       which is -- there was no confirmed seizure before then.  
15       Might that have -- depending how much time you had --  
16       prompted you to go back and see Claire?

17   A. It would depend on what I was involved in, but it's more  
18       likely that that really reinforced my concern that there  
19       was a recurrence of seizures in someone who was at risk  
20       of having seizures, and this was the first clinical  
21       event, if you like, the first obvious event.

22   MS ANYADIKE-DANES: Can I help you with the timing in this  
23       way? It's not quite right to say that your note is the  
24       only timed one. Dr Stevenson appears to have timed his  
25       note of his entry in relation to the calculation of

1       phenytoin at 2.30. Then his note in relation to you  
2       comes after that. Of course, these timings are not  
3       always precise, but the observation chart is completed  
4       by Claire's mother at 3.25 and she's very clear about  
5       that. She makes that entry herself. She's very clear  
6       about the fact it happened and very clear about the time  
7       it happened.

8               Then if what you're saying happened is that that  
9       seizure occurred and then you were contacted, as  
10      I understand what happened you were contacted, that  
11      would have been explained to you, you would have had  
12      some thoughts about what you would want to do in those  
13      circumstances. Ultimately, your thoughts ran to  
14      changing the anticonvulsant medication, trying  
15      midazolam, which is something you'd had some familiarity  
16      with in Canada, going into your office, checking what  
17      the appropriate dosage was, then phoning that through,  
18      then that would have meant -- in this case it was  
19      Dr Stevenson -- he would have then had calculated that,  
20      made this entry or in whichever order he did it, that  
21      would have emerged there, and then it would have been  
22      administered. That's roughly it, isn't it?

23   A.   Mm.

24   Q.   Then if one looks at actually the timings of the  
25      administration, which you find at 090-026-075, the time

1 of the administration of the midazolam appears to be  
2 3.25. Who gave it is not signed, although the nursing  
3 note seems to indicate that it was given because that is  
4 the nurse's note. But certainly Dr Stevenson is signing  
5 it off at 3.25 as the time of administration.  
6 Recognising that people's watches are slightly different  
7 and maybe how they record times aren't always accurate,  
8 but it may well be quite a lot to happen from the time  
9 when the seizure happens at 3.25, all of that, and then  
10 for the entry to be made at 3.25.

11 So is it possible that the suggestion that midazolam  
12 be administered is not something that's done in response  
13 to that seizure, but is something that is done before  
14 that to allow all that I just described as to what might  
15 be going on, if you received such a call, and to allow  
16 it to be administered at roughly 3.25? Is that  
17 possible?

18 A. It's possible, but I think unlikely. Because I think  
19 it's most unlikely that the drug would have been given  
20 at the exact time that the seizure occurred and it's  
21 most unlikely that Claire's mother wouldn't have  
22 recalled the administration.

23 Q. Sorry?

24 A. It's most unlikely that Claire's mother wouldn't have  
25 recalled the administration of midazolam. It's most



1           unlikely it would occur at the time of the seizure,  
2           which is documented at 3.25.

3   Q.   Well, there's been expert evidence as to the extent to  
4           which midazolam, which is extremely fast acting, could  
5           produce paradoxical seizures or something of that sort,  
6           perhaps in combination with the phenytoin, which has  
7           quite a long half-life.   So there are some possibilities  
8           around that and that's part of obviously what we have  
9           sought expert guidance on, as to whether those two  
10          things could be related.   In any event, the point that's  
11          being put is that an alternative is not that you phoned  
12          that through at 3.25 or thereabouts, but actually you  
13          had come a little earlier, maybe just briefly, to have  
14          that discussion with the SHO, which is what's recorded,  
15          and the reason that Claire's mother might not have seen  
16          you is maybe she's unfortunately at the loo just at that  
17          time or something of that sort.

18   MR QUINN:   Claire's mother will definitely say that she went  
19                  for a cup of coffee.   When she came back, the lady in  
20                  the opposite bed was tending her daughter in the same  
21                  little room that they were in and she said, "You have  
22                  just missed the doctor".

23   THE CHAIRMAN:   And that time was?

24   MR QUINN:   Some time around 4 o'clock, 4.15.

25   THE CHAIRMAN:   But midazolam's given earlier, Mr Quinn.

1        Nothing really fits here because if we don't -- if  
2        Dr Webb did see Claire at about 3 o'clock, which led to  
3        the midazolam being prescribed, it's almost like nothing  
4        in particular's happened by then, so he's almost having  
5        second thoughts, "I've given the phenytoin, maybe I'll  
6        give the midazolam as well".

7    MR QUINN:    Yes.

8    THE CHAIRMAN:  If this is prescribed or suggested by Dr Webb  
9        before the 3.25 seizure entry, it's not because, so far  
10       as we can work out, anything new has developed with  
11       Claire.

12   MR QUINN:    Yes.   I understand.

13   THE CHAIRMAN:  It's because he has come back and maybe had  
14       an additional thought or, "I've been thinking about  
15       this", as you might well do, because everything isn't  
16       clear-cut.  You've been thinking about it and maybe come  
17       back and say, "Let me try the midazolam".  Is that --

18   A.   I just don't think it's likely that I would have missed  
19       the mum twice.  I don't think we can be certain that the  
20       mum -- the other lady in the room knew it was me or knew  
21       it was Dr Stevenson.

22   MS O'ROURKE:   Sir, can I add into that?  Mr Quinn is  
23       entirely right that mother said the lady across the bay  
24       said, "You've missed the doc", but she didn't say,  
25       "You've missed two doctors": "You've missed one doctor".

1       We know there was a doctor there that afternoon because  
2       there's a note after 2.30 in the records and it comes  
3       from Dr Stevenson. So more likely than not it would  
4       look like it's Dr Stevenson's at the bed to write on the  
5       chart and that's the doctor she missed because  
6       Mrs Roberts was very clear: she came back from lunch at  
7       2.10 and at 5 o'clock she saw no doctor and she was only  
8       away once. Therefore, she hasn't seen Dr Stevenson and  
9       you have the fact that Dr Webb doesn't write in the  
10      notes or sign anything.

11    MS ANYADIKE-DANES: How quickly did you expect Claire to  
12      respond to the phenytoin if you were on the right track  
13      with that medication?

14    A. You can get a response within 15 minutes.

15    Q. So she was prescribed the phenytoin at 2.45.

16    A. Mm.

17    Q. Sorry, I beg your pardon. She was administered the  
18      phenytoin at 2.45. So you might have expected  
19      a response by about 3?

20    A. At 3, possibly.

21    Q. Yes. And if you hadn't, or they had not seen a response  
22      at that time, might they be contacting you to say,  
23      "She's had the diazepam, she's now had the phenytoin"?

24    A. I think it's a bit early. I think it's unlikely they  
25      would have jumped to ring me at 3 o'clock.

1 Q. That's when they might have done an hourly observation,  
2 so that might have prompted some consideration of: where  
3 do we stand with her? And if that had happened in  
4 response to when you might think you had seen  
5 a response, then that might provide some explanation for  
6 why you might have come by and thought about  
7 administering something else.

8 THE CHAIRMAN: Sorry, what was the hourly observation at  
9 3 o'clock? Can somebody tell me quickly?

10 MS ANYADIKE-DANES: The hourly observation at 3 o'clock was  
11 7.

12 THE CHAIRMAN: Compared to what at 2 o'clock?

13 MS ANYADIKE-DANES: It doesn't actually seem to be filled in  
14 at 2 o'clock because that's the one that Dr Webb himself  
15 includes. It's 9 when it starts at 1 and it's at 7 at  
16 3 o'clock.

17 THE CHAIRMAN: Would that be a reason to call you back,  
18 doctor? The GCS score of 9 is low-ish already. And if  
19 there's a 3 o'clock observation some time around 3 pm,  
20 which has it down at 7, that would be raising a warning  
21 flag, wouldn't it?

22 A. I think it would have been reported in the nursing notes  
23 if that was the case.

24 THE CHAIRMAN: You mean if it was the case that you were  
25 asked to come back?

1 A. Yes, I think they would have made a record of that.

2 THE CHAIRMAN: In a sense, we're focussing on whether you  
3 did actually see Claire at 3 o'clock-ish. But that may  
4 not be the critical point here. The critical point here  
5 is whether you saw her or whether you were given  
6 information by phone and your response was to prescribe  
7 midazolam.

8 A. And I think it's most likely that I would have done that  
9 in the context of her having had a seizure.

10 MS ANYADIKE-DANES: Then let's go to the prescription of  
11 midazolam. Would you not have wanted to see her before  
12 you prescribed that?

13 A. In an ideal world, I probably would have, but I don't  
14 know what I was doing at the time.

15 Q. When you went to check the dose of midazolam, that's  
16 because you needed to because it wasn't one of those  
17 things at the forefront of your mind. Had you used it  
18 in the Children's Hospital since your return from  
19 Canada?

20 A. No.

21 Q. So it's not one of those things that you were regularly  
22 using? Would it be fair to say that it's likely that it  
23 wasn't something that the junior SHOs or the nursing  
24 staff would be familiar with?

25 A. It was a drug that was on the ward and it's a drug

1           that's a member of a family of drugs that are very  
2           well-known, the benzodiazepines. So it wasn't one that  
3           was completely unfamiliar in that sense.

4   Q. Yes, but would it be fair to say -- in fairness, you  
5           yourself have said that you hadn't actually used it  
6           since you had come back from Canada --

7   A. Yes.

8   Q. -- and you're the consultant.

9   A. Yes.

10   Q. So is that why it would be fair to expect that the SHOs,  
11           particularly if they were fairly early in their  
12           rotation, may not have come across it?

13   A. That's correct.

14   Q. And it's probably fair to say that the nursing staff may  
15           also not have come across it.

16   A. Possibly, although ...

17   Q. If you're phoning through, presumably you know whether  
18           you're speaking to Dr Sands --

19   THE CHAIRMAN: Dr Stevenson.

20   MS ANYADIKE-DANES: -- or Dr Stevenson.

21   A. I don't know who -- I can't recall who I spoke to.

22   Q. But if you had been speaking to Dr Sands, you would have  
23           know you had spoken to him because you have spoken to  
24           him before.

25   A. Yes.

1 Q. And Dr Stevenson has written the note so the probability  
2 is that you were communicating that to the junior SHO,  
3 who had been there, or one of them there, when you  
4 examined her at about 2 o'clock.

5 A. Yes, he could have got the information from Dr Sands  
6 possibly.

7 Q. Yes. So you're communicating that to him, you're  
8 communicating that at the telephone, I think. In your  
9 third witness statement, do you think that happened? Is  
10 it something that you would have wanted to check  
11 afterwards or explained to him what some of the features  
12 of midazolam might be?

13 A. Well, I think I would have explained that.

14 Q. It can be a pretty powerful drug, can it not?

15 A. Midazolam is probably the drug that's used most now to  
16 stop seizures in children. We give it almost -- every  
17 patient that we see with seizures, so it's a very  
18 widely-used drug now.

19 Q. I appreciate that, but if we're back in 1996 --

20 THE CHAIRMAN: It doesn't matter whether in 1996 or 2012;  
21 I think the question to you was: is it quite a powerful  
22 drug?

23 A. Yes, it is a powerful drug in terms of its effect.

24 THE CHAIRMAN: Right.

25 A. It's a very effective anticonvulsant.

1 MS ANYADIKE-DANES: So it's a pretty powerful drug and one  
2 which perhaps the characteristics of it or the adverse  
3 effects of it may be something that the junior SHO may  
4 not be aware of.

5 A. I wouldn't expect that because it's a member of a family  
6 of drugs that's very well-known, the Valium group, if  
7 you like, and part of the reason that I thought it might  
8 be helpful was because Claire had responded to diazepam.  
9 It's related to diazepam and the side effects of the  
10 drugs are very similar.

11 Q. When I said "might not be aware of" -- and this is a  
12 time when 1996 is relevant because although it may be in  
13 common usage now and maybe an SHO now might be aware of  
14 it and familiar with it and perhaps even have used it,  
15 in 1996, I think you've already said that, in fairness,  
16 you wouldn't necessarily expect an SHO to be familiar  
17 with it. So what I'm trying to get at is: in those  
18 circumstances, what would it have been reasonable for  
19 you to have told the SHO about this medication that you  
20 are suggesting is administered to Claire?

21 A. I think the SHO would have known that it had a potential  
22 to cause sedation. I would have expected that.

23 Q. You, I think, said that you would have explained certain  
24 things to him. I think I had gone off rather quickly to  
25 another question. What do you think you would have



1           explained to an SHO about midazolam?

2   A.   Well, that you give a bolus and then you start an

3           infusion, and that sedation is a potential side effect.

4   Q.   Is respiratory arrest?

5   A.   It's a rare side effect, which it is for diazepam too.

6   Q.   Yes.   When I was taking the experts -- Dr Aronson, who's

7           the expert pharmacologist for the inquiry and also,

8           I think, to some extent Professor Neville -- through

9           some of the product literature about midazolam, now

10          recognising that drug companies want to err always on

11          the side of caution, nonetheless it would appear to be

12          being described as a drug to be used with a fair degree

13          of respect in terms of some of the potential adverse

14          consequences.

15  A.   I think that's correct.

16  Q.   Is that something that you think you might have

17          communicated to Dr Stevenson?

18  A.   Perhaps not in those words.   I think the other thing

19          that I almost certainly did communicate is that Claire

20          should have an oxygen saturation monitor.

21  Q.   As she was being administered it?

22  A.   Yes.

23  Q.   Did you explain why?

24  A.   As you've suggested, it can affect breathing.

25  Q.   No, did you -- I know that's what I suggested.   Did you

1 explain why to Dr Stevenson or at least to the doctor  
2 that you had on the other end of the phone?  
3 A. I can't recall that, but I think it would have been  
4 implicit in the suggestion.  
5 THE CHAIRMAN: In the sense that if you suggested that to  
6 a doctor, a doctor would know what the reason was?  
7 A. Yes.  
8 MS ANYADIKE-DANES: If one pulls up again 090-022-055, if  
9 you look there at what Dr Stevenson has taken down as to  
10 the dosage, you're quite clear, are you, as to what you  
11 told him for the dose?  
12 A. The dose that I would have recommended was 0.15.  
13 Q. Can I just pause there with you? You've just said "the  
14 dose I would have recommended".  
15 A. Yes.  
16 Q. Do you have an independent recollection of what you  
17 actually told him about the dose?  
18 A. No, I don't. I had to go and check the dose.  
19 Q. Sorry, that's not what I mean. Do you now have an  
20 independent recollection of the telephone --  
21 THE CHAIRMAN: I'd be astonished if Dr Webb could sit here  
22 and give evidence on oath to say, "I remember saying  
23 0.15".  
24 MS ANYADIKE-DANES: So you don't have that?  
25 A. No, I don't.

1 Q. So what you're relying on is the fact that you do  
2 remember checking it in the literature and the  
3 literature says a particular kind of thing and, as far  
4 as you're concerned, that implies or at least suggests  
5 to you that that's what you told Dr Stevenson?

6 A. Correct. And I have to be responsible if he  
7 misconstrued it.

8 Q. And given that you were telling him that on the phone  
9 and if it's something that even you had to check, if,  
10 when he took down the dosage and did the calculations,  
11 he had got something that appeared to be completely out  
12 of range, he wouldn't necessarily appreciate that.  
13 Is that something that you felt that you ought to check  
14 yourself what had been administered to her?

15 A. No, at the time. I wouldn't have because my expectation  
16 would have been that if I had given a dose and he was  
17 drawing up the medication, that he would have checked  
18 that with another individual, either a doctor or  
19 a nurse.

20 Q. No, it's not so much the case that he wasn't clear on  
21 it; it's the case of speaking on the phone, somebody may  
22 simply have misheard or made an error of that sort and  
23 wouldn't necessarily appreciate that was an error  
24 because to them, whether it's 12 milligrams or 3.6 or  
25 whatever, if it's not a drug that they're familiar with,

1           they may not appreciate the significance of that.

2           That's the point I'm making.

3    A.   Yes, I'm not sure -- I think ... That may be a counsel

4           of perfection.

5    Q.   Sorry?

6    A.   I'm not sure. That may be a counsel of perfection to go

7           checking with him that he had got what I had said

8           correctly.

9    Q.   You have a note of seeing Claire that is timed at

10          1700 hours and his calculation of what he's recorded you

11          told him is immediately above it.

12   A.   That's correct.

13   Q.   And it's not too difficult to see that 3.6, which is

14          what your dosage would have amounted to, is fairly

15          different from 12.

16   A.   And I missed that.

17   Q.   But that was the point I was getting at.

18   A.   Yes.

19   Q.   I appreciate that you might not have thought that I'll

20          just immediately go back to the ward and see what he's

21          done, but since you are actually there with Claire,

22          would it not have been a responsible thing to at least

23          see what he had administered to her?

24   A.   It would not be something that I would do routinely.

25   Q.   But it's just above your note.

1 A. I understand that. As I said, I missed it.

2 THE CHAIRMAN: I think that's all he can say.

3 MS ANYADIKE-DANES: When you came to see Claire and you made  
4 your note, Claire has had a loading dose of phenytoin  
5 and a bolus of midazolam, who was there when you were  
6 examining Claire at that stage?

7 THE CHAIRMAN: If you're going to go to the 5 o'clock  
8 examination, I think we'll leave it for today.

9 MS ANYADIKE-DANES: I was going to come back to a bit  
10 in relation to Dr Stevenson on that point.

11 MR COUNSELL: We passed over it.

12 I wonder whether the witness perhaps could explain  
13 the source of his information that the dose was 0.15.  
14 And just to help, if the document, which is attached to  
15 his third witness statement, which appears at witness  
16 statement 138/3, page 5, is brought up. It may be of  
17 assistance if, alongside that, a page from his second  
18 witness statement, 138/2, page 13, is brought up.  
19 I think the first document on the left-hand side is the  
20 piece of literature which Dr Webb tells us he would have  
21 had. I don't want to anticipate his evidence in front  
22 of him. Perhaps he could deal with that and then  
23 explain the last sentence in the answer to (d).

24 MS ANYADIKE-DANES: Let's start with the left-hand side.  
25 This is a document that you attached to your witness

1 statement. Is this the document that you went to look  
2 at in your office?

3 A. I can't be certain of that, but it's the major paper  
4 describing midazolam use in this way at that time and  
5 it's likely that it would have been. My source of  
6 information might well have included other sources from  
7 my time in Vancouver.

8 Q. Just to be clear: you mean there were other documents  
9 that you would have looked at at that time in your  
10 office?

11 A. I would have had a file that related to  
12 status epilepticus and I would have had notes  
13 in relation to midazolam that could have been made at  
14 meetings, from conferences that I attended or  
15 interesting patients that I had been involved with.

16 Q. And do you think that you flicked through that file  
17 at the time when you were checking on whether it seems  
18 that midazolam would be an appropriate medication and  
19 that the dose ought to be 0.15?

20 A. To confirm the dose, yes.

21 Q. Just to confirm the dose?

22 A. Yes.

23 Q. So you already had in your mind that you were going to  
24 suggest midazolam; what you really wanted to know is the  
25 appropriate dose.

1 A. Exactly.

2 Q. So that's why I'm asking you: do you think you were  
3 looking through that file or was it just this paper or  
4 something like this that you used?

5 A. I think it was likely to be this paper and notes that  
6 I had as well.

7 THE CHAIRMAN: Was Canada a bit ahead of the UK in using  
8 midazolam, or your particular hospital?

9 A. No, I don't think so. I can't speak for the UK, but  
10 there were certainly other centres around the world that  
11 were using it. So the paper that was published in 1997  
12 was from, I think, the Far East.

13 MS ANYADIKE-DANES: This was the description, was it not, of  
14 a piece of research?

15 A. The 1997 paper?

16 Q. No, the paper here.

17 A. The 1993 paper, yes.

18 Q. Yes. That was described by Dr Aronson, on the use of  
19 midazolam, as perhaps experimental at that stage; do you  
20 accept that?

21 THE CHAIRMAN: "Innovative", I think, was his term.

22 MS ANYADIKE-DANES: And we had "avant-garde".

23 THE CHAIRMAN: He wasn't being critical of the use of it.

24 MS ANYADIKE-DANES: I wasn't being critical of it, but that  
25 is how he characterised it. Nobody was saying that it

1       wasn't a good idea that you were seeing all that you  
2       could as to what might be a successful drug therapy for  
3       Claire. That's not the issue. The issue was -- or at  
4       least it was at that time in the evidence -- the extent  
5       to which to use it could still be regarded as a little  
6       experimental. There had been no large drugs trial  
7       involving it in the use of children.

8   A. That's true of a lot of the drugs that we use,  
9       unfortunately. It's just a fact of life. But  
10      I wouldn't have considered it experimental.

11   Q. How would you have characterised it at that stage?

12   A. Well, perhaps innovative. As I said, it was a drug that  
13      was very effective.

14   THE CHAIRMAN: In any event, the reason why these two  
15      documents are in front of you, doctor, is you've  
16      referred to this 1993 publication in your third  
17      statement, but when you were preparing your second  
18      statement and you were asked at (d) to:

19           "Explain why you recommended the administration of  
20      midazolam in Claire's case and provide a paediatric text  
21      in your answer."

22           And you ended by saying:

23           "I do not have a textbook reference for intravenous  
24      midazolam dating back to 1996. But there is  
25      a publication from 1997 documenting its use in



1 children."

2 And I think implicit in this is the question that  
3 since you didn't have a paediatric text, a textbook to  
4 refer to, and you were going to refer to something else,  
5 why didn't you actually refer to the 1993 paper, which  
6 is the one you are suggesting was the one that you  
7 relied on when you prescribed to Claire with this  
8 particular dose?

9 A. I did a number of literature searches around this time  
10 and I think what happened is I just mislaid that paper  
11 and when I was asked the question again, I found it.

12 MS ANYADIKE-DANES: I think actually the question was more  
13 directed towards if you're trying to explain to the  
14 inquiry why you recommended the administration of  
15 midazolam in Claire's case when she was being  
16 administered that in October 1996, how can you be  
17 referring to a paper in 1997?

18 A. Well, I think it's important to understand that when  
19 papers are published, quite often they've been around  
20 for a little while. The information in them has been  
21 around for quite a while. It's not unusual, for  
22 example, for the authors to present them at meetings.  
23 So it's quite conceivable that paper was presented and  
24 that I would have had some knowledge of it.

25 Q. Given that you've included it in your witness statement,

1           are you saying that that paper in the Archive of  
2           Diseases in Childhood, 1997, 76, 445 to 448, is  
3           something that you saw or a version of it before  
4           Claire's admission?

5   A.  No, I wouldn't have seen the paper.  What I'm saying is  
6           the contents of the paper related to patients that were  
7           treated between 1993 and 1995.  So there was certainly  
8           a possibility that that information was available  
9           through presentation at scientific meetings or --

10  Q.  Well, did you know that?  Sorry, let me frame it  
11           a different way.  Do you have any evidence to indicate  
12           to you --

13  A.  No.

14  Q.  So that's perhaps, one might say, not a terribly helpful  
15           reference for the inquiry.

16  A.  I think it's helpful in the sense that it documents that  
17           that drug was being used at that time in other units for  
18           this condition.

19  MR COUNSELL:  One other question only in relation to that.  
20           I wonder whether the witness could be asked: if he had  
21           relied on the contents of this study in order to arrive  
22           at correct dosages, then what would have been the  
23           maintenance dose which he would have fixed upon?

24  A.  Between 1 and 5 micrograms per kilogram.

25  MS ANYADIKE-DANES:  I think the question is: where do you

1           get that from this paper?

2   A.   From the second paper?

3   Q.   No, from the 1993 paper.

4   A.   It reports an infusion rate at 1 microgram per kilogram

5           per minute.   That's the starting infusion rate.

6   Q.   What you are recorded as having prescribed is

7           2 milligrams per kilo per minute.

8   A.   No.

9   THE CHAIRMAN:   I don't think it has been suggested before

10           that there has been specific evidence about whether

11           Dr Stevenson and you, between you, miscommunicated about

12           the stat dose.   But I don't think it has been suggested

13           that the infusion rate was mistaken by Dr Stevenson.

14   MS ANYADIKE-DANES:   No, not mistaken.

15   MR COUNSELL:   The purpose of the question was that if, as I

16           understand Dr Webb's evidence to be, that he may have

17           relied upon this document, which he has now discovered

18           again, and from this document he gave instructions to

19           Dr Stevenson that the bolus dose should be 0.5, then it

20           may be that looking at this document he would have given

21           an instruction that the maintenance dose should have

22           been 1 rather than 2.   I'm not suggesting for one moment

23           that either would necessarily be correct.

24   THE CHAIRMAN:   Yes.

25   MS ANYADIKE-DANES:   Well, can you help with that?

1 A. It's perfectly conceivable that I had a note that  
2 suggested starting with a dose of 2 micrograms per  
3 kilogram per minute was preferable.

4 Q. Did you have a note that said that?

5 A. I don't know. I don't know.

6 Q. Do you still have that file?

7 A. No. I don't, no.

8 Q. I stand to be corrected but I think there might have  
9 been an issue as to not only was the stat dose obviously  
10 high, but the infusion itself might be high. I will  
11 check that for you over the weekend, but I think there  
12 was an issue about that.

13 A. I think the infusion range is 1 to 5 micrograms per  
14 kilogram per minute. And Claire was receiving  
15 2 micrograms per kilogram.

16 THE CHAIRMAN: If there was an issue, it wasn't an issue  
17 that had been raised on behalf of Dr Webb.

18 MS ANYADIKE-DANES: No, I think it was raised when  
19 Dr Aronson was being asked.

20 THE CHAIRMAN: The point I'm looking at here is to the  
21 extent it is suggested that there was somehow an error  
22 made somewhere along the line between Dr Webb and  
23 Dr Stevenson, which led to Dr Stevenson writing down  
24 0.5, it has not been suggested to him that he made  
25 a mistake or there was a misunderstanding about the

1           infusion rate.

2   MS ANYADIKE-DANES:  No, it has not been suggested that he

3           told Dr Stevenson one thing and Dr Stevenson's written

4           another thing in relation to the infusion rate.  You're

5           absolutely right, Mr Chairman.

6   THE CHAIRMAN:  That's the point I was making following on

7           from Mr Counsell's point about the infusion rate.

8   MS ANYADIKE-DANES:  I simply want to check whether there has

9           been any evidence given as to whether that was an

10          appropriate infusion rate.

11  THE CHAIRMAN:  That's a different point because that is now

12          the point that's between Dr Webb and Dr Stevenson.

13  MS ANYADIKE-DANES:  No, it's not.

14  THE CHAIRMAN:  Okay.

15  MS ANYADIKE-DANES:  I thought that is a little bit of where

16          Mr Counsell was going to ask about that, but that's not

17          a point in terms of miscommunication between the two of

18          them.  I accept that.  So maybe I'll pick that up with

19          you on Monday.

20  MR COUNSELL:  Sir, can I thank you very much for taking that

21          evidence out of turn?

22  THE CHAIRMAN:  Not at all.  You're not the only person who

23          has been inconvenienced this week.

24                 Doctor, I'm sorry we've had to sit late this

25          afternoon.  I'm sure it has been a long afternoon for

1       you. We're going to resume again on Monday.

2           I understand from an enquiry that was made early  
3       that you can convenience us by being available from  
4       9.30, and I'm grateful to you for that. We're very keen  
5       for you -- as is everybody, including Mr and  
6       Mrs Roberts -- that we finish our investigation and  
7       evidence into Claire's case before Christmas. It has  
8       been going on for perhaps a bit too long and we would  
9       like to bring this limb of the inquiry to a end. So  
10      we'll start again with Dr Webb, who will be the only  
11      witness on Monday, at 9.30.

12           Could I ask you, doctor, to remember that now that  
13      you have started to your give evidence, you're under  
14      oath, and you should not be consulting with anybody or  
15      talking about your evidence over the weekend with  
16      anybody.

17   MS O'ROURKE: Sir, can I just raise one issue in respect of  
18      that? We were reminded this morning about a letter from  
19      the assistant solicitor to the inquiry dated  
20      6 November 2012, asking for Dr Webb to clarify in  
21      respect of his witness statement 138/3, question 2(a) on  
22      page 2, in respect of a CT scan and him making  
23      a comment:

24           "I was aware of the published concerns about sending  
25      children to an adult facility for emergency

1 investigations."

2 We asked Dr Webb about it this morning while you

3 were hearing other evidence. He's going home to look

4 for the papers and to let us have them over the weekend.

5 May we have permission to talk to him to that

6 limited extent only to clarify from him what papers and,

7 indeed, to receive them so that we can respond to the

8 letter sent to my instructing solicitor?

9 THE CHAIRMAN: If he knows what papers it is that you're

10 looking for, then I'm quite happy for Dr Webb to forward

11 those papers to you, but there's not to be a discussion

12 about them.

13 MS O'ROURKE: Thank you, sir. There won't be a discussion

14 about them. It is simply to clarify that these are the

15 papers he means and to receive them from him.

16 THE CHAIRMAN: Thank you very much, ladies and gentlemen.

17 Monday morning at 9.30.

18 (5.22 pm)

19 (The hearing adjourned until 9.30 am on

20 Monday 3 December 2012)

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