

1 Tuesday, 11 December 2012  
2 (10.00 am)  
3 Discussion  
4 THE CHAIRMAN: Good morning. Mr Stewart, just before we  
5 start, has everyone now received the documents from  
6 file 139 for which the Trust has now waived privilege?  
7 You have those? Okay.  
8 There's nobody here for Dr Webb today? Does anyone  
9 have any idea if Mr Sephton is coming back or his  
10 solicitor? Okay, let me raise this now. There are two  
11 issues that concern me. One is that if you turn to the  
12 page you just got this morning, 139-165-001, which is  
13 the first page of a two-page letter from Gary Daly,  
14 solicitor of Brangam Bagnall, to Mr Walby. At the end  
15 of the last paragraph on the first page, Mr Daly says:  
16 "In particular, I understand that you are to bring  
17 to the attention of the clinicians that the sodium serum  
18 level was measured at 121 on two separate occasions."  
19 As a matter of fact, I don't think that's right, is  
20 it?  
21 MR McALINDEN: There's no evidence at all that the serum  
22 sodium was measured at 121 on two separate occasions and  
23 I can't explain where that comes from.  
24 THE CHAIRMAN: The only record we have is the reading which  
25 came back at about 11.30, isn't it?

1 could make a full recovery from this."  
2 That's 3 December at page 189. Then I followed that  
3 up on page 190 at line 14:  
4 "Question: Did you think she was seriously ill?  
5 We've discussed this in a number of ways. I think you  
6 thought she was ill, but that you thought she was going  
7 to improve.  
8 "Answer: That's correct.  
9 "Question: Had you thought she was seriously ill,  
10 then you would definitely have spoken to PICU.  
11 "Answer: Yes, and I would have spelt it out to her  
12 mother, but I thought she was going to improve."  
13 I don't understand on the face of the document how  
14 that sits with Dr Webb being of the view that the family  
15 were fully aware of the extent of Claire's illness,  
16 unless Dr Webb is saying that her illness wasn't all  
17 that serious.  
18 MR McCREA: That can't sit with his view that he thought he  
19 should refer the child to PICU or at least speak --  
20 those two facts don't sit side by side. This is simply  
21 another one.  
22 THE CHAIRMAN: Yes. Well, I'll refer this specifically  
23 to Tughans. I'm not terribly keen, as you'll  
24 understand, to try to bring back Dr Webb back in again,  
25 but we will need some explanation for that statement if

1 MR McALINDEN: Yes.  
2 MR McCREA: Mr Chairman, that's not correct. I think it was  
3 measured on two occasions. The second occasion may have  
4 been at the admission to PICU or thereabouts.  
5 THE CHAIRMAN: We'll check that. Thank you, Mr McCREA.  
6 Later on, it was measured at 129. We'll double-check  
7 whether it was 121. Okay?  
8 The second issue -- and the reason I was looking for  
9 Dr Webb's representatives -- is this: if you then go on  
10 to 139-166-001 and 002, you'll see this is a letter,  
11 a further letter from Mr Daly, again to Mr Walby, and it  
12 talks about who's going to give evidence at the inquest  
13 on the following day.  
14 If you go to the second page, the third paragraph  
15 up:  
16 "Dr Webb is also of the view that the family were  
17 fully aware of the extent of the deceased's illness."  
18 When Dr Webb gave evidence here on 3 December he  
19 said -- and this was about the fact that he had seen  
20 Claire at about 5 o'clock and had then left the  
21 hospital:  
22 "Certainly, if I thought that Claire was going to  
23 get worse, I would have conveyed that to Mr and  
24 Mrs Roberts, but my expectation, as I've said, was that  
25 Claire was going to respond to treatment and that she

1 that's the impression and understanding which had been  
2 picked up by the Trust solicitor immediately before the  
3 inquest.  
4 MR McALINDEN: Mr Chairman, could I refer you back to the  
5 sodium readings? The comment that I previously was made  
6 in relation to the period prior to her admission to  
7 PICU.  
8 THE CHAIRMAN: Okay.  
9 MR McALINDEN: If you look at 090-057-207, you'll see  
10 a number of sodium readings at the top of the page.  
11 That might well be the information that was contained  
12 in that letter.  
13 THE CHAIRMAN: Okay. 121.6 and then 121?  
14 MR McALINDEN: Yes.  
15 THE CHAIRMAN: Thank you very much.  
16 MR McALINDEN: Certainly prior to the deterioration, there  
17 seems to have been only one 121 reading, and that would  
18 have been the 11.30 one.  
19 THE CHAIRMAN: Let me get that. What file is that, 090?  
20 MR McALINDEN: 090-057-207. It's the intensive care  
21 records.  
22 THE CHAIRMAN: I can't quite make out on that copy,  
23 Mr McAlinden, what the timing is of the second ...  
24 MR McALINDEN: If you look at the previous page, it's  
25 a continuation on from the previous page, so the timing

1 is in the bottom column of 090-057-206.

2 THE CHAIRMAN: Okay. Thank you very much.

3 MR McCREA: Mr Chairman, if you also look at 090-022-056 and

4 the following page, 057, you get the results taken at

5 9.30 and received at 11.30 pm on the 22nd. If you turn

6 over the page, in the margin, what you have is another

7 set of results.

8 THE CHAIRMAN: 4 am.

9 MR McCREA: And I think you have 4 am, and then below that

10 at 3 am. Then below that again, you have another set of

11 results among which are the sodium, which is in the

12 middle of those results, "Na 121".

13 THE CHAIRMAN: So that's a fresh reading?

14 MR McCREA: It's a fresh reading because the potassium at

15 11.30 is different from that. So it's another reading.

16 When it was taken, we don't know, but it's simply

17 a measurement of 121.

18 THE CHAIRMAN: Thank you.

19 MR FORTUNE: Sir, if I could just ask a question apropos the

20 documents we were handed this morning. In looking

21 through them, there seem to be three pairs of letters.

22 In each case, there is a letter that certainly does not

23 bear the stamp of the Royal Hospitals litigation

24 management. And in two cases, the letters do. Are

25 these supposed to be file copies? How does it work? If

1 I take you through the letter, 139-159-001 and

2 139-160-001, the two letters are what should be the

3 16 June, no stamp.

4 THE CHAIRMAN: I think if you pause there, the difference

5 between 159 and 160 is that 159 is a signed letter.

6 MR FORTUNE: It's also dated, sir.

7 THE CHAIRMAN: Yes. That's a signed copy which has gone

8 from Mr Walby to Mr Daly so that the 160, one might

9 guess, is a file copy.

10 MR FORTUNE: Well, then, 164 and 165 are both signed, both

11 dated, and the former, 164, bears the stamp of the Royal

12 Hospitals litigation management. Then the same appears

13 at 166.

14 THE CHAIRMAN: Just before you go on, let's compare 164 and

15 165. 164 is the document which we originally were

16 advised yesterday was the one in respect of which

17 privilege would be waived. I think we'll come to it

18 during the evidence, but I think, Mr McAlinden, that's

19 because Mr Walby wants to refer to the note on it, the

20 handwritten note; is that right?

21 MR McALINDEN: Yes.

22 THE CHAIRMAN: So the difference between 164 and 165 is that

23 about halfway down on the right-hand side, there's the

24 handwritten date "4/5/06". And then on the one above it

25 and the other one below it, there's a signature, and

1 then there's the hospital stamp. Can you help us,

2 Mr McAlinden? This is the coroner's file.

3 MR FORTUNE: If that's right, sir, then what is the copy

4 letter in each case doing in the coroner's investigation

5 file, unless of course it's litigation management's file

6 named as the coroner's investigation file?

7 THE CHAIRMAN: This comes from the Mallusk inspection,

8 doesn't it? This is from Brangam Bagnall.

9 MR McALINDEN: My understanding is that it's not. These are

10 Royal documents that were in the litigation office.

11 THE CHAIRMAN: Okay. So the letters come in from Mr Daly

12 and it's stamped on one version at 164. I think your

13 query, Mr Fortune, is that it's not stamped on the other

14 version at 165.

15 MR McALINDEN: I think Mr Walby will be able to explain why

16 there are two copies of letters in the file. In some

17 cases it may be that the letters were first of all faxed

18 to the litigation office and then a hard copy posted.

19 That could be one explanation. But I think Mr Walby

20 will be able to explain why there are two copies of each

21 letter.

22 THE CHAIRMAN: Okay.

23 MR FORTUNE: Sir, bearing in mind that we've only just been

24 presented with these letters, through you, could we

25 establish whether legal professional privilege is still

1 claimed for any other documents? Because it seems to us

2 that if privilege is claimed for any document, then

3 that's one thing, but if privilege is waived for

4 a document, privilege is waived completely. And I see

5 my learned friend Mr Stewart would nod in agreement.

6 Is there anything being withheld that might be

7 material, bearing in mind that the purpose for which

8 privilege is now waived is to enable Mr Walby to give

9 evidence about the handwritten entry on 164?

10 THE CHAIRMAN: Well, I think what has now happened simply

11 is that the privilege has been waived in relation to

12 this file. I'll need to go back and check. Do you know

13 off the top of your head, Mr McAlinden? There must be

14 some other claim for privilege.

15 MR McALINDEN: As far as I'm aware, this was the only file

16 in which legal professional privilege has been claimed.

17 There are other documents that were not provided on the

18 basis of relevance in other files.

19 THE CHAIRMAN: That's right, there were.

20 MR McALINDEN: Certainly, in relation to legal professional

21 privilege, it was only sought to claim legal

22 professional privilege in relation to the contents of

23 this file and all the documents in the file as

24 I explained yesterday. I'm not sure if Mr Fortune was

25 here at the time, but as I explained yesterday, all the

1 documents for which it was previously claimed have been  
2 provided.  
3 MR FORTUNE: I'm grateful for that because my concern was  
4 clearly that any document that has so far formed the  
5 basis of questions to Professor Young might, of course,  
6 provide the basis for questions to Dr Steen.  
7 THE CHAIRMAN: Yes. Okay. Thank you very much.  
8 Mr Stewart?  
9 MR STEWART: Thank you, sir. Dr Elaine Hicks, please.  
10 DR ELAINE HICKS (called)  
11 Questions from MR STEWART  
12 THE CHAIRMAN: Just before you start, I have just been  
13 handed a note that there is an extant claim for  
14 privilege for some documents in file 140. Let's deal  
15 with Dr Hicks' evidence and then we can look at that.  
16 MR STEWART: Good morning.  
17 A. Good morning.  
18 Q. Doctor, you've been kind enough to give us two witness  
19 statements: WS244/1 in Adam Strain's case and WS264/1 in  
20 Claire Roberts' case. Are you content that those  
21 statements should be adopted in this inquiry as your  
22 formal evidence?  
23 A. I am.  
24 Q. Thank you. You have also forwarded to us a copy of your  
25 CV. That's at 311-013-001. This sets out your

1 THE CHAIRMAN: [Inaudible: no microphone]. Doctor, the  
2 reason why this has arisen is, when Professor Young gave  
3 evidence yesterday, this records the amount of fluid  
4 being given intravenously to Claire at about midnight  
5 and 1 am on 22 and 23 October; okay?  
6 A. Yes.  
7 THE CHAIRMAN: What had happened was Dr Stewart had been  
8 called to see her at between 11 and 11.30, and he has  
9 prepared a note on that. If we could bring this note up  
10 side by side, please. It's 090-022-056.  
11 You'll see there that this is his note at the top of  
12 the page, 22 October, 11.30, where he'd been called to  
13 see Claire. He thinks actually he was called because  
14 a result had come back showing how much phenytoin was in  
15 her system. But at the same time, he was given a sodium  
16 reading of 121 and that led him to make the entry about:  
17 "Hyponatraemia, query fluid overload with low-sodium  
18 fluids, query SIADH."  
19 And he then has:  
20 "Query need for increase in the sodium content in  
21 fluids."  
22 I think the next entry in effect means he spoke to  
23 the registrar:  
24 "Reduced the fluids to two-third of the present  
25 value, send urine for osmolality."

1 employment history and your medical education.  
2 Can I ask a question of you -- I don't mean to  
3 surprise you, but it's a question that arose from the  
4 evidence of Professor Young given yesterday in relation  
5 to a fluid balance chart entry. I don't mean to bounce  
6 you, I wanted to simply ask you for what you interpret  
7 an entry to mean. It's at page 090-038-135.  
8 Do you recognise this format of fluid balance and IV  
9 prescription sheet?  
10 A. Yes.  
11 Q. Can I take you down the left hand amount column in the  
12 IV intake side, and do you see three entries from the  
13 bottom, timed at 2400 hours, "1037" and, just  
14 immediately after the number, there is what appears to  
15 be a small "H"; do you see that?  
16 A. Yes.  
17 Q. How would you interpret that little symbol, that H?  
18 A. I'm not sure. A symbol like that can, on occasion, be  
19 used to indicate discontinuation --  
20 Q. Yes.  
21 A. -- of fluid or of whatever is in the column.  
22 Q. And why would an H indicate discontinuance?  
23 A. I'm not sure whether it is an H or whether it's usually  
24 a longer line with two shorter lines at the end.  
25 Q. All right. Very well. Thank you.

1 Okay?  
2 A. Yes.  
3 THE CHAIRMAN: The registrar was Dr Bartholome, as you may  
4 know, and the idea was that she would hurry along as  
5 soon as she possibly could to see Claire, but  
6 unfortunately she wasn't able to see her for the next  
7 few hours, and Dr Stewart did not return. So on that  
8 plan, which we had understood until Professor Young  
9 picked up the point yesterday, the fluids were reduced,  
10 but not stopped, and there was a query about whether the  
11 type of fluid should be changed to have one with more  
12 saline in it.  
13 What's then curious is that on the note on the  
14 left-hand side of the screen in front of you, if this  
15 record is right, she received no fluid between midnight  
16 and 1 am, and you'll see how the 1,037 reading stands  
17 between midnight and 1 am. But that was not as a result  
18 of any action which we're aware of from any doctor. It  
19 wasn't as a result of what Dr Stewart said and it can't  
20 be as a result of what Dr Bartholome said because she  
21 didn't see her.  
22 So if it's right -- and Professor Young was  
23 speculating a bit yesterday by querying whether the H  
24 meant "halt" and he was suggesting, in context, that's  
25 what it might mean because the total fluid administered

1 does not increase between midnight and 1 am, so on the  
2 face of it, it's at least a sensible guess at what  
3 happened.  
4 But if neither of the doctors did it, then  
5 presumably the only other person who could have stopped  
6 the fluid would have been a nurse. We've heard evidence  
7 from some of the nurses. They weren't specifically  
8 asked about this, but there is no note to say that they  
9 stopped the fluid. Accepting records are imperfect, if  
10 a nurse did stop fluid being administered, that is  
11 something that you would expect a note on, isn't it?  
12 A. You would expect, sorry?  
13 THE CHAIRMAN: That there would be an entry or note to that  
14 effect in the records.  
15 A. I would normally, yes.  
16 THE CHAIRMAN: On the other hand, the fact that the reading  
17 is 1,037 at midnight and again at 1 am would support  
18 Professor Young's theory that it was stopped, but by who  
19 and for what reason, we don't know. The other curious  
20 thing is it was stopped and then started again. So who  
21 decided to stop it if it was stopped and then who  
22 decided to start it again if it was started again? It  
23 doesn't really make sense, does it?  
24 A. Well, I can't explain it.  
25 THE CHAIRMAN: Well, there are two points. The H might mean

13

1 "halt", but not necessarily so. That isn't necessarily  
2 the indicator you'd expect to find in the records to  
3 show that a fluid was stopped, is it?  
4 A. I can't ... I'm afraid I can't recall what would  
5 happen. There would normally be a note somewhere to say  
6 that fluid was to be stopped.  
7 THE CHAIRMAN: Yes. And I think your other point was that  
8 you weren't sure if that was actually an H at all.  
9 A. Yes.  
10 THE CHAIRMAN: Because if it is an H, it is rather broad and  
11 short.  
12 A. Yes.  
13 THE CHAIRMAN: Thank you.  
14 MR McALINDEN: I have taken preliminary instructions on that  
15 point. It would appear that the symbol that's been  
16 used -- there are two short vertical lines and then  
17 a long horizontal line between them. My preliminary  
18 instructions from senior nursing staff in the Trust  
19 is that that is an indication of discontinuation. And  
20 I have instructed the Trust to provide a statement to  
21 the inquiry from a senior nursing person, indicating the  
22 abbreviation used and what it was meant to describe.  
23 THE CHAIRMAN: Okay. Well, that's a start, Mr McAlinden,  
24 thank you. We might have to revisit this with the  
25 particular nurses.

14

1 MR McALINDEN: Yes.  
2 THE CHAIRMAN: We'll come back to that in due course.  
3 MR STEWART: Doctor, back to your CV. You were, in 1996,  
4 the clinical lead for the paediatric directorate.  
5 A. I took that on on 1 October 1996, yes.  
6 Q. That in essence means that you're leading the Children's  
7 Hospital.  
8 A. It means the paediatric directorate, which is not  
9 exactly the same as the whole of the Children's  
10 Hospital.  
11 Q. Explain the difference, please.  
12 A. The Royal Hospital, at this stage, was managed by  
13 a directorate system and there were a number of  
14 directorates which were made up of, to some extent,  
15 areas such as the Children's Hospital, but more likely  
16 around, if you like, medical or surgical specialties.  
17 For example, there was a medical directorate, surgical  
18 directorate, a neurosciences directorate. Paediatrics  
19 covered most of what was carried out in the Children's  
20 Hospital, but not all the consultant staff were, if you  
21 like, managed directly by the paediatric directorate.  
22 Q. Would ATICS, the theatre and intensive care staff, have  
23 been outside the --  
24 A. The consultant anaesthetists were managed through the  
25 ATICS directorate.

15

1 Q. But to all intents and purposes you were directing most  
2 of the operations of the Children's Hospital?  
3 A. Yes.  
4 Q. Were you in post as clinical lead in the paediatric  
5 directorate in 2004?  
6 A. No.  
7 Q. Who was in late 2004?  
8 A. I believe that Dr Heather Steen took over.  
9 Q. Dr Steen?  
10 A. Yes. I can't remember at what stage she took over.  
11 Q. Would it have been the beginning of the year or the  
12 middle of the year?  
13 A. I don't know. I ceased at the end of -- I believe, at  
14 the end of March 2002.  
15 Q. Thank you.  
16 THE CHAIRMAN: And did Dr Steen take over from you  
17 straightaway?  
18 A. I think not, but I can't remember exactly.  
19 THE CHAIRMAN: But at some point, and if not immediately  
20 afterwards, reasonably soon afterwards?  
21 A. I think so, but I can't be certain of the date.  
22 THE CHAIRMAN: I presume it's a post that the Trust would  
23 not want to leave empty for too long. It does have some  
24 responsibilities attached to it.  
25 A. Quite.

16

1 THE CHAIRMAN: Thank you.

2 MR STEWART: The medical notes and records from Claire

3 indicate that you, in fact, treated her in your practice

4 as a neurologist in 1991. I don't suppose you retain

5 any memory of that, do you?

6 A. No, I'm afraid not.

7 Q. Do you remember the case of Adam Strain?

8 A. I know about it now. At the time, I knew very little

9 about it. I think I may have been aware that a child

10 had died following renal transplant surgery. I didn't

11 know the circumstances of the case or the details.

12 Q. How long before you assumed duties as clinical lead did

13 you know that you were going to take up the post?

14 A. I suppose -- well, I was interviewed and I was in formal

15 roles for some months beforehand.

16 Q. So you were sort of director-in-waiting for a period?

17 A. Well, yes. I mean, I think my interview was quite close

18 to the time before I took up the post. I can't remember

19 exactly.

20 Q. Do you remember hearing of the inquest into

21 Adam Strain's death in June 1996?

22 A. I have no memory of that at all.

23 Q. After that inquest, Dr Murnaghan and Dr Carson

24 considered convening a seminar to discuss issues arising

25 out of Adam Strain's case in totality. Was it ever

17

1 getting around. Did you not view it at the time?

2 A. I can't remember the circumstances under which I saw it.

3 I didn't see the original broadcast, but I did see it

4 subsequently.

5 Q. The day or so after it was broadcast, Mr Roberts

6 telephoned the Royal and they were put into contact with

7 Dr Rooney, who was deployed to contact them and liaise

8 with them. She told them that the case, Claire's

9 medical notes and records, would be reviewed, and

10 Mr Roberts remembers that your name was mentioned as

11 somebody who would take part in that review of the case

12 notes.

13 A. I've had no part in that at all. I wasn't involved.

14 Q. That appears in his witness statement WS253/1, page 18.

15 It's paragraph (c), half way down:

16 "She informed me that Dr Steen, Dr Webb, Dr Hicks

17 and Dr Sands would carry out the review and a meeting

18 would be arranged in two or three weeks time."

19 Do you know why Dr Rooney might have said such

20 a thing?

21 A. Well, presumably she believed that that might happen.

22 Q. And was there any reason why she might hold such

23 a belief?

24 A. I'm not -- I don't know why she would have included my

25 name there, other than that I was clinical director

19

1 mentioned to you?

2 A. I don't believe so.

3 Q. Do you have any recollection of hearing anything about

4 it?

5 A. No.

6 Q. Because your name appears on a list, you probably are

7 aware of this, of people who should be contacted as soon

8 as possible in relation to setting up this meeting.

9 A. I understand that. I've seen that on the inquiry

10 website. But I had no knowledge of it prior to seeing

11 it there.

12 Q. At that time in 1996, did you know anything about

13 hyponatraemia? Had you read the paper, the Arieff et al

14 paper that's been referred to?

15 A. I knew about hyponatraemia. I can't recall whether

16 I knew of the Arieff paper.

17 Q. When UTV came to broadcast their programme

18 in October 2004, did you see it at that time?

19 A. I didn't see it initially, no.

20 Q. Did you see it soon afterwards, was there a recording?

21 A. I saw it subsequently. I can't remember when I saw it.

22 Q. It must have been talked about a great deal in the

23 hospital.

24 A. It was the subject of discussion, yes.

25 Q. I'm sure. I'm sure there were copies, tapes of it

18

1 at the time that Claire died.

2 Q. And you're a consultant neurologist.

3 A. Yes. I'm not sure whether she would have determined

4 that or who would have.

5 Q. In 1996, did you have responsibility for ensuring

6 nursing staffing levels?

7 A. Yes, that was part of the directorate, paediatric

8 directorate.

9 Q. Did you have responsibility for appraising the

10 performance of nurse managers?

11 A. I can't recall whether that was ... I can't recall

12 doing that.

13 Q. Okay.

14 A. I think the directorate manager would have ... They

15 answered to him, so I think he would have been

16 responsible for that.

17 Q. I see. It was the director of nursing, Miss Duffin, who

18 told us yesterday that she wasn't responsible for

19 appraising nurse managers, so that's why the question is

20 posed to you. Would you have been responsible then for

21 the managers who were appraising the nurse managers?

22 A. Yes.

23 Q. And would you have appraised their performance?

24 A. Yes. I'm not sure whether the word "appraisal" was used

25 in 1996, but there would have been a performance review.

20

1 Q. How often would you have conducted a performance review?  
2 A. Once a year, I think.  
3 Q. And which members of staff would have their performance  
4 reviewed by you?  
5 A. The directorate manager.  
6 Q. And anybody else?  
7 A. At that stage, no. Later on, towards 2000, then the  
8 consultant staff in the paediatric directorate had an  
9 annual appraisal.  
10 Q. Was the annual appraisal just a spot-check and a comment  
11 made at one time of the year or did it take into account  
12 a monitoring that had been performed throughout the  
13 year?  
14 A. There was a performance monitoring system in the Royal  
15 called an accountability review, where the directorates  
16 were ... And I think that occurred twice yearly.  
17 I can't exactly remember the details, but we gave  
18 account to the team from the executive: the medical  
19 director, the director of finance, and maybe another  
20 director. So the directorate manager and I, along with  
21 the directorate accountant, would attend that.  
22 Q. Were these meetings minuted?  
23 A. Yes. Well, they were minuted along -- yes, I think they  
24 must have been.  
25 Q. And the performance reviews that you conducted annually

21

1 Q. Did it cause any concern for you at the time?  
2 A. At times it did cause concern.  
3 Q. What was the concern?  
4 A. Well, the concern was that we should maintain a safe  
5 service at all times and that we had sufficient,  
6 appropriately-trained staff to --  
7 Q. Is there an implication in what you say that at times  
8 the service was not safe and that risk was posed?  
9 A. No, I think what I'm saying is that we constantly worked  
10 to monitor the situation so that the service was safe.  
11 Q. Did you have responsibility for the budget?  
12 A. I did.  
13 Q. And was the staffing provided for from the budget that  
14 you had responsibility for?  
15 A. Mostly, yes.  
16 Q. Did you have to go begging annually for your budget?  
17 A. For, sorry?  
18 Q. Was there an annual budget review?  
19 A. Yes.  
20 Q. And would you have to make a representation for your  
21 budget at that?  
22 A. Yes.  
23 Q. Were staffing levels something that featured in your  
24 annual pitch?  
25 A. Always.

23

1 for the manager, was that recorded in writing?  
2 A. I think it must have been. I don't recall the details.  
3 Q. Do you remember, in 1996, who the nurse managers were?  
4 Because we've been told that three sisters were acting  
5 up and jointly sharing responsibility of nurse managing.  
6 A. Yes. Sister Surgenor, Sister Jackson and another one.  
7 I'm sorry, I have forgotten the name.  
8 Q. Moneypenny?  
9 A. Yes.  
10 Q. Do you recall which of those sisters had responsibility  
11 for the wards and for Allen Ward specifically?  
12 A. I think Sister Surgenor.  
13 Q. Thank you. Were there, in your recollection, any  
14 changes in the clinical governance pertaining to the  
15 Children's Hospital between October/November 1995  
16 and October 1996?  
17 A. I don't recall any specific changes in that time.  
18 Q. Did you have any concerns at that time about staffing  
19 levels and workloads imposed upon staff?  
20 A. I think it's true to say that many, many staff in the  
21 Children's Hospital had very busy workloads and there  
22 was really a continual review of workloads. It was  
23 a core part of the work of the clinical director and the  
24 team at senior medical, junior medical, nurse staffing  
25 level and other staff.

22

1 Q. Always.  
2 THE CHAIRMAN: In that you're always looking for more?  
3 A. Generally speaking, yes.  
4 MR STEWART: Can I refer you to a Children's Hospital  
5 strategy document called "Getting it together" from  
6 1996? The cover page is at WS266/1, page 28. Do you  
7 remember that? It's a rather hazy photocopy.  
8 A. I did, yes.  
9 Q. If we go through to page 51. And I just want to draw  
10 your attention to the first paragraph:  
11 "It was acknowledged that nursing and medical staff  
12 are under considerable pressure of work, but there were  
13 cases where mothers felt that standard of care were  
14 inadequate or insensitive. The first phase of the  
15 redevelopment of the Royal Belfast Hospital for Sick  
16 Children will alleviate some of these problems (see  
17 section 7) but the Trust is concerned that the pressure  
18 on staff has continued to intensify."  
19 Was this a problem that was growing as the years  
20 went on during the course of your directorship?  
21 A. Well, it was continuous, I think, and constant. We  
22 constantly worked with a number of agencies on a number  
23 of fronts to increase and improve the staffing levels.  
24 Q. The sense of that is there was a problem and it was  
25 intensifying, it was getting worse.

24

1 A. One of the things that's happened in, I think, all  
 2 children's hospitals, and certainly in our Children's  
 3 Hospital, was that while the overall number of beds and  
 4 indeed the overall number of admissions to hospital may  
 5 not increase -- and this is alluded to, I think, in  
 6 documents around that time -- the nature of the work  
 7 that is performed changes all the time and that  
 8 particularly happens because of increasing  
 9 specialisation and the increasing complexity of the work  
 10 that is done. So that children, compared to a decade or  
 11 two earlier, would be less likely to be admitted to  
 12 hospital for some conditions, for simple conditions.  
 13 There is much more likely to be more complicated and  
 14 complex work carried out in many, if not all, areas of  
 15 the hospital.

16 THE CHAIRMAN: Which makes it all the more important that  
 17 your staffing levels are increased.

18 A. Yes.

19 THE CHAIRMAN: Because you're dealing with children who are,  
 20 on your broad approach, sicker and need more care?

21 A. Yes.

22 THE CHAIRMAN: Thank you.

23 MR STEWART: The inquiry has received evidence, for example,  
 24 that Dr Bartholome, who was the registrar on duty of the  
 25 evening of 22 October, when Claire's condition was

25

1 "The Royal Hospitals have recently reviewed staffing  
 2 levels and cost pressures within the Royal Belfast  
 3 Hospital for Sick Children on the basis of current  
 4 activity levels and the key conclusions were ..."

5 I wonder can we go through these so you can give  
 6 comment on each of the paragraphs:

7 "Medical staff. Junior medical staff in post exceed  
 8 current funded staffing levels -- a shortfall equivalent  
 9 to at least four whole time equivalent senior house  
 10 officer posts. Given current activity levels, there is  
 11 no scope to reduce the medical staff complement."

12 What do you interpret that to imply?

13 A. All the junior medical staff posts were approved and had  
 14 been approved for training, so there were no new posts  
 15 developed that hadn't gone through the training approval  
 16 and the necessary approvals, if you like. There was  
 17 a funding shortfall and my memory is that when the  
 18 budgets were handed down from boards to hospitals and  
 19 thence to directorates, there was a shortfall in  
 20 a number of places throughout the Royal. I can't  
 21 remember the details, but I do know that the paediatric  
 22 directorate had to work for years to agree and get the  
 23 funding correct for the number of junior medical staff  
 24 posts that we had.

25 Q. Then under "nursing staff", the commentary continues:

27

1 deteriorating, that she was the only registrar on duty  
 2 in the hospital between 5 o'clock that evening and  
 3 4 o'clock the following morning and she had to look  
 4 after 114 patients in 12 wards and was also covering  
 5 casualty. That seems to have imposed upon her a very  
 6 extraordinary workload. Would that have been  
 7 a commonplace occurrence at that time?

8 A. I ... The junior staff posts in children's were all  
 9 approved for training and regularly inspected and there  
 10 was a very frequent need to review and improve staffing  
 11 levels. To say that it was constantly under pressure,  
 12 I think is reasonable. However, the medical registrar  
 13 didn't provide primary cover for absolutely all the beds  
 14 in the hospital. For example, the surgical beds. She  
 15 was there in case there was a crisis in the surgical  
 16 beds. And I would acknowledge that these were  
 17 hard-pressed posts. And in time, the number of staff  
 18 were increased along with recommendations of the  
 19 Royal Colleges, the recognition of the Commissioners,  
 20 the regional task force and junior doctors' hours and so  
 21 on, and we constantly worked to improve that.

22 Q. Yes. If we can move forward to page 54 of this  
 23 document, at paragraph 6.3.3, a discussion ensues  
 24 in relation to funding, but specifically in relation to  
 25 staffing levels. The second paragraph:

26

1 "A review of nurse staffing, current work practices  
 2 and standards of care was recently completed by  
 3 a project team ... The review confirmed that services  
 4 are under-resourced and that an increase of at least  
 5 18.2WTE [whole time equivalent] nursing staff is  
 6 required to sustain service levels."

7 How long did that continue for?

8 A. Well, I'm sure it's still going now.

9 Q. What is meant by "clinical professions"?

10 A. Clinical professions are physiotherapy, occupational  
 11 therapy, clinical psychology. They were managed in  
 12 a separate directorate.

13 Q. When individuals were unable to be at their posts,  
 14 whether nurses, ward sisters or indeed consultants, did  
 15 you have any role in ensuring that cover was provided  
 16 for the wards?

17 A. Yes, I had the overall responsibility for that.

18 Q. How did you discharge that?

19 A. It was discharged by having the nurse managers -- they  
 20 were delegated to look after the nursing complement,  
 21 take responsibility for the nursing complement. We had  
 22 a team of people, really, looking after junior doctors.  
 23 There was a specific management-appointed or  
 24 directorate-appointed consultant, as well as an  
 25 administration -- a person from administration. Also

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1 junior staff representatives and representatives of the  
2 approving colleges who made up a subcommittee, and they  
3 took responsibility for overseeing the junior medical  
4 staff cover.

5 Q. Dr Steen made reference to a consultant-led service  
6 within the Children's Hospital at the time, which  
7 I think referred to perhaps her role in ambulatory  
8 paediatrics, out in the community. Was this something  
9 that you were much involved with?

10 A. "Consultant-led service" is a phrase that has become,  
11 I think, core to the NHS over the last -- throughout the  
12 UK, throughout the last several decades. It reflects  
13 the fact that, compared to the past, consultants have  
14 become more and more personally involved in the  
15 day-to-day care of patients --

16 Q. In the community?

17 A. -- than they would have been in the past. In the  
18 community and in hospital. Community paediatrics is  
19 a specialty that has developed really from nothing over  
20 the last perhaps three decades.

21 THE CHAIRMAN: So consultants are more and more involved in  
22 day-to-day care of patients in the hospital and children  
23 in the community than before?

24 A. Yes. I think that's true. I didn't have any  
25 responsibility in the community, obviously, and I never

29

1 Hospitals in 1996. The pharmacy staffing complement for  
2 the Royal Hospitals was the lowest of any tertiary care  
3 teaching hospital in the United Kingdom. Sheffield  
4 Children's Hospital, which is approximately the same  
5 size as Belfast had, I believe, seven clinical  
6 pharmacists."

7 Were you ever trying to get a paediatric pharmacist  
8 for the hospital in the 1990s?

9 A. I can't remember the timing of it, but we did. I mean,  
10 Dr O'Hare's department -- we worked very closely with  
11 them and we certainly, at a later date, did have ward  
12 pharmacists and a much more direct daily presence in the  
13 hospital on the ward.

14 Q. And did those appointments come as a result of a long  
15 campaign by you or others? Was this a problem that you  
16 had to address?

17 A. I really can't recall the details, but ... I can't  
18 remember the details of how that came about.

19 Q. In relation to the other mechanisms of internal control  
20 over the clinical governance at that time, audit,  
21 of course, is one of the main machines. What would have  
22 happened at the mortality section of the paediatric  
23 audit meeting?

24 A. The audit coordinator would determine cases to be  
25 discussed. They would not be detailed on the notice of

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1 worked in the community.

2 THE CHAIRMAN: Is part of the rationale for the community  
3 service that that pre-empts -- are those some of the  
4 conditions or treatments which mean that children don't  
5 need to be admitted to hospital?

6 A. That's one of the reasons.

7 THE CHAIRMAN: Thank you.

8 MR STEWART: Can we go back to the page on the screen, back  
9 to the "clinical professions" again, which says:

10 "A shortfall in staffing across the range of  
11 clinical professions continues to inhibit the provision  
12 of comprehensive assessment, treatment and  
13 rehabilitation."

14 Would paediatric pharmacists come under the umbrella  
15 of the term "clinical professions"?

16 A. I suppose in a way they would, but I'm not sure whether  
17 they were included -- specifically included there.

18 Q. I'm sorry?

19 A. I'm not sure whether this definitely refers to them.  
20 But they --

21 Q. I ask because Dr Sean O'Hare, who was previously head of  
22 pharmacy at the Royal, gave a statement to the inquiry  
23 at WS295/1, page 4, where at paragraph (j) towards the  
24 bottom of the page he says:

25 "There were no paediatric pharmacists in the Royal

30

1 the meeting for confidentiality reasons. The involved  
2 consultant or consultants, however, would be given  
3 notification so that they could prepare a presentation  
4 of the case at the meeting and then, at the meeting, the  
5 cases would be presented and discussed in turn.

6 Q. In terms of attendance, would all the doctors or  
7 clinicians involved in the particular case be there, or  
8 just the lead?

9 A. Usually, you would try to have all of the doctors  
10 involved. That wasn't always possible.

11 Q. Would that be conventionally a cast of six or two or ...

12 A. It varied from case to case.

13 Q. If an autopsy had been performed, would the mortality  
14 meeting take place before or after the report was  
15 available?

16 A. Ideally, it would take place after the autopsy.

17 Q. If it took place before, would it be perhaps adjourned  
18 for further discussion upon receipt of the --

19 A. Possibly, yes.

20 Q. Would such a meeting have been multidisciplinary?

21 A. Multidisciplinary involvement in audit was becoming  
22 a priority at that time, so that it would be encouraged,  
23 so there would be nursing staff and other staff present.

24 Q. And would all aspects of the case and care and records  
25 have been examined or would there have been focus only

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1 on a particular part of it, the cause of death, for  
2 example?

3 A. In general, the details of the case would be presented  
4 and the course of the illness or whatever. The case  
5 notes weren't examined as part of that audit.

6 Q. Were the case notes examined as part of a separate  
7 audit?

8 A. Case note audit was performed as part of the overall  
9 audit programme, but it was generally random selection  
10 of case notes that were audited.

11 Q. Why would a death case not trigger a specific case note  
12 review given that it was a mortality?

13 A. In a way, the consultants that were involved as part of  
14 the process in preparing the presentation would have  
15 reviewed the case notes.

16 Q. Do you remember any audit or mortality meeting or review  
17 of Claire Roberts' case?

18 A. I don't.

19 Q. If such a review had taken place, would there have been  
20 a discussion of the adequacy of the notes?

21 A. There might have been.

22 Q. Would there have been a discussion about the drug  
23 prescription and administration if that was noteworthy?

24 A. Yes, there should have been.

25 Q. Would there have been a discussion of communications

1 perhaps, rather than failings of other doctors.

2 Q. Might that amount to the same thing?

3 A. It might ultimately.

4 Q. Would they be shy about doing that?

5 A. There was a significant reticence to doing that.

6 Q. That's natural, isn't it?

7 A. It is.

8 Q. Was that something that was encouraged?

9 A. To be -- no, increasingly, there was an attitude of  
10 openness in discussing matters where there was  
11 a disagreement.

12 Q. And what would have happened if there had been an  
13 obvious disagreement amongst the clinicians involved in  
14 a case? What would have been the next step after that?

15 A. It would depend on what the disagreement was.

16 Q. But if there was a fundamental difference of view, for  
17 example, as to what had led to the death, would that  
18 have caused or provoked a further investigation to be --

19 A. It could have.

20 Q. And who would have been responsible for making that  
21 decision?

22 A. What one might have expected to happen would be the  
23 person chairing the meeting, who was normally the audit  
24 coordinator, would bring that to the attention of the  
25 relevant people -- perhaps the clinical director, if

1 between clinicians and parents?

2 A. If that was an issue, yes.

3 Q. If the care plan was in some sense deficient, would that  
4 have caused a discussion?

5 A. You mean the medical care plan or the nursing care plan?

6 Q. Nursing care plan or medical care plan.

7 A. Yes. The management ... I mean, I'm not sure at that  
8 stage -- I'm not sure whether at any stage in clinical  
9 audit meetings we discussed nursing care plans in huge  
10 detail.

11 Q. If for example there was a query between or a difference  
12 between the content of a medical certificate of cause of  
13 death and the diagnosis recorded or there was  
14 a difference apparent between the autopsy report  
15 findings and the conclusion of the surgeon in the notes,  
16 would that have been the subject of debate?

17 A. I would have expected so.

18 Q. Would it have been the subject of quite intense and  
19 heated debate or would it have been a leisurely  
20 discussion?

21 A. No, I think if there was -- it would have been the  
22 source of possibly quite intense discussion.

23 Q. On occasions, would doctors point out the failings of  
24 other doctors in such a meeting?

25 A. Well, they would point out discrepancies in care,

1 that was the circumstance.

2 Q. And if such a debate had occurred, presumably, at the  
3 end of it, people would try to draw the strands together  
4 and crystallise lessons to be learnt?

5 A. Yes.

6 Q. Were those lessons ever recorded anywhere?

7 A. I don't think there was a formal -- at that stage,  
8 certainly, there was a formal system for doing that.

9 THE CHAIRMAN: Well, how do we know if any lesson is learnt?

10 Accepting that there's no formal record, what do we look  
11 for to see if any lesson is learnt?

12 A. Um ... I suppose examples of circumstances where  
13 a problem had been highlighted. I'm not sure I can  
14 answer your question.

15 THE CHAIRMAN: That's rather the problem, isn't it?

16 Mr Fortune?

17 MR FORTUNE: Two matters, one I should have raised earlier.  
18 Let me deal with the second matter first.

19 Does it matter whether there was a formal or an  
20 informal record? Because so far, we've been told -- and  
21 we'll hear from Dr McKaigue that he remembers  
22 a mortality meeting relating to Claire Roberts -- that  
23 there's no record at any stage. That was true in Adam's  
24 case as well.

25 The other matter, it's at the bottom of page 25 of

1 today's [draft] transcript. My learned friend  
2 Mr Stewart asked Dr Hicks a very straightforward  
3 question:  
4 "Was it a daily occurrence that the registrar ran  
5 the hospital at night?"  
6 It's a matter for you whether you thought there was  
7 a straightforward answer. It could or should have been  
8 a "yes" or a "no". The bottom of page 25, top of  
9 page 26.  
10 THE CHAIRMAN: Yes.  
11 MR FORTUNE: Would you wish to press for a short answer?  
12 THE CHAIRMAN: Let me go back on that.  
13 Doctor, the question that was asked to you when  
14 Mr Stewart was talking about Dr Bartholome, she was on  
15 duty on 22 October and then through the night of the  
16 22nd into the morning of the 23rd as the registrar on  
17 duty. He suggested that that would have imposed a very  
18 extraordinary workload on her:  
19 "Would that have been a commonplace occurrence at  
20 that time?"  
21 And you answered by reference to the fact that there  
22 were junior staff posts and that the registrar didn't  
23 provide primary cover for absolutely all the beds.  
24 But it was, wasn't it, a commonplace occurrence for  
25 somebody like Dr Bartholome to be the registrar on duty,

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1 Dr Bartholome, as far as we can make out, and they have  
2 some discussion, as a result of which he reduces the  
3 volume of fluid, but there's some debate between them  
4 about whether he should change the type of fluid.  
5 In any event, he leaves it on the basis that he  
6 understands from her that she will be along to see  
7 Claire as soon as she possibly can. And when Claire has  
8 an arrest at approximately 3 am, Dr Bartholome has not  
9 been able to get to Claire for the previous  
10 three-and-a-half hours. I don't believe for one second  
11 that Dr Bartholome was taking it easy or doing something  
12 she shouldn't have been doing, but she does not appear  
13 to have had the time in that evening to go back and  
14 Dr Stewart didn't get back to her. You can't possibly  
15 think that that's acceptable.  
16 A. Well, it's not acceptable that nothing happened.  
17 THE CHAIRMAN: No, but as a matter of fact, subject to one  
18 query about fluid, that appears to be what happened in  
19 Claire's case. And if I assume, as I'm inclined to  
20 assume, that the doctors who were there are doing their  
21 best, the only conclusion I can reach, I think, is that  
22 they're doing their best, but they can't look after  
23 Claire because there's so much pressure on them left,  
24 right and centre. This leads on to further issues, but  
25 what astonishes me about this is that this just passed

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1 the only registrar on duty overnight?  
2 A. Yes. On the medical side she was the most senior person  
3 resident at night.  
4 THE CHAIRMAN: We know in this inquiry the previous night it  
5 was Dr O'Hare who had the same workload, which has been  
6 described by a number of witnesses to the inquiry,  
7 witnesses who have experienced it in English hospitals,  
8 but I don't think you need to go to England for this.  
9 They've described this as "extraordinary",  
10 "overwhelming" and "unacceptable". Would you disagree  
11 with them?  
12 A. Could you repeat that, please?  
13 THE CHAIRMAN: Some of the previous witnesses who have given  
14 evidence over the last few weeks have described this  
15 burden being carried on the Monday/Tuesday, by  
16 Dr O'Hare, and Tuesday/Wednesday, by Dr Bartholome,  
17 they've described it in different terms, but they  
18 include "overwhelming" and "unacceptable".  
19 A. I'm not sure that I can ... that I can agree with that  
20 because I don't recall anyone coming to me at the time  
21 to say specifically, "This is overwhelming or  
22 unacceptable".  
23 THE CHAIRMAN: Well, if we take the specific example in  
24 Claire's case, Dr Stewart sees Claire at about 11 or  
25 11.30, she has a sodium reading of 121. He talks to

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1 by everybody in the Royal after Claire's death. As  
2 I understand it, not a single voice was raised after  
3 Claire died to say, "We really can't continue like  
4 this". Is that your understanding too?  
5 A. That's what seems to have happened.  
6 THE CHAIRMAN: Is that remotely acceptable?  
7 A. No.  
8 MR FORTUNE: Sir, even if a voice had been raised, would  
9 senior managers have actually listened and acted upon  
10 it? That's the follow-on question.  
11 MR McALINDEN: If my learned friend wishes to continue in  
12 this vein of making submissions, I think it's important  
13 that it's appreciated that he is representing the  
14 consultant who was in charge of this patient's care.  
15 And it would be very interesting, and I am sure you will  
16 be very interested to hear --  
17 THE CHAIRMAN: I'll surely be coming to Dr Steen about this  
18 on Monday, Mr McAlinden. I accept that there's  
19 a specific point about Dr Steen. I'm more concerned at  
20 the moment about the overall position because I think  
21 what we're going to come to in a few minutes is that  
22 Dr Hicks was not aware of Claire's death. Sorry, let me  
23 take you to that now.  
24 Were you aware of Claire's death?  
25 A. No.

40

1 THE CHAIRMAN: Do you understand how that seems absolutely  
2 extraordinary?  
3 A. I do.  
4 THE CHAIRMAN: Because I'm told -- and I'm sure it's  
5 right -- that actually very few children die in the  
6 hospital. Obviously some children die, but the numbers  
7 of children who die are quite small. There are some  
8 children who are chronically ill and, regrettably,  
9 there's nothing anyone can do to save them, and those  
10 children will die. But the Children's Hospital is the  
11 hospital in Northern Ireland where children have the  
12 best prospect of being saved because it is the regional  
13 centre for this part of the United Kingdom; right?  
14 A. Correct.  
15 THE CHAIRMAN: When a child dies, I am told from Claire's  
16 case and particularly from Adam as case, that it can be  
17 quite a traumatic event for the staff; right?  
18 A. Correct.  
19 THE CHAIRMAN: And despite that happening, I've had a series  
20 of witnesses in Claire's case as well as in Adam's, who  
21 didn't know, can't really remember, heard about it in a  
22 bit of general chit-chat around the hospital and, in  
23 Claire's case, absolutely nothing was done. If you were  
24 Mr and Mrs Roberts sitting here today and you know that  
25 they're only finding out about this because they picked

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1 THE CHAIRMAN: Right. Can you help with that, doctor?  
2 A. The debate can be triggered by anyone in the room if I'm  
3 understanding the question right.  
4 THE CHAIRMAN: Can you give us an example? I don't want  
5 names, but can you give us an example of a debate being  
6 triggered?  
7 A. It's a completely different type of case, but I do  
8 recall a case being presented -- I think it possibly was  
9 a child with meningitis -- and there was an issue about  
10 ambulance transport and the child being taken to another  
11 hospital, which was closer to home, and that delaying  
12 treatment before they arrived at Children's. It was  
13 much later on, by my memory, than this. It triggered  
14 a considerable discussion about how to take that forward  
15 and it was pointed out that maybe that was something  
16 that should be referred on to be discussed regionally  
17 with other hospitals, with the ambulance service.  
18 That's just one example.  
19 MR STEWART: Did that happen?  
20 A. It did.  
21 Q. And therefore, did that leave a paper trail --  
22 A. It should do.  
23 Q. -- of what happened in consequence of the mortality  
24 meeting?  
25 A. Yes.

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1 up from a documentary some concerns, which then  
2 translated into them going to the hospital, things being  
3 opened up sufficiently for an inquest to be held and  
4 then sufficiently for Claire's case to be added to the  
5 inquiry, what confidence would you have in the Health  
6 Service if you were Mr and Mrs Roberts?  
7 A. I understand. Not much.  
8 THE CHAIRMAN: And you had just come into the position of  
9 paediatric lead. If the news of Claire's death doesn't  
10 reach you, it's not going to get very far at all, is it?  
11 A. Yes.  
12 THE CHAIRMAN: Okay. Mr Fortune, was there something else?  
13 MR FORTUNE: No, sir, I'm grateful to my learned friend  
14 Mr McAlinden. I'm well aware of the questions that  
15 Dr Steen may face.  
16 MR UBEROI: Sir, if that matter is concluded, to return to  
17 the matter of the mortality meetings. I wonder  
18 if we might establish with this witness -- she has  
19 talked about how the clinician responsible for the  
20 patient would present the case in the mortality meeting  
21 on the one hand, and on the other she has been asked  
22 hypothetically about debate being triggered and has said  
23 debate could be triggered. Could it be established with  
24 this witness how that debate is to be triggered? Is it  
25 to be triggered by the individual who presents the case?

42

1 Q. I see. Tell me, at the sort of meetings you're  
2 describing, how many doctors would attend?  
3 A. Well ...  
4 Q. Clinicians.  
5 A. All the consultants from -- most of the consultants from  
6 the Children's Hospital. You'll appreciate other  
7 directorates were having audit meetings at the same time  
8 because we had this calendar that most of the  
9 directorates followed whereby the meeting rolled from  
10 one session to another each month, Tuesday morning,  
11 Tuesday afternoon, and so on. And this was because all  
12 elective activity was cancelled at the time of the  
13 meeting, so there were no clinics, there was no elective  
14 surgery.  
15 So most of the junior doctors who were present  
16 in the hospital at that particular time and most of the  
17 consultants --  
18 Q. There'd be 30 people?  
19 A. It could be 30 people.  
20 Q. Who would have the medical notes and records relating to  
21 the child's case that was being discussed? Would they  
22 be circulated or would it be only the clinicians  
23 involved in the case?  
24 A. No, the clinician involved in the case would have them.  
25 Q. Nobody else would have them?

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1 A. Only if there was another consultant involved.

2 Q. In answer to the chairman's questions, you indicated

3 that you hadn't received complaints from registrars or

4 from medical staff about being overburdened with work.

5 Was there an ethos about complaining at that time?

6 Would people complain or would they stoically continue?

7 A. No, there was a system for them to make their views

8 known. When I say "no complaint", I meant I don't

9 recall any specific complaint around that time. But

10 if -- the registrars had an open door to comment, to

11 come to the clinical director, to come to their

12 representative, the consultant that had special

13 responsibility for supervising the junior staff or

14 overseeing them. And that was ongoing.

15 Q. Did that system have documentation attached to it?

16 Would it leave a trace?

17 A. I believe that the minutes of the junior doctors'

18 subcommittee would have been kept in the directorate.

19 Q. In answer to another of the chairman's questions, you

20 indicated that Claire's case was not brought to your

21 attention. Can I ask for WS264/1, page 3, paragraph 6,

22 please?

23 "Would you have expected the death of Claire Roberts

24 to have been brought to your attention? If so, how? If

25 not, how do you explain this? I would not have expected

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1 in the Children's Hospital to assist people?

2 A. I don't recall.

3 Q. So really, it was left to individuals to report

4 themselves or each other?

5 A. Yes.

6 Q. Do you remember the King's Fund --

7 THE CHAIRMAN: Sorry, before you move on.

8 An untoward event. Dr Webb has told the inquiry

9 that he went home after he saw Claire or soon after he

10 saw Claire at about 5 or 5.30 on Tuesday 22 October. He

11 knew that she was unwell, but he expected her to

12 recover; okay? Dr Steen has said that she was out in

13 Cupar Street that afternoon. There was some level of

14 contact between her and the hospital, however that was

15 triggered, as a result of which she understood that it

16 was not necessary for her to return to the hospital to

17 see Claire, or any other child for that matter.

18 So both the consultant who was formally responsible

19 for Claire, Dr Steen, and the consultant who had been

20 intervening to help identify what was wrong with Claire

21 and treat her, Dr Webb, they left work at 5, 5.30, 6,

22 something like that, on Tuesday evening, expecting

23 nothing untoward would happen; okay?

24 They come back into the hospital in the early hours

25 of Wednesday morning at 3 am -- maybe 4 am on Dr Webb's

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1 the death to have been brought to my attention unless it

2 was thought that there had been an untoward event."

3 So you were leaving the reporting of such cases to

4 the judgment of others and on the basis of whether or

5 not they thought there might have been an untoward

6 event?

7 A. Yes.

8 Q. Was there any system for the reporting of untoward

9 events?

10 A. There was.

11 Q. What was that?

12 A. There was a -- well, there was a paper system. At this

13 stage -- it became much more developed later on, but at

14 this stage there was a pro forma held. I can't remember

15 whether it was held at ward level at this stage -- it

16 certainly was later on -- or whether it was held in the

17 administration office. So that could be performed, that

18 could be completed and sent in.

19 I would have expected that people were particularly

20 concerned -- anyone that was particularly concerned

21 could come verbally outside of that.

22 Q. Was any guidance given to staff as to what may or may

23 not constitute an adverse clinical incident?

24 A. I'm not sure that there was at that stage.

25 Q. Were there any published criteria available at that time

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1 case -- to find that, to all intents and purposes,

2 Claire is dead. Entirely unexpected on their parts for

3 a girl who had arrived in on Monday evening with her

4 parents and was dead less than 36 hours later. Does

5 that strike you as something untoward?

6 A. Yes.

7 THE CHAIRMAN: Do you understand or can you help me

8 understand why that would not be regarded as an untoward

9 event?

10 A. I can't understand it.

11 THE CHAIRMAN: Do you understand how either one or both of

12 them, depending on which version I take, took the view

13 that they were sufficiently confident about identifying

14 the cause of Claire's death that it need not be referred

15 to the coroner?

16 A. I don't.

17 THE CHAIRMAN: Or that they advised Mr and Mrs Roberts that

18 it would be sufficient to have a brain-only autopsy?

19 A. I don't.

20 THE CHAIRMAN: Do you understand my problem?

21 A. I do.

22 THE CHAIRMAN: And more particularly, do you understand

23 Mr and Mrs Roberts' problem?

24 A. I do. I appreciate it.

25 THE CHAIRMAN: If their understanding, as they've told the

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1 enquiry, was correct, they should have come back into  
2 the hospital on Wednesday morning and Claire would still  
3 have been there, recovering or not recovering to some  
4 level, and the treatment would have continued. But what  
5 happened just doesn't stand up to any scrutiny at all,  
6 does it?

7 A. No.

8 THE CHAIRMAN: I heard some evidence yesterday and I'm going  
9 to hear more evidence today and tomorrow about what took  
10 place in 2004 and what took place before Claire's  
11 eventual inquest and the activity which, on one view, is  
12 entirely legitimate activity in presenting statements to  
13 the coroner and tweaking statements to the coroner and  
14 making sure that the Trust put its best foot forward  
15 publicly for the inquest. And what is utterly missing  
16 from the evidence is any sign that anybody did anything  
17 internally in 1996 or 1997. Can you help me with that?

18 A. I can't. I don't know.

19 THE CHAIRMAN: And it seems that even after the autopsy  
20 report was provided, which I think was in March 1997,  
21 that that did not provoke any discussion between the  
22 pathologists and the consultants, which, on the evidence  
23 of Dr Herron, would have been worthwhile because, to the  
24 extent that he identified any sign of encephalitis, he  
25 did not identify it as a contributory cause of Claire's

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1 death. But that's not what the parents were being told.  
2 Mr and Mrs Roberts were told something different.

3 So I assume that a discussion between the  
4 pathologists and the consultants would have been helpful  
5 when the autopsy report came through; would that be  
6 fair?

7 A. I think that would be fair.

8 THE CHAIRMAN: Or even if it didn't tell them anything very  
9 much different, a discussion between the pathologists  
10 and the consultants would have been helpful in any event  
11 because of the sudden deterioration and collapse in  
12 Claire's condition, as it appeared to Dr Webb and  
13 Dr Steen; would that be right?

14 A. Yes.

15 THE CHAIRMAN: Well, let me take it on from that. I think  
16 you retired, doctor, in 2007.

17 A. Yes.

18 THE CHAIRMAN: Suppose Claire had died 10 years later,  
19 suppose Claire had died in 2006 instead of 1996. At the  
20 time when you retired or immediately before you retired,  
21 what was different about the system for reporting or  
22 investigating an untoward event?

23 A. I think there was much more awareness of the need for  
24 referrals to the coroner.

25 THE CHAIRMAN: Right.

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1 A. The framework for incident reporting within the Trust  
2 had been strengthened and clinical governance itself had  
3 been implemented so that all of those systems for  
4 detecting errors or mishaps were stronger.

5 THE CHAIRMAN: Correct me if I'm wrong, but I understood  
6 that the trigger for this is still a recognition by the  
7 doctors involved that there is an untoward event.

8 A. That's true.

9 THE CHAIRMAN: So if it wasn't an untoward event in 1996,  
10 why would an equivalent death be an untoward event in  
11 2006?

12 A. Well, because by 2006 there had been more work to  
13 highlight the need to recognise and perhaps acknowledge  
14 mistakes and bring them forward.

15 THE CHAIRMAN: You see, even if it's not a mistake -- let's  
16 suppose that Dr Webb and Dr Steen didn't recognise any  
17 mistakes. When Claire died, they were left with  
18 what was, on their evidence, an entirely unexpected  
19 situation: the fact that Claire had died. Even if  
20 you are not looking to see, "Did we make mistakes?",  
21 you're presumably looking to see, "What can we do better  
22 next time?", or, "If this arises again, how can we go  
23 differently?" Is that right? Taking an issue up isn't  
24 necessarily -- it may be pointing the finger at yourself  
25 a bit or letting other people point the finger at you,

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1 but it is essentially a learning curve, isn't it?

2 A. It should be.

3 THE CHAIRMAN: But the Children's Hospital did have the  
4 procedures in place in 1996 and 1997 for learning from  
5 deaths or from incidents short of death. Maybe a bit  
6 less formal, maybe a bit less developed, but they were  
7 still there.

8 A. Yes.

9 THE CHAIRMAN: They just weren't followed; is that right?

10 A. So it seems.

11 THE CHAIRMAN: Thank you.

12 MR STEWART: That has largely covered the questions I was  
13 going to pose.

14 THE CHAIRMAN: Nothing further?

15 MR STEWART: Nothing further.

16 THE CHAIRMAN: Okay.

17 MR MCCREA: Mr Chairman, a question that might be put to  
18 this witness would be: what does she expect the  
19 consultants themselves to actually do? In this  
20 instance, you have one registrar and two consultants.  
21 A registrar who believes the child, Claire, to be  
22 seriously ill, a consultant who has never seen the  
23 child, and another consultant, depending on which  
24 version you accept, doesn't appreciate how ill the child  
25 is. In those circumstances, would the consultants not

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1 meet with each other and then consider referring the  
2 matter further up the chain, independently of --  
3 THE CHAIRMAN: If we take the two consultants, Dr Steen and  
4 Dr Webb did meet each other in the hospital at about  
5 3 am or 4 am on Wednesday 23rd; isn't that right?  
6 MR McCREA: They did.  
7 THE CHAIRMAN: And whatever discussion they had --  
8 MR McCREA: They chose not to do anything.  
9 THE CHAIRMAN: Ended up with no internal report, no referral  
10 to the coroner and a brain-only autopsy.  
11 MR McCREA: So what would she expect the consultants in 1997  
12 and 2007 to actually do? What should they do?  
13 MR FORTUNE: Sir, before that question is put, it depends on  
14 the factual basis. There's speculation built on  
15 speculation there.  
16 THE CHAIRMAN: Well, I think I understand from Dr Hicks --  
17 and please correct me if this is wrong, doctor, before  
18 you leave the witness box. I think I understand from  
19 you that knowing now what you do know about even the  
20 broader circumstances of Claire's death, you are  
21 surprised that her death was not referred to the coroner  
22 and you are surprised that it was not reported to you.  
23 A. Yes.  
24 THE CHAIRMAN: Okay. Thank you. Anything further?  
25 MR FORTUNE: No, if that's the end of the questioning on my

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1 passing between the same two people, Mr Walby and  
2 Mr Daly. Mr McAlinden?  
3 MR McALINDEN: I did receive a list of ten documents sent by  
4 Ms Dillon to my instructing solicitor in relation to  
5 that issue. Number 1, the exact letter also appears in  
6 both files and that has been disclosed.  
7 THE CHAIRMAN: Okay, thank you.  
8 MR McALINDEN: Number 3, again, it has been disclosed.  
9 THE CHAIRMAN: Thank you.  
10 MR McALINDEN: Number 5 has been disclosed. Number 7 has  
11 been disclosed.  
12 THE CHAIRMAN: Right.  
13 MR McALINDEN: Numbers 8, 9 and 10 relate to legal advice  
14 passing between MSC Daly and the Trust in relation to  
15 the inquiry and a claim for privilege is still  
16 maintained in relation to that.  
17 The other documents on the list, numbers 2, 4 and 6,  
18 they relate to consultation notes between the solicitor  
19 and Dr Webb and Professor Young in relation to number 2;  
20 an attendance note between Mr Daly and Dr Webb, that's  
21 number 4; and a consultation note between  
22 Brangam Bagnall and company and Professor Young, that's  
23 number 6. Those three documents relate to the inquest.  
24 The Trust is prepared to waive privilege in respect  
25 of those, but because they also involve clinicians who

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1 learned friend's question, that's fine.  
2 THE CHAIRMAN: Okay. Mr McAlinden, have you anything?  
3 Doctor, thank you for coming along. Can I make  
4 clear, I'm absolutely not picking on you about what  
5 happened in 1996 and 1997, but, as you'll understand,  
6 I'm very, very worried about a system which was  
7 activated in such a way that you as the paediatric lead  
8 weren't even told about Claire's death.  
9 Thank you very much indeed. We'll break for 10  
10 minutes, ladies and gentlemen.  
11 (11.30 am)  
12 (A short break)  
13 (11.40 am)  
14 Discussion  
15 MR McCREA: Mr Chairman, just before this witness is sworn,  
16 if I could refer back to the issue about privilege and  
17 the waiving of privilege. We've just looked, over the  
18 break, at file 140, which is the Brangam Bagnall file on  
19 Claire Roberts' inquest. Throughout the contents of  
20 that, there are numerous references to letters that  
21 legal professional privilege has been claimed on. The  
22 issue is --  
23 THE CHAIRMAN: And significantly, they're letters at  
24 approximately the same time as some of the letters for  
25 which privilege has been waived and some of them are

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1 have given evidence at the inquiry or are proposed to  
2 give evidence at the inquiry, it would probably be the  
3 case that those clinicians should be asked if they wish  
4 to waive privilege in respect of those before they're  
5 furnished to the inquiry. But certainly, the Trust has  
6 no objection to those documents being provided to you at  
7 this stage.  
8 THE CHAIRMAN: Okay. I'll get this letter copied so that  
9 you all have the references. What Mr McAlinden is  
10 referring to there is: the document 140-036, that's  
11 a consultation note; 140-046, that's in effect  
12 a consultation note, but Dr Webb was on the phone for  
13 that; and document 140-061 is again a consultation note.  
14 So the Trust is no longer claiming privilege. Were the  
15 individuals Trust witnesses at the inquest, being  
16 represented by Trust solicitors?  
17 MR McALINDEN: Yes.  
18 THE CHAIRMAN: So do they have a separate, individual claim  
19 for privilege or do either of us know off the top of our  
20 heads?  
21 MR McALINDEN: There certainly is an argument in relation to  
22 that and the practice so far adopted by the Trust was  
23 that the individuals involved should have some say  
24 before the documentation is provided because they may  
25 well have been under the impression at the time that the

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1 lawyer/client relationship was a personal relationship  
2 between them and the lawyer.  
3 THE CHAIRMAN: We did that for Dr Taylor once before, didn't  
4 we?  
5 MR McALINDEN: Yes.  
6 MR UBEROI: Sir, the situation there was we didn't actually  
7 bottom out the thorny question which you have just  
8 raised because, even if privilege had vested in him as  
9 well, Dr Taylor didn't seek to assert it.  
10 THE CHAIRMAN: Let's see if any of the individuals want to  
11 assert a privilege which the Trust no longer claims.  
12 It would be interesting.  
13 Just for the record, you'll see this letter in the  
14 next half hour, but there are ten documents on file 140  
15 for which privilege was claimed. Four of them duplicate  
16 letters on file 139 for which privilege has been  
17 claimed, so we don't need to worry about those. There  
18 are effectively three consultation notes -- you'll see  
19 them on this list as items 2, 4, 6 -- for which the  
20 Trust waives privilege and there is now a question of  
21 whether the individuals waive privilege. The last  
22 three -- items, 8, 9 and 10 -- are legal advice given by  
23 the Trust's former solicitors, MSC Daly, in relation to  
24 the inquiry itself.  
25 So why don't we park this until lunchtime and we'll

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1 are contactable to see what they say about claiming  
2 privilege which the Trust no longer claims and if they  
3 need to see the documents. Okay, let's leave that until  
4 2 o'clock. Dr Taylor, please.  
5 DR ROBERT TAYLOR (called)  
6 Questions from MR STEWART  
7 MR STEWART: Dr Taylor, you have kindly given us two further  
8 statements in relation to this case, WS157/1 and 2. Are  
9 you content that they be received into evidence as  
10 a formality?  
11 A. Yes.  
12 Q. Thank you. Can I take you back to 1996, June 1996? You  
13 appeared at the inquest into Adam Strain's death and you  
14 had prepared for that with considerable research into  
15 the medical literature surrounding hyponatraemia;  
16 is that correct?  
17 A. I think so, yes.  
18 Q. The result of the inquest, the finding of the coroner,  
19 was something with which you did not agree.  
20 A. Well, I've given previous answers to that. I had some  
21 problems with the mechanism that the coroner had used to  
22 achieve his cause of death. I think that's been well  
23 documented previously. I don't wish to ...  
24 Q. At that time, there was also a medical negligence case  
25 outstanding in relation to Adam Strain's death.

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1 get on with Dr Taylor's evidence?  
2 MR McALINDEN: Just for the sake of completeness,  
3 Mr Chairman, you'll see that your list, 8, 9 and 10  
4 refers to 140-069-078 and 080. There is another  
5 document on file 140, 079, which is not on this list,  
6 but for which legal professional privilege is claimed,  
7 and that is in relation to the inquiry as well.  
8 THE CHAIRMAN: Right. So that's 069, 078, 079 and 080?  
9 MR McALINDEN: Sorry, there's also 072. Again, it's an  
10 inquiry-related piece of advice.  
11 THE CHAIRMAN: Thank you. Okay, we'll come back to that  
12 issue later on. Obviously it's preferable to resolve it  
13 before Mr Walby gives evidence.  
14 MR FORTUNE: Sir, if you're inviting a submission about  
15 whether the individual has a right to claim privilege,  
16 then firstly the witness concerned must see the document  
17 because, otherwise, how is he or she to know whether  
18 there is to be a claim of privilege maintained? At the  
19 moment, all we have are redacted documents.  
20 THE CHAIRMAN: We'll see, Mr Fortune. The individuals  
21 concerned are Dr Webb and Professor Young. There's only  
22 two individuals concerned.  
23 MR FORTUNE: In which case, it doesn't concern Dr Steen.  
24 THE CHAIRMAN: No. The two individuals concerned are Dr  
25 Webb and Professor Young. We'll see how quickly they

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1 A. I wasn't aware of that --  
2 Q. You weren't aware of that?  
3 A. -- until I received a letter from Dr Murnaghan to say it  
4 had been settled.  
5 Q. You weren't informed by Dr Murnaghan that a claim had  
6 been brought?  
7 A. I was given a letter after the claim had been settled.  
8 Q. But you weren't aware that it had been brought in the  
9 immediate aftermath of the initiation of proceedings?  
10 A. I was given a letter to say it had been settled. That's  
11 the only recollection I have of the negligence claim.  
12 THE CHAIRMAN: Is that a case, doctor, in which you were not  
13 named as an individual defendant, but the Trust was  
14 named as the defendant?  
15 A. I'm sorry to repeat my answer, but the only knowledge  
16 I remember of the medical legal case was the letter  
17 I received to say that it had been settled.  
18 THE CHAIRMAN: Thank you.  
19 A. And that's been in evidence, I believe.  
20 THE CHAIRMAN: Yes.  
21 MR STEWART: Does that surprise you now that a case in which  
22 you were involved and which provoked litigation was not  
23 brought to your attention at the time?  
24 A. Yes, I would have liked to have been involved in the  
25 decision, yes.

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1 Q. That surprised you?

2 A. I would like to have been involved in the decision --

3 Q. Okay.

4 A. -- about the case.

5 Q. Can I ask the question a third time: are you surprised

6 that you were not notified of the commencement of legal

7 proceedings?

8 A. I'm not sure I'm happy with the word "surprised" in your

9 question.

10 Q. Puzzled?

11 A. I would have preferred to have been informed of the

12 decision.

13 Q. Did it strike you as odd that you were not?

14 A. Yes.

15 MR FORTUNE: Sir, can I assist in relation to Dr Taylor on

16 this point? If you recall, Professor Savage was not

17 aware there was litigation going on in respect of Adam.

18 He learnt after or at the time of the settlement.

19 THE CHAIRMAN: That doesn't take away from the questioning.

20 It's a point perhaps in passing, but it's a point,

21 however way this litigation is conducted, when the

22 individuals who have been involved in the treatment of

23 a child who dies, the fact is that, on this evidence,

24 they're not informed the Trust is being sued over what

25 happened.

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1 a vast number of years. We know the hyponatraemia

2 working party is established and Dr Taylor is asked to

3 sit on that. If the question is relating to the

4 immediate aftermath of Adam Strain's inquest, I'd be

5 grateful if it could be put in that sphere.

6 MR STEWART: Perhaps I can do just that, but divide it into

7 two parts. Did you actually conduct searches of the

8 medical literature in preparation for and at the time of

9 the inquest?

10 A. I believe so, yes.

11 Q. After the inquest, did you continue that interest and

12 continue your reading of medical literature in all

13 aspects of fluid management?

14 A. Well, I can't remember, but my statement is a statement

15 of a generic knowledge of what a paediatric anaesthetist

16 would know about fluid management. I don't claim to

17 have had specific expertise on hyponatraemia, for

18 instance. I think I was in keeping with my peer group,

19 my colleagues.

20 Q. Would you categorise that as a general awareness?

21 A. I was in keeping with what my job as a paediatric

22 anaesthetist and as a teacher of the aspects of

23 paediatric anaesthesia would involve.

24 Q. You had read the Arieff paper at the time of the

25 inquest, hadn't you?

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1 MR FORTUNE: Yes. I didn't mean to be unhelpful, sir. It

2 is just that it is an extraordinary coincidence that, in

3 two sets of litigation, the clinicians involved do not

4 seem to have been told.

5 MR STEWART: After the inquest, did you maintain your

6 interest in hyponatraemia and reading about it?

7 A. I can't remember.

8 Q. Okay. WS008/1, page 8. This is the penultimate

9 paragraph:

10 "As a consultant in the Royal Belfast Hospital for

11 Sick Children, with my colleagues, I have had the

12 opportunity since 1995 to teach and train junior

13 anaesthetic and paediatric trainee doctors in all

14 aspects of fluid management in children undergoing major

15 surgery. I have maintained my professional knowledge of

16 all aspects of such cases by reading widely on the

17 subject of fluid management and passed on such knowledge

18 in formal and informal teaching sessions."

19 So it looks as though you have at least told us at

20 one stage that you did maintain an interest and

21 maintained a reading interest.

22 MR UBEROI: May I rise to request perhaps that the question

23 is phrased a little more specifically? That answer

24 coming from one of Dr Taylor's earlier witness

25 statements to the inquiry could potentially engage

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1 A. Yes.

2 THE CHAIRMAN: I think, doctor, it must be fair to say that

3 because of the tragic circumstances of Adam's treatment

4 and death, you had a particular interest in

5 hyponatraemia as a direct result of that, didn't you?

6 A. It's hard to remember exactly if my knowledge was more

7 or less than my colleagues' knowledge. I'm not claiming

8 to have been a world expert on hyponatraemia.

9 THE CHAIRMAN: I understand that, but because of what

10 happened with Adam and because of what we've already

11 been through before about the inquest and what was being

12 said about your treatment by the coroner's experts, that

13 prompted you to go into your own research?

14 A. Yes.

15 THE CHAIRMAN: And you had considerable difficulty in

16 accepting Dr Sumner's line of thought and his approach;

17 isn't that right?

18 A. The mechanism, yes.

19 THE CHAIRMAN: So at least in that regard you had read up on

20 hyponatraemia more than you had previously done? How

21 far ahead of your colleagues that puts you is

22 a different matter, but you had unfortunately found out

23 a lot more about it during the previous year than you

24 had done previously.

25 A. I think that's fair.

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1 THE CHAIRMAN: Thank you.

2 MR STEWART: WS157/2, page 4. This is just at question 13:

3 "Did you accept the coroner's findings in the case

4 of Adam Strain? At the time, 1996, I did not agree with

5 the coroner's findings that dilutional hyponatraemia

6 caused his death."

7 And that's the mechanism point to which you refer.

8 A. Yes.

9 Q. Were you smarting a bit after the inquest finding?

10 A. I don't understand what you mean.

11 Q. Did you perceive it to be a professional setback that

12 your view had not prevailed and that Dr Sumner's had?

13 A. No, I think I've said that I was devastated at the death

14 of Adam Strain.

15 Q. I'm asking a different question. Were you smarting from

16 the finding of the coroner?

17 A. I don't think so. I don't recognise that --

18 Q. Did you entertain any feelings that you wished to prove

19 your argument?

20 A. No, I think that ... No.

21 Q. When you were on duty in the intensive care unit on the

22 morning of 23 October 1996, you had to review

23 Claire Roberts' history and make a care plan for her.

24 A. That's correct.

25 Q. To do that, you had to presumably acquaint yourself with

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1 consultant, were from approximately 08.30 to 17.00 on

2 23 October. From my note [that is the note we are just

3 looking at], at around 10 am on the morning of

4 23 October, I had knowledge of her recent medical

5 history, examined her and produced a management plan to

6 prepare to meet the requirements for brainstem

7 testing ..."

8 And so forth. Did you have access to her medical

9 records at that time?

10 A. I would have.

11 Q. Yes.

12 MR UBEROI: I rise again. Dr Taylor's note seems to have

13 disappeared from the screen. Could it be placed back

14 up, please?

15 MR STEWART: Dr McKaigue made a note, which immediately

16 preceded the note you made in the entry; did you read

17 it?

18 A. Well, I can't remember, but I believe I would have, yes.

19 Q. And would you have read any of the entries that preceded

20 Dr McKaigue's entry?

21 A. I can't remember, but bearing in mind it was a busy ward

22 round with potentially -- I can't remember how many, but

23 up to six patients to see, examine and manage in PICU,

24 I would have potentially read the latest entry and the

25 latest summary, which was actually a very -- I believed

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1 her recent medical history.

2 A. In the time I had available on the ward round, I believe

3 I would have -- I believe I had a verbal handover from

4 Dr McKaigue that morning. He was going off duty, having

5 been on the night before, and obviously up the night

6 before. And I believe he gave me a verbal handover and

7 then a summary.

8 MR UBEROI: To assist the witness and perhaps my learned

9 friend, may I suggest the note be put on the screen so

10 the witness has the benefit of it?

11 MR STEWART: Of course. 090-022-061. This is your writing

12 at the top of the screen, the note dated 23 October;

13 is that correct?

14 A. Yes.

15 MR UBEROI: It strikes me in light of the witness's previous

16 answer, perhaps if the previous page could be placed

17 side by side with it. He has referred back to

18 Dr McKaigue and the previous entry is, of course, his.

19 MR STEWART: I wonder if we could just go through what

20 you have said in your witness statements about what you

21 did before we actually examine the note. Because you

22 explained what you did at WS157/1, page 3. 4(a):

23 "Describe in detail your actions in the care and

24 management and treatment of Claire. My actions in the

25 care, management and treatment of Claire, as the PICU

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1 a very complete summary of the recent illness that

2 I referred to.

3 Q. Yes. But it was not the only summary written when

4 Claire was in PICU.

5 A. Sorry?

6 Q. If we go back to 090-022-057, we find that, at 4 am,

7 Dr Steen has written this synopsis and the most recent

8 test results down the left-hand side after her admission

9 into the intensive care unit; would you have read that?

10 A. I can't remember. If Dr McKaigue's note, which it was,

11 was very complete, I may have -- I was on a busy ward

12 round, seeing a patient, taking over her management, and

13 there was clearly quite a bit of management to do with

14 her, to set her up prior to her second set of brainstem

15 tests, which was obviously my duty for her that day.

16 Q. Would you have read what the consultant neurologist had

17 written at 4.40 am in PICU?

18 A. I can't remember what I read. I was on a busy ward

19 round, as I said.

20 Q. Well, might you, in this world of hypotheticals, have

21 read the entries recorded in the notes whilst she was in

22 PICU?

23 A. That would be my usual practice.

24 Q. And if you had pursued your usual practice, you'd have

25 seen that Dr Webb had recorded his diagnosis there:

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1 "SIADH, hyponatraemia, hyposmolality, cerebral  
2 oedema and coning following prolonged epileptic  
3 seizures."  
4 You'd have read that, wouldn't you?  
5 A. Potentially, yes.  
6 Q. In which case, you would have been aware of the  
7 involvement of hyponatraemia in Claire's case as a word,  
8 hyponatraemia, just as you were aware of it as a sodium  
9 reading.  
10 A. I believe so. I believe it was in Dr McKaigue's note as  
11 well.  
12 Q. I'm so sorry?  
13 A. I believe it was mentioned in Dr McKaigue's summary  
14 note.  
15 Q. I'm not sure he used the word "hyponatraemia", but I'll  
16 stand corrected. I wonder if we could look at WS157/2,  
17 page 14, at (c)(viii) at the top and the end comment:  
18 "I was not aware that Claire Roberts' death involved  
19 hyponatraemia until 2012."  
20 Can you explain how you were able to tell the  
21 inquiry you weren't aware that her death involved  
22 hyponatraemia until this year?  
23 MR UBEROI: If I may rise, I'm slightly concerned the  
24 question is put slightly unfairly. The word  
25 "hyponatraemia" has been fished out of medical records,

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1 suggest that it must have struck him from looking back  
2 through the notes when he was on the ward round on that  
3 morning.  
4 THE CHAIRMAN: Maybe it's a question with multiple parts or  
5 a number of questions one after the other about why he  
6 didn't realise or ascertain from the notes at the time  
7 and from what Dr McKaigue had said, at a very thorough  
8 handover, that hyponatraemia may have played a part.  
9 MR STEWART: On that basis, Dr Taylor, it seems to me that  
10 Dr Webb's note at 090-022-057 links as almost  
11 a sequence:  
12 "SIADH, hyponatraemia, hyposmolality, cerebral  
13 oedema and coning following prolonged epileptic  
14 seizures."  
15 It's almost an encapsulation of death and the causes  
16 of it.  
17 A. What was the question? Is there a question, sorry?  
18 Q. From that, would it not be reasonable to conclude that  
19 hyponatraemia might be implicated in the death?  
20 A. Well, if I can go back to my statement that you showed  
21 a few minutes ago, the reference to 2012.  
22 Q. Yes, of course. WS157/2, page 14.  
23 A. Why I put that as an answer to that particular question,  
24 which was actually about my presentation to the --  
25 presentation of the hyponatraemia working party, was

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1 which also mention other word such as "encephalitis",  
2 "status epilepticus", and hyponatraemia can be present  
3 without causing death. So I'm slightly concerned the  
4 impression is being given that the notes rather point to  
5 hyponatraemia when, in fact, they don't.  
6 THE CHAIRMAN: Sorry, apart from the notes in 1996, we have  
7 the referral of Claire's case to the coroner in 2004,  
8 we have the referral to the inquiry after the inquest,  
9 and I have to say, Mr Uberoi, I'm taken aback that  
10 Dr Taylor, both from his knowledge of Adam's case and  
11 from his continued working in the Royal, has told the  
12 inquiry that he didn't know that Claire's death involved  
13 hyponatraemia until 2012.  
14 I'll broaden the question out beyond Dr McKaigue's  
15 note, if you want, but it's a matter for you. That may  
16 make the question more difficult for Dr Taylor to answer  
17 as to how he didn't know there was any involvement of  
18 hyponatraemia until this year.  
19 MR UBEROI: No, sir, I think my point really chimes with the  
20 observations that you have just made, where I can  
21 entirely understand if Dr Taylor is to be asked about  
22 Claire Roberts governance, about the systems that were  
23 in place and how it could be that, through any systems  
24 which were in place, this information didn't reach him.  
25 That's one matter, but it is a separate matter to

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1 that was the first time, actually this year, that I had  
2 read the coroner's inquest, which was done in 2004, and  
3 the cause of death that he had written down on the death  
4 certificate, which involved hyponatraemia. Prior to  
5 that, I wasn't aware of the use of the word or the cause  
6 of death in the death certification process as being due  
7 to hyponatraemia.  
8 Q. Are you trying to make the very, very subtle distinction  
9 between not knowing what the coroner had found and not  
10 understanding what you had read?  
11 A. Sorry, I don't understand what you're saying.  
12 Q. When you read Dr Webb's entry, if you did, and it would  
13 have been your usual practice, what did you understand  
14 that to mean?  
15 A. I can't remember reading it and I can't remember what  
16 I understood it to have meant. But there was clearly  
17 a diagnosis going on of encephalitis/encephalopathy with  
18 Claire, and at that time --  
19 Q. Sorry, let's go back to 090 --  
20 MR UBEROI: Could the witness be allowed to finish his  
21 answers at all times, please?  
22 THE CHAIRMAN: You were saying, doctor, you can't remember  
23 reading Dr Webb's note, there was clearly a diagnosis  
24 going on of encephalitis/encephalopathy with Claire.  
25 And at that time ...

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1 A. I think, as I remember at the time, in the mid-1990s,  
2 there was unfortunately several children -- I wouldn't  
3 say many -- but it was not an uncommon presentation to  
4 intensive care to have seizures, encephalitis, and to  
5 die as a result of that. That's changed with  
6 vaccination and better care, recognition of meningitis,  
7 these days. But clearly, it appears that I was under  
8 the presumption that the cause of her illness was  
9 encephalitis, meningitis. That's what she has been  
10 treated for and that was the overriding diagnosis,  
11 I believed, at that time.

12 MR STEWART: Okay. Can I take you back to your statement  
13 here?

14 "I was not aware that Claire Roberts' death involved  
15 hyponatraemia."

16 It says "involved hyponatraemia", it doesn't say  
17 "principal diagnosis", it doesn't say "sole cause of  
18 death"; it merely indicates you were not aware that  
19 there was an involvement of hyponatraemia in the death.  
20 I'm suggesting to you from the notes that that seems  
21 extraordinary.

22 A. Well, that's what I understood.

23 THE CHAIRMAN: Sorry, remind me again, just to go on to  
24 where you were. Your first knowledge that Claire's  
25 death did involve hyponatraemia came about as a result

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1 THE CHAIRMAN: But not sufficient for you to have any  
2 awareness that there was suggested to be any connection  
3 between hyponatraemia and Claire's death? You must have  
4 thought: what was I doing adding Claire to the inquiry  
5 if her death didn't involve hyponatraemia?

6 A. I wasn't aware of my time with her -- my role looking  
7 after her in intensive care between her first and second  
8 set of brainstem tests until I received the witness  
9 statements.

10 THE CHAIRMAN: And even if I acknowledge that your  
11 involvement at the very, very end of Claire's life was  
12 a limited one, you weren't one of the treating  
13 consultants and you came into work on 23 October and  
14 find a girl who is, to put it bluntly, to all intents  
15 and purposes already dead or in a condition from which  
16 she cannot be saved --

17 A. Yes.

18 THE CHAIRMAN: So your role at that stage as a treating  
19 consultant is very limited. Okay. I'll leave it at  
20 that.

21 MR STEWART: So back in intensive care unit, I'm sure that  
22 you didn't fancy a second trip to the coroner's court  
23 in relation to another death involving hyponatraemia  
24 back in 1996.

25 MR UBEROI: Sorry, sir, I'm not really sure that's a proper

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1 of what in 2012?

2 A. I believe that's the first time that I had set eyes on  
3 the coroner's cause of death -- the narrative cause of  
4 death that the coroner, and that was through visiting  
5 the documents on the website.

6 THE CHAIRMAN: Doctor, there must have been discussion  
7 within the hospital after 2004 about this inquiry and,  
8 in particular, after 2006 when Claire's inquest had  
9 taken place. I presume you knew that the inquest took  
10 place in 2006. I presume that was fairly common  
11 knowledge in the Children's Hospital.

12 A. I don't remember it as being common knowledge, whether  
13 I was on leave at the time, I can't remember, but  
14 I don't recall it being reported as common knowledge.

15 THE CHAIRMAN: Well, do you remember Claire's death being  
16 added to the inquiry in 2008 when the inquiry resumed  
17 after the completion of the various police  
18 investigations?

19 A. I remembered her name being highlighted as one of the  
20 children involved in the inquiry.

21 THE CHAIRMAN: And did it strike you that since Claire had  
22 died in the Children's Hospital a year after Adam and  
23 a few months after Adam's inquest, did that prick your  
24 interest at all?

25 A. I presume so. I can't remember.

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1 question or a fair question in an inquiry.

2 THE CHAIRMAN: Yes. Let's put it more ...

3 MR STEWART: Were you interested in whether or not Claire's  
4 death might be referred to the coroner?

5 A. I don't think I took a view on it.

6 Q. You took no view?

7 A. I was managing up to six patients in the paediatric  
8 intensive care unit. Some would have required more of  
9 my attention than others and, in those days, I had one  
10 SHO and myself and the nurses looking after up to six  
11 patients. So I had to prioritise and divide my time to  
12 those patients. So I don't imagine I would have spent  
13 an inordinate amount of time investigating a child  
14 whose -- my main duty that day was to have a management  
15 plan to prepare her for a second set of brainstem tests,  
16 which were to be taken place later that day. That's the  
17 perspective of my knowledge and attention with Claire.

18 Q. How many children would you have had dying in PICU on  
19 any given day?

20 A. I think there are approximately 24 deaths a year.

21 Q. Two a month. So in any given day, it would have been  
22 something that you might have stopped to think about?

23 A. Well, as is quite clear in the records, Claire was  
24 presented to me on the morning, on that morning, as  
25 a child who had succumbed to an illness. Her first set

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1 of brainstem tests had been completed. There was little  
2 I or anybody else could do to reverse that process, and  
3 my duty at that time was to my other patients and to her  
4 to ensure that the requirements for the second set of  
5 brainstem tests were met that day in quite a challenging  
6 situation of polyuria.

7 Q. I'm not seeking in any sense to question what you did  
8 for Claire at that time. What I am suggesting is that  
9 the issue of whether or not it might have been  
10 a reportable death to the coroner should have exercised  
11 you.

12 A. If I had been present at the time when she died and was  
13 taken off the ventilator, then I would have taken a view  
14 on that. But during the day, when my attention was  
15 clearly divided between my other patients and her,  
16 I can't remember -- it clearly didn't strike a chord  
17 that I took a view about whether she -- and she had  
18 other clinicians that were looking after her at that  
19 time.

20 Q. The reason I ask you that is that, at that time, you  
21 believed that hyponatraemia was a treatable condition;  
22 yes?

23 A. With Claire, do you mean, or in general?

24 Q. In general, hyponatraemia was a treatable condition.

25 A. In general, symptomatic hyponatraemia is a treatable

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1 Q. Did anyone ask you for your opinion?

2 A. I can't remember.

3 THE CHAIRMAN: Sorry, doctor, let me go back a bit. When  
4 you were asked about reporting Claire's death to  
5 the coroner, you said that:

6 "[You] may have taken the view, had I been there  
7 when she died and was taken off the ventilator."

8 A. That's a time when there would be discussion about  
9 whether it's a reportable death or not.

10 THE CHAIRMAN: In Claire's case, the discussion had taken  
11 place long before that. In Claire's case, when she died  
12 and was taken off the ventilator, that's after the  
13 second brainstem test, isn't it?

14 A. Yes.

15 THE CHAIRMAN: The decision not to report to the coroner was  
16 taken in Claire's case before the first brainstem test.  
17 You have just told me that the time to make a decision  
18 about reporting to the coroner is after the second test.  
19 Is that your experience in the Children's Hospital?

20 A. That's my experience.

21 THE CHAIRMAN: So if that's your experience in the  
22 Children's Hospital, can you help me on something, which  
23 I understand from your evidence is not something that  
24 you're involved in? Can you help me to understand how  
25 a decision was taken not to report Claire's death to

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1 condition. But after the performance of the first set  
2 of brainstem tests, which is --

3 Q. I'm not intending --

4 A. -- [OVERSPEAKING] to Claire, it was not a treatable  
5 condition.

6 Q. I do accept that. But in general, it's a treatable  
7 condition. She had it, you knew that, you had recorded  
8 her sodium levels, and you'd also read the Arieff paper,  
9 which repeatedly made the point that timely treatment  
10 can save children suffering from hyponatraemia. Did you  
11 not think there perhaps might be a connection between  
12 what looked like a death from hyponatraemia and a want  
13 of timely treatment?

14 A. You'll correct me if I'm wrong, but I believe Arieff  
15 reported hyponatraemia in healthy children undergoing  
16 surgery.

17 Q. No. I do correct you. It's a range of children  
18 with [OVERSPEAKING].

19 A. I believe it looked at children undergoing surgery and  
20 that's what I understood at the time, but I may have  
21 been wrong.

22 Q. Did you have any conversation with any of the other  
23 clinicians about whether or not the matter might ought  
24 properly to be referred to the coroner?

25 A. I can't remember.

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1 the coroner before any brainstem testing?

2 A. I'm not familiar with that scenario.

3 THE CHAIRMAN: No, because the scenario that you're familiar  
4 with is that a decision about reporting to the coroner  
5 is taken only after the final brainstem test, which has  
6 confirmed the position, and the child has died and is  
7 taken off the ventilator, or is taken off the ventilator  
8 and then dies?

9 A. If I can be helpful, the coroner won't accept a phone  
10 call from a doctor until the patient has died, and then  
11 he will make a decision whether it's a coroner's case or  
12 not and where he wants the body to be, unless there's  
13 organ donation. And if there's organ donation, then  
14 clearly a discussion has to take place with the coroner  
15 before the child is taken off the ventilator because the  
16 organs must be preserved by remaining on the ventilator.  
17 In all other cases, I believe the decision to phone  
18 the coroner -- and it would be my practice to wait until  
19 the patient is actually no longer has a heartbeat.

20 THE CHAIRMAN: Your practice is to wait beyond the point  
21 when the condition is irreversible to the point where  
22 the patient is actually dead?

23 A. Yes. I have on occasions phoned the coroner in advance  
24 when there's been a difficult case and he's left me in  
25 no doubt that he would only wish to be informed when the

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1 patient is actually no longer -- beating heart.

2 THE CHAIRMAN: Okay. That being so, does that mean that

3 that is invariably a decision in which, in the

4 Children's Hospital, a paediatric anaesthetist who is in

5 PICU is involved?

6 A. It's not hard and fast. It's usually the lead clinician

7 who would phone the coroner, but on occasion it has been

8 my job. I have taken on the responsibility to phone

9 the coroner after the death.

10 THE CHAIRMAN: But even when the lead clinician contacts

11 the coroner, that's where the coroner is being

12 contacted, obviously.

13 A. Yes. You have to phone the coroner after the patient's

14 died.

15 THE CHAIRMAN: But even where the lead clinician is making

16 that call -- and we're talking about the mid-1990s and

17 subsequently, unless you tell me there has been a change

18 in practice -- is it typically the position that the

19 lead clinician will engage you in some discussion if

20 you've been involved with the child's care?

21 A. Yes.

22 THE CHAIRMAN: That's if you've been involved in the child's

23 care in PICU?

24 A. Yes. I believe all the consultants involved in the care

25 of the child at that time, around the time of death, or

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1 may not require a coroner's view.

2 THE CHAIRMAN: In effect, is that to help Mr Leckey as the

3 senior coroner in reaching a decision?

4 A. It may well help Mr Leckey, but it certainly helps

5 doctors. And if it is after the organ ...

6 THE CHAIRMAN: Let me take you back to Claire's case. The

7 discussion with the parents about a brain-only autopsy

8 and about non-referral to the coroner, that takes place

9 before any brainstem testing. In your experience,

10 that's unusual.

11 A. Um ... Yes. There's a certain choreography, there are

12 certain methods of ... I guess there's some clinical

13 freedom in how one pursues that, but certainly my

14 practice would be to perform the brainstem test, tell

15 the relatives after the first set that it's most likely

16 an irreversible condition, but we are required by good

17 practice to have a confirmatory set of brainstem tests,

18 so there's an element of preparation for that. It's

19 usually after the patient's separated from the

20 ventilator or the organs are retrieved, if it's an organ

21 donor, that we sit down with the parents and discuss

22 what happens, either certification of the body or

23 referral to the coroner, the medical adviser to

24 the coroner.

25 THE CHAIRMAN: If it is the case that with Claire the

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1 leading to the death, would normally have a discussion

2 about how to proceed with either death certification or

3 with a coroner's phone call.

4 THE CHAIRMAN: Right. That in your experience in the Royal

5 over how many years, 21 years?

6 A. 21 years.

7 THE CHAIRMAN: That has been the standard approach?

8 A. Yes.

9 THE CHAIRMAN: The coroner is contacted after the second

10 brainstem test and after the child has formally died,

11 and there is a discussion between those who are involved

12 at that time, including the lead clinician, but also

13 including the paediatric anaesthetists, about whether

14 this is a death to refer to the coroner?

15 A. Yes. Basically, I would discuss it with the surgeon or

16 the paediatrician to see if they could write a death

17 certificate. So if we're certain as to the cause of

18 death and a death certificate can be written, then that

19 would obviate the call. There's been another change

20 recently, as you may be aware in the coronial system,

21 there's a medical adviser now available to discuss cases

22 with. That was not the case in 1996.

23 THE CHAIRMAN: Right. That's a link between --

24 A. It's a doctor who I can phone, and many of us have used

25 that as an improved way of discussing cases that may or

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1 decision was taken not to refer her to the coroner

2 before any brainstem testing, that's unusual?

3 A. In my practice, that's unusual.

4 THE CHAIRMAN: And also the practice which you see around

5 you in the Children's Hospital? Because from what you

6 said earlier, you don't have a unique practice in this,

7 but this is the general practice in the Children's

8 Hospital.

9 A. I'm only present at the death of patients that I'm

10 involved with, so I can't comment on my presence because

11 I'm not present at the death of --

12 THE CHAIRMAN: It's also the practice that, whether or not

13 you're the treating clinician -- and I presume very

14 often you're not the treating clinician -- but very

15 often, even if you're not the treating clinician,

16 you will be involved in the discussion about whether

17 this is a death to be referred to the coroner?

18 A. Yes.

19 THE CHAIRMAN: Thank you.

20 MR STEWART: Do you think Claire's death should have been

21 referred to the coroner?

22 A. Well, after what we've heard in this inquiry, yes.

23 I think things have changed in the last number of years

24 and that, as I said earlier, deaths with encephalitis,

25 meningitis, were not uncommon in the mid-1990s.

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1 Unfortunately, children did die and actually died quite  
2 suddenly having been relatively well with seizures and  
3 death could be quite sudden with or without  
4 hyponatraemia being present. And I believe -- I can  
5 only go by what I thought at the time -- my belief was  
6 that Claire was such a sudden death that the underlying  
7 diagnosis, tragic diagnosis of encephalitis, is what I'd  
8 been led to believe was resulting in her cause of  
9 seizures. I believe that's why she was admitted to  
10 intensive care after that had caused an irreversible  
11 brain injury. That was a very, unfortunately, not  
12 uncommon form of death in young children. It still does  
13 occur. I had a recent death with meningitis.

14 THE CHAIRMAN: If that is the cause of death, how would that  
15 be categorised in the Trust records? If it is as  
16 a result of encephalitis, how would that be categorised?

17 A. In terms of coding or in terms of ... What do you mean  
18 by --

19 THE CHAIRMAN: I have a letter, which we will now have to  
20 share with everybody. It's a letter dated  
21 12 November 2012, which we got from the DLS in response  
22 to an inquiry we made about deaths in the Children's  
23 Hospital and in paediatric intensive care. It says:  
24 "The Trust does not code the cause of death, but  
25 rather the primary diagnosis treated or investigated."

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1 MR STEWART: Would it assist, sir, to bring up the actual  
2 coding that was applied to Claire's case?

3 THE CHAIRMAN: Yes, perhaps.

4 MR STEWART: It's at 302-153-003. (Pause).

5 THE CHAIRMAN: We can come back to that, if we can.

6 MR STEWART: We'll come back to that.

7 THE CHAIRMAN: Sorry, do you have a reference there what the  
8 coding was?

9 MR STEWART: It's a detailed document with a considerable  
10 number of primary and subsidiary diagnoses. It might be  
11 easier to follow if everyone had a chance to look at it.

12 THE CHAIRMAN: Okay.

13 MR STEWART: So Dr Taylor, you say that now, with hindsight,  
14 you can see that Claire's case is one which probably  
15 should have been referred to the coroner. Of course,  
16 the next obvious question is: could you not have seen  
17 that at the time, given the content of the medical notes  
18 and records?

19 A. Well, clearly, I didn't see it at the time.

20 Q. All right.

21 A. But then I didn't participate in the decision to refer  
22 to the coroner or, nowadays, the medical adviser to the  
23 coroner, which I believe possibly would have been the  
24 way I would have perceived it being dealt with nowadays.

25 Q. Given the level of interest that you had achieved in

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1 And we have the details for 1995 and 1996. I'm  
2 looking to see "encephalitis", which you say was not  
3 uncommon in the mid-1990s, and I can't see encephalitis.  
4 So I'm asking you what else would it be under?

5 A. Well, meningitis, I think. One of the diagnoses was  
6 meningoencephalitis. So meningitis can cause a swelling  
7 of the brain and can look like encephalopathy or a  
8 clouding of consciousness.

9 THE CHAIRMAN: Unless I'm missing it, I don't have  
10 meningitis either.

11 A. That was my recollection, that children did die  
12 suddenly.

13 THE CHAIRMAN: I'll tell you what, for the moment -- we'll  
14 copy this later on, ladies and gentlemen -- but doctor,  
15 would you look at this? (Handed). It's a list of  
16 deaths in 1995 and 1996 in the Children's Hospital  
17 generally and in paediatric intensive care. I would  
18 like you to identify -- these are not coded, this is the  
19 primary diagnosis.

20 A. Meningococcaemia, which -- certainly meningococcal  
21 septicaemia is a form of meningitis caused by  
22 a meningitis organism, Neisseria meningitidis, and there  
23 are three deaths out of 42 in 1995 and one death  
24 unspecified in 1996.

25 THE CHAIRMAN: Thank you.

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1 hyponatraemia following your researches and the finding  
2 of the inquest, why did you not take a closer interest  
3 in this case of hyponatraemia?

4 A. I don't know. I clearly had a duty, as I've said  
5 before, to manage Claire with my five other children in  
6 PICU that day, about her complex fluid management with  
7 diabetes insipidus, to prepare her in the best possible  
8 way for this second set of brainstem tests. That was my  
9 job with her. That appears to be what I set out to do  
10 and I can't explain or understand or even know why.  
11 I presume because that was my main job with her, that  
12 was my job with her that day.

13 Q. Would you have had a reluctance to get involved in  
14 another case going back to the coroner with  
15 hyponatraemia?

16 MR UBEROI: The question doesn't make sense on any logical  
17 or factual basis, in my submission. Given the limited  
18 role which Dr Taylor has just explained he had in the  
19 clinical care that was given to Claire Roberts, why  
20 would he have any reluctance? I think this matter's  
21 been pursued and it's been answered in various ways now.

22 THE CHAIRMAN: Okay. Let's look at it another way,  
23 if we actually look at the note, which gives the sodium.  
24 Let's look at Dr Taylor's note, which gives the sodium  
25 reading.

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1 MR UBEROI: 090-022-061.  
2 MR STEWART: Thank you very much.  
3 We have it, the fifth line down:  
4 "Sodium 129 from 121."  
5 At that stage you note:  
6 "Appears brainstem dead informally."  
7 And it's 7 hours post arrest, so that gives you  
8 a timing for your entry.  
9 A. Yes.  
10 Q. That's a case of hyponatraemia.  
11 A. Well, hyponatraemia is present in the diagnosis of other  
12 severe infection.  
13 THE CHAIRMAN: What has happened is that the sodium level,  
14 Claire's sodium level, has risen from 121. Where do you  
15 get the 121 from? Do you get it from the earlier notes?  
16 A. Yes, presumably.  
17 THE CHAIRMAN: If you go back into the earlier notes to get  
18 the 121 --  
19 MR STEWART: At 090-022-059, is, I think, the immediate  
20 reference closest to Dr Taylor's entry. It's there down  
21 at the end of the first paragraph:  
22 "Serum Na also noted to be low, down to 121,  
23 presumably on the basis of SIADH."  
24 THE CHAIRMAN: So you have the 121, you assume, from  
25 Dr McKaigue's note?

1 that at all. But I am curious as to the entries about  
2 hyponatraemia apparently being missed by you and no flag  
3 being waved.  
4 A. Sir, I believe in those days, certainly before the other  
5 later deaths, that we, in hospital medicine, did see  
6 hyponatraemia on occasion in patients, not fatal. It  
7 was sometimes -- it was not infrequently recorded with  
8 any type of fluid. Obviously, Solution No. 18 was  
9 a very commonly used fluid at that time. I don't  
10 believe Adam and Claire were the only patients prior to  
11 1996 that did have hyponatraemia present during their  
12 hospital stay; they did not die from it or get cerebral  
13 oedema from it, and I don't think doctors at that time,  
14 including myself, put -- the knowledge now is different  
15 and trying to look back with the knowledge we have now  
16 into this time of the mid-1990s, I honestly don't  
17 believe myself or other doctors believed that sodiums of  
18 121 on their own would cause fatal cerebral oedema.  
19 That's just a reflection of what I remember at the time.  
20 It is different now and it's hard now with the knowledge  
21 we have, and certainly what this inquiry is going  
22 through, to understand that doctors might have had that  
23 knowledge. But that was the knowledge at the time.  
24 THE CHAIRMAN: Let me ask you something slightly different,  
25 but a variation. As it happens, it was Dr McKaigue who

1 A. Well, I could have got it from several sources.  
2 Presumably it would have been written on the PICU blood  
3 results record, which is part of the clinical record of  
4 the nursing obs. So I'd certainly have been looking at  
5 that during a ward round as well as the fluid balance,  
6 the blood gases, the blood pressure, the heart rate and  
7 the urinary output. That would all be probably -- well,  
8 that would definitely have been part of the clinical  
9 records that I would have examined during my time on the  
10 ward round with Claire.  
11 MR STEWART: There's also, further down, a reference to:  
12 "CT scan shows severe cerebral oedema."  
13 That's about ten lines down.  
14 THE CHAIRMAN: The point is, doctor, that's bringing in the  
15 records, and when you go into the records and look  
16 through the records from which you are gathering some of  
17 this information, that brings you back closer to  
18 Dr Webb -- never mind Dr Stewart for the moment -- at  
19 11.30, but that brings you back to Dr Webb, who's  
20 recording hyponatraemia. I'm just curious as to why  
21 this was missed. Not half as curious as Mr and  
22 Mrs Roberts, I suspect. I understand your role was  
23 limited, I understand that you were looking after  
24 intensive care that day, children who probably did  
25 survive thanks to your treatment. I don't doubt any of

1 was in PICU when Claire came in.  
2 A. Yes, he attended Claire before me.  
3 THE CHAIRMAN: And as it happens, this is a 9 year-old  
4 girl -- sorry, were you here earlier this morning?  
5 A. Yes.  
6 THE CHAIRMAN: So you'll have heard me going through this  
7 sequence of events with Dr Hicks.  
8 A. Yes.  
9 THE CHAIRMAN: Right. Doctors Webb and Steen finished their  
10 duty at 5.30, 6-ish on Tuesday evening. Their  
11 understanding, as relayed to the inquiry, is neither of  
12 them had a concern that there was any immediate risk to  
13 Claire's life. Dr Webb said -- and he knew the position  
14 best because he'd be treating her all afternoon -- had  
15 he apprehended a risk to her life, he wouldn't have  
16 left, and I don't have any doubt about that because  
17 Dr Webb came back a number of times to see Claire and to  
18 see what more he could do and to see if what he had done  
19 was working. They're both called into the hospital  
20 in the early hours of the morning to find, to all  
21 intents and purposes, Claire is dead, she's in an  
22 irreversible condition, and they decide -- either  
23 Dr Steen on her own or with Dr Webb -- that they're  
24 sufficiently clear about the cause of death that they're  
25 able to tell Mr and Mrs Roberts, when they arrive in the

1 hospital, that they recommend a brain-only autopsy,  
2 which indicates a striking degree of confidence in their  
3 understanding of the reason for Claire's death and no  
4 need to refer to the coroner.

5 Even without the benefit of hindsight and even  
6 without knowing that in the intervening years the bar  
7 has been lowered for referrals to the coroner, does that  
8 not strike you as very surprising?

9 A. Well, I wasn't there at the time so I don't know what  
10 was said or how it was said. But certainly it's one of  
11 the great difficulties in paediatric practice, the  
12 rapidity of which a reasonably well child can suddenly  
13 deteriorate in general practice and in hospital  
14 medicine, much more so than in adult medicine. Children  
15 do go from being at school, playing, to moribund within  
16 minutes and hours. Unfortunately, if we could get  
17 a crystal ball and see which ones were going to have  
18 a runny nose and a cough and which would develop  
19 life-threatening illnesses, then one would be a very  
20 good doctor, but unfortunately children continue up to  
21 the present day to suffer overwhelming infectious  
22 diseases and succumb very rapidly, whether care is good  
23 or less than good. But certainly in those days, by  
24 today's standards, the care was not as good as what  
25 I would have expected by today's standards and possibly

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1 knowledge of what I see being the tip of the iceberg  
2 with very sick children. But I don't think any doctor  
3 or nurse has the skills to definitively say which child  
4 is going to get through the seizures and through the  
5 encephalopathy without referral to intensive care. It's  
6 one of the difficulties that I have when a doctor asks  
7 me to go and visit a ward in casualty or on the ward and  
8 assess the child for intensive care treatment.

9 THE CHAIRMAN: What I'm asking you really is a slight  
10 variation on that. I understand from a lot of the  
11 evidence which has been given over the last few weeks  
12 here that encephalitis and status epilepticus are  
13 comparatively unusual, but they're very, very dangerous,  
14 and that --

15 A. Yes.

16 THE CHAIRMAN: -- each of them can cause a comparatively  
17 quick death in their worst forms; right?

18 A. I'd agree with that, yes.

19 THE CHAIRMAN: That explains, I think at least in part, why  
20 Dr Webb was so conscientious on that Tuesday afternoon  
21 by repeatedly coming back.

22 A. Yes.

23 THE CHAIRMAN: But once he starts, as he did, to treat  
24 Claire for both of those conditions and as he steps up,  
25 for instance, the anticonvulsant and as he starts the

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1 even by those standards.

2 THE CHAIRMAN: The plus side for children is that they  
3 recover quicker and the downside is that they may  
4 deteriorate more quickly?

5 A. Well, anybody who's practised acute paediatrics will  
6 certainly testify to that, sir.

7 THE CHAIRMAN: But Claire was a girl who had been in  
8 hospital from Monday evening, was being treated with  
9 drugs for both status epilepticus and for encephalitis.

10 A. Yes. Either of which can be a rapidly fatal condition.

11 THE CHAIRMAN: She was being treated by Dr Webb, she was  
12 given drugs for both of those conditions.

13 A. Yes.

14 THE CHAIRMAN: So does that not make the prospect of her  
15 being overwhelmed within the space of a few hours lower?  
16 The risk is lower because she's actually being treated  
17 with drugs for those conditions?

18 A. I can't give you a percentage, 90 per cent. I would say  
19 most children with seizures are managed outside the  
20 paediatric intensive care unit. There are currently  
21 eight beds for every child in Northern Ireland who could  
22 become critically ill and often we go over those eight  
23 beds. We're trying to go up at the moment to 12 beds  
24 because of the need, and if I were on the wards, I would  
25 admit every child to intensive care because of my

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1 acyclovir, don't those treatments reduce the prospect  
2 that Claire is going to be overwhelmed because she's  
3 actually been treated for these conditions, which can  
4 have such a disastrous effect on a child's health?

5 A. If you want me to comment, it's outside my clinical area  
6 of expertise to comment on neurological conditions.

7 THE CHAIRMAN: The point I'm getting to is: surely in that  
8 scenario, Claire is less likely to be overcome in a very  
9 short time by those conditions, since she has already  
10 been treated for them, as compared to a child in whom  
11 the set in more quickly and has not been treated for  
12 them. The point of giving her the drugs is to prevent  
13 this disastrous effect.

14 A. I understand.

15 THE CHAIRMAN: If she is being treated for those conditions  
16 and still deteriorates, as she did, then it should raise  
17 question marks about whether in fact that diagnosis was  
18 the correct one, at least to the point where you want to  
19 verify it.

20 A. I don't think it necessarily follows, with respect, sir,  
21 that a child who has got a chronic condition lasting  
22 several hours can still deteriorate as a child with an  
23 acute rapidly deteriorating condition.

24 THE CHAIRMAN: Okay.

25 A. And as an intensivist, you're asking the wrong person

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1 because I would go to the ward and pick up lots of  
2 children who are at risk of sudden death and fill five  
3 intensive care units, but the clinicians who have more  
4 knowledge about which children can get through certain  
5 illnesses will make the decision whether they want to  
6 phone the intensivist to make an assessment of their  
7 child.  
8 THE CHAIRMAN: Okay, thank you.  
9 MR QUINN: Mr Chairman, if I can come in on this point while  
10 this point is being aired. At page 92 of the [draft]  
11 transcript today, lines 8 and 9, the question that the  
12 Roberts family are concerned about is what you led up  
13 to, Mr Chairman:  
14 "Does that not strike you as surprising?"  
15 It's page 92, lines 6, 7, 8, and 9 is the lead into  
16 it. It's about lowering the bar for referral to the  
17 coroner:  
18 "Does that not strike you as very surprising?"  
19 Meaning: does it not strike you as surprising that  
20 this case was not referred to the coroner? That  
21 question wasn't really answered because he then  
22 discussed the difficulties with treating children on  
23 a paediatric ward and how they go down quickly and come  
24 up again quickly, but he didn't really answer that  
25 question, with respect, and that was the question that

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1 the coroner?  
2 A. Knowing what we now know in retrospect, it should have  
3 been. I would have expected it to be discussed with the  
4 medical adviser, who wasn't present in 1996.  
5 THE CHAIRMAN: That's not what I'm asking you. I'm asking  
6 you something different. I'm not asking you about what  
7 would happen today. For you to contact the medical  
8 adviser at all, that means you're considering referring  
9 it to the coroner, doesn't it?  
10 A. Yes. You're having difficulty writing a death  
11 certificate.  
12 THE CHAIRMAN: Yes.  
13 A. So you would obviously want to discuss it.  
14 THE CHAIRMAN: You see, when I asked Dr Hicks about this  
15 earlier today, she really could give no explanation for  
16 the decision not to refer Claire's death to the coroner.  
17 A. I have to add another difficulty that we have in the  
18 clinical circumstance, even today, sir, which is  
19 contacting the coroner out of hours.  
20 THE CHAIRMAN: But again, that's a problem which only arises  
21 once you decide you're going to contact the coroner.  
22 A. That's correct.  
23 THE CHAIRMAN: The point here is there was no contact with  
24 the coroner. There was no attempt at contact with  
25 the coroner. A decision was taken in the early hours of

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1 the Roberts were very concerned about.  
2 THE CHAIRMAN: Yes. Can I take you back to that, Dr Taylor?  
3 It is the decision -- and I do understand from what  
4 we have heard that the bar is now set lower for  
5 referrals to the coroner, the coroner has more cases  
6 referred to him now than he did in the mid-1990s.  
7 A. Yes.  
8 THE CHAIRMAN: Even allowing for the bar being somewhat  
9 higher than it is now, do you not find it  
10 surprising that Claire's case was not referred to  
11 the coroner in 1996? Sorry, let me add one more point.  
12 There was no resistance from Mr and Mrs Roberts. They  
13 weren't resisting post-mortems or a referral to the  
14 coroner. This was all led from within the Royal.  
15 A. With respect, the parents wouldn't be part of the  
16 decision to refer to the coroner.  
17 THE CHAIRMAN: Yes.  
18 A. That's between the doctors and --  
19 THE CHAIRMAN: Right. So the decision not to refer Claire's  
20 death to the coroner is taken entirely independently of  
21 the parents?  
22 A. It has to be.  
23 THE CHAIRMAN: Let's go back to the question. Knowing what  
24 you now know about Claire's case, isn't it still  
25 surprising that, in 1996, her death was not referred to

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1 Wednesday morning, before any brainstem testing, that  
2 Claire's death would not be referred to the coroner and  
3 that there would be a brain-only autopsy. And that's  
4 a feature of what happened to Claire, which I have great  
5 difficulty in understanding.  
6 A. I understand.  
7 THE CHAIRMAN: I'm not asking you to repeat what you have  
8 said before, but can you help me understand that beyond  
9 anything that you have said before?  
10 A. No.  
11 MR QUINN: Does that mean he is saying that he does find it  
12 surprising that it wasn't reported to the coroner?  
13 THE CHAIRMAN: Dr Hicks says it was surprising.  
14 MR QUINN: But does this witness say it is surprising? He  
15 still hasn't answered the question.  
16 THE CHAIRMAN: Do you find it surprising that Claire's death  
17 was not referred to the coroner?  
18 A. From retrospect, from what I believe now --  
19 [OVERSPEAKING].  
20 MR QUINN: Sorry for overspeaking, but this --  
21 THE CHAIRMAN: Not with hindsight --  
22 MR QUINN: Not with hindsight --  
23 THE CHAIRMAN: Knowing --  
24 MR UBEROI: The witness has attempted to answer and there's  
25 confusion over when knowledge occurs. He said that

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1 knowing now what he knows about the facts of  
2 Claire Roberts, he was surprised that the case wasn't  
3 referred, as I understood his answer.  
4 THE CHAIRMAN: But knowing now what we know includes what  
5 was learnt at the coroner's inquest, which eventually  
6 took place. So knowing what we now know doesn't answer  
7 the question. Saying "with the benefit of hindsight"  
8 doesn't answer the question because some of what we know  
9 now -- some of it -- came out at the inquest, so we  
10 can't say: because there was an inquest, I now think  
11 there should have been an inquest earlier. What I'm  
12 really saying -- and Dr Hicks really didn't have much  
13 difficulty dealing with this this morning, Mr Uberoi.  
14 I'm trying to clarify with Dr Taylor what his  
15 position is. At that time, given the apparently sudden  
16 deterioration in Claire's condition, consultants who had  
17 limited concern about her health -- and I don't mean  
18 that in any pejorative sense -- I mean limited concern  
19 in that they were not immediately worried that her  
20 condition was going to deteriorate with the result that  
21 she would die. They both expected to come back into  
22 hospital on Wednesday morning and to find Claire still  
23 there on Allen Ward. Instead, the decision is taken at  
24 that time before any brainstem testing not to refer to  
25 the coroner. And that's what I'm asking Dr Taylor, does

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1 If the clinicians can write a death certificate and have  
2 a known cause of death and, on the back of the death  
3 certificate, there's a box to tick to say if further  
4 information is found, for instance at post-mortem, the  
5 death certificate can be amended. That's on every death  
6 certificate.  
7 THE CHAIRMAN: But doctor, my question is how could they be  
8 confident?  
9 A. I don't know.  
10 THE CHAIRMAN: How could they have been confident at 3 or 4  
11 in the morning?  
12 A. I don't know. I'm trying to picture the practice in  
13 1996. If the clinicians are confident about writing  
14 a cause of death on a death certificate, they wouldn't  
15 refer it to the coroner.  
16 THE CHAIRMAN: To have that necessary information, either  
17 one or both clinicians who went home at about 6 o'clock  
18 on Tuesday evening, expecting to see Claire in hospital  
19 on Wednesday morning and not having warned her parents  
20 that she was in serious jeopardy of dying, then have to  
21 come back in at 3 or 4 in the morning and say, "Oh well,  
22 we know what happened here, it's perfectly clear to us,  
23 therefore we can complete a death certificate without  
24 referral to the coroner". That's what has to happen,  
25 doesn't it? They have to have that degree of confidence

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1 that surprise him by the standards of 1996 and what was  
2 available on these notes and records in 1996.  
3 MR UBEROI: I understand the question, sir. I would simply  
4 raise -- I may have misunderstood, but I was under the  
5 impression he had answered it; he may not have done.  
6 I do understand the difference between today and 1996.  
7 THE CHAIRMAN: Can I ask you one more time on this,  
8 Dr Taylor.  
9 A. I'm certainly not trying to avoid the question, I'm just  
10 having difficulty trying to remember what the practice  
11 was in 1996. I believe the practice in 1996 ...  
12 MR UBEROI: Sorry, the witness was distracted there by some  
13 comments. I think the witness needs to be asked the  
14 question and then he needs to answer it and then we need  
15 to move on, would be my suggestion.  
16 A. I'm trying to answer why I would have referred the case  
17 in 1996 or been involved in that decision. To answer  
18 that, it's hard to remember back to what the practice  
19 was in 1996 because it has changed so much with medical  
20 advisers and, as you said, the bar being lowered. If  
21 the bar's being lowered now to what we report to the  
22 coroner, the bar was theoretically higher by definition  
23 to where it was in 1996. The key element in referring  
24 or not, referring a case to the coroner, is: can the  
25 clinicians write with confidence a death certificate?

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1 in order to do that?  
2 A. That's correct, and there's an element of subjectivity  
3 rather than objectivity involved in that decision.  
4 MR STEWART: Would you be surprised to hear that the death  
5 certificate was completed without reference to  
6 encephalitis?  
7 A. It's hard to use the word "surprised" in that. I'm  
8 trying to reflect on what the practice was, and the  
9 requirement to phone the coroner in 1996. It's  
10 different.  
11 THE CHAIRMAN: No, that's not the point, I think, with  
12 respect. You have said that in 1995 and 1996 there were  
13 a number of deaths which no longer occur now because of  
14 things like encephalitis, and that can explain a sudden  
15 dreadful deterioration in a child's health, which causes  
16 her death.  
17 A. Yes.  
18 THE CHAIRMAN: Right. So if that is a putative explanation  
19 for not referring Claire's death to the coroner, one  
20 would then expect to find encephalitis on the death  
21 certificate.  
22 A. Yes.  
23 THE CHAIRMAN: But it's not. It's not on the death  
24 certificate.  
25 A. I understand.

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1 THE CHAIRMAN: So they didn't decide not to refer Claire's  
2 death to the coroner because of encephalitis. You  
3 agree?  
4 A. I didn't know what was on the death certificate.  
5 THE CHAIRMAN: Yes. So you can't say, "She died of  
6 encephalitis, that's why we're not going to refer it to  
7 the coroner" if you then don't put encephalitis on the  
8 death certificate.  
9 A. Yes.  
10 MR STEWART: Just one more thing. Can I ask for document  
11 WS012/2, page 26, to be shown? This is an autopsy  
12 request form filled out in respect of the patient  
13 Adam Strain. Is that your handwriting?  
14 A. I believe so, yes.  
15 Q. This was in Adam Strain's case. And over the page,  
16 please, to 28. If those pages could be placed side by  
17 side, you'll see that you started to request a hospital  
18 autopsy for Adam Strain, but you decided better; is that  
19 right? Why did you stop completing this form?  
20 A. Sorry, which terms? I don't understand the question,  
21 sorry.  
22 Q. The question is: that is your handwriting?  
23 A. Yes.  
24 Q. And the form is not completed?  
25 A. Yes.

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1 enable her to conduct the autopsy, whether it's  
2 a coroner's autopsy or a hospital post-mortem.  
3 Q. Why did you not then complete the form anyway, if you  
4 were providing information, and sign it, if that was the  
5 basis on which this form was filled in?  
6 A. I --  
7 Q. Why didn't you sign it?  
8 A. I completed it --  
9 MR UBEROI: I'm very puzzled and slightly concerned, on the  
10 question of fairness, why we're going back to questions  
11 of Adam Strain in governance. This witness has been  
12 cross-examined on matters to do with Adam Strain's  
13 governance. He has answered the question as best he can  
14 already. As I say, I'm puzzled as to why  
15 a cross-examination on the basis of a matter pertaining  
16 to Adam Strain governance is being raised now at this  
17 point.  
18 MR STEWART: Because, on the face of it, it would appear as  
19 though Dr Taylor was wrestling with the question about  
20 whether or not an autopsy should be requested in  
21 hospital or, perhaps not, and allow the coroner to  
22 pursue an autopsy.  
23 MR UBEROI: Wrestling with the question in relation to  
24 Adam Strain? This is the Claire Roberts governance  
25 hearings and this witness has already been

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1 Q. You stopped the process of completion of the form.  
2 A. I was unable to complete the death certificate element  
3 because it says if a death certificate has already been  
4 prepared ... So obviously it hadn't been prepared  
5 because it was a coroner's case, so I didn't complete  
6 that part. That's an optional part on the second page.  
7 Q. "If a death certificate has already been prepared, copy  
8 below".  
9 A. Yes.  
10 Q. And you were not prepared to issue the death  
11 certificate --  
12 A. You can't write a death certificate in advance of  
13 a coroner's case. It would be ridiculous.  
14 Q. You can issue a medical certificate of cause of death.  
15 Why were you filling this out if there was a referral to  
16 the coroner?  
17 A. Because this is an autopsy request form, this is the  
18 same form we use for forensic post-mortems or hospital  
19 post-mortems.  
20 Q. I thought that a coroner directed his own autopsy and  
21 that this is a request for the hospital to perform an  
22 autopsy.  
23 A. Under the direction of the coroner. I think Dr Armour  
24 explained, if I can remember, that the clinician has to  
25 complete as much clinical information as possible to

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1 cross-examined on governance in relation to Adam Strain.  
2 I don't follow where this can take us at this stage.  
3 MR STEWART: The relevance is that this is an issue he's  
4 talked about before.  
5 MR UBEROI: That's my point.  
6 THE CHAIRMAN: You're contrasting it to Claire's case?  
7 MR STEWART: Yes. I'm saying that if Dr Taylor had  
8 considered the issues before in a hyponatraemia case and  
9 had thought about them, then perhaps it should have been  
10 at the forefront of his mind when it came to this case  
11 and that he ought to intervene and suggest that  
12 a referral to the coroner --  
13 THE CHAIRMAN: So I think that's getting to the point about  
14 why, although Dr Taylor had such a limited role  
15 in relation to Claire, he didn't proactively intervene  
16 and suggest a referral to the coroner.  
17 MR STEWART: Yes.  
18 THE CHAIRMAN: I think that question is appropriate,  
19 Mr Uberoi.  
20 MR UBEROI: It is, and if that's the question, I'd be  
21 grateful if that's the question that's put.  
22 THE CHAIRMAN: Do you understand, Dr Taylor? The question  
23 is: knowing what you did about Adam's case and knowing  
24 what you must have picked up about Claire's case,  
25 despite your limited involvement, why did you not

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1 proactively intervene and say that Claire's was a case  
2 which should be referred to the coroner?  
3 A. I think I've answered the question before. I was in  
4 PICU on the day Claire died. I looked after her amongst  
5 my other PICU patients. My involvement with her,  
6 clinically, was to prepare her from the first set of  
7 brainstem tests to the second set of brainstem tests.  
8 I don't recall any conversation I had with the other  
9 clinicians involved and it was only after my duties  
10 finished around 5.30 that day that the other doctors  
11 convened and performed the brainstem tests and made the  
12 decision about death certification. I do not believe  
13 I was involved or ... I was not cognizant with her  
14 underlying diagnosis, that was a neurological paediatric  
15 diagnosis. I'm not a trained paediatrician, nor  
16 a neurologist. I'm an anaesthetist by training and  
17 that's a decision I would have left to the more  
18 appropriate authorities.  
19 THE CHAIRMAN: Okay. It's 1.10. You have some other issues  
20 to cover.  
21 MR STEWART: Indeed, sir.  
22 THE CHAIRMAN: Let's take a break until 2 o'clock, ladies  
23 and gentlemen.  
24 Have you managed to make contact yet at all with  
25 Professor Young or Dr Webb about your privilege?

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1 "Audit in paediatric intensive care deaths" in February  
2 of that year. Was that a publication or what was that?  
3 A. Well, if you read on, it says, "Submitted to the medical  
4 audit department".  
5 Q. Yes. Describe what that work was.  
6 A. Well, that was related to a paper that I'd read in the  
7 Journal of Medical Ethics from a PICU in England, and  
8 they actually looked at the deaths of an intensive care  
9 unit over a period of a year, and they looked at the  
10 number of patients who had died despite full intensive  
11 care, despite everything, and then looked at the  
12 patients who had died having treatment withheld or  
13 withdrawn. So I repeated a similar design for Belfast  
14 really to look at our practice to see if we were in  
15 keeping with a similar UK paediatric intensive care  
16 unit, and I believe the results were very similar: about  
17 50 per cent of the children who died, unfortunately died  
18 despite full intensive care management. So all the  
19 ventilation, the drugs, the antibiotics, everything that  
20 could be given was given, and despite that, about half  
21 the children died. That was similar to the other  
22 intensive care unit that had published in the Journal of  
23 Medical Ethics.  
24 And the other 50 per cent of children who died had  
25 treatment either withdrawn or withheld and, again, that

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1 MR McALINDEN: They have been informed of the situation.  
2 We're just waiting for their responses. Hopefully we  
3 should be able to inform you at 2 pm.  
4 THE CHAIRMAN: Thank you very much.  
5 (1.13 pm)  
6 (The Short Adjournment)  
7 (2.00 pm)  
8 THE CHAIRMAN: Mr McAlinden, any word?  
9 MR McALINDEN: I'm still waiting for my instructing  
10 solicitor to ascertain the position.  
11 THE CHAIRMAN: Okay, thank you. Mr Stewart?  
12 MR STEWART: Thank you, sir.  
13 Dr Taylor, following on from what we were discussing  
14 before lunch and if you didn't pick up in PICU that  
15 hyponatraemia was involved in Claire Roberts' death,  
16 I wonder, did you pick it up at the audit stage? You  
17 were, from December 1996, the coordinator of the audit  
18 programme in the Children's Hospital --  
19 A. Yes.  
20 Q. -- and you were something of an enthusiast for audit.  
21 A. Clinical audit, yes.  
22 Q. And indeed, an expert on it: you had published on audit.  
23 A. Well, I sent some audit projects to the audit committee.  
24 Q. If we look at your CV at page 306-019-012. In fact, at  
25 10 there, we see that there is a submission by you of

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1 was similar to our experience in Belfast. And the  
2 children who were brainstem dead with treatment  
3 withdrawn and some children who, after discussion with  
4 the parents, didn't wish their child to be -- didn't  
5 wish any further aggressive treatment to be given to  
6 their child. So they agreed to withholding certain  
7 medical treatments. We managed those children in,  
8 obviously, a very sensitive manner, but they died  
9 in that manner.  
10 That was an audit to compare our standards to the UK  
11 standards, to what was really the only publication  
12 in that area that I could find.  
13 Q. So that's really a benchmarking exercise, is it?  
14 A. That's what audit is.  
15 Q. Yes.  
16 A. Audit is comparing your outcomes to a guideline or  
17 a publication or some sort of standard that one can  
18 find.  
19 Q. Yes, and so all these pieces of work listed here on this  
20 page and the preceding page, they're all examples of  
21 your work in this area of audit?  
22 A. Of clinical audit, yes.  
23 Q. Would it be correct to describe you as something of an  
24 evangelist for audit at that time?  
25 A. No, I wouldn't dare describe myself as an evangelist.

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1 Q. What term would you have used?

2 A. I was a person who was keen on audit.

3 THE CHAIRMAN: On the basis that it's important to learn

4 lessons and it's important to know how we compare with

5 other parts of the UK?

6 A. Yes. I think working in a provincial area -- if you can

7 call Belfast a provincial area -- I attended every

8 Paediatric Intensive Care Society meeting in the UK --

9 it visits different cities; this year it was in

10 Dublin -- and talking to colleagues and networking with

11 various ... presenting some papers. If you read my CV,

12 I presented some at the PICS meeting.

13 I was very concerned that Belfast had the resources

14 and the outcomes, really. I mean, that's what it boils

15 down to. That we were not -- for our patients and for

16 our staff to ensure that we weren't slipping behind what

17 might be expected in the UK, if not Europe.

18 MR STEWART: So when you became audit coordinator in

19 succession to Dr Shields in December 1996, what did that

20 role entail?

21 A. That role entailed many elements. Of course, it was

22 a voluntary appointment, it wasn't a job. I was

23 continued in a full-time, quite busy specialty. But it

24 involved chairing the audit half-days, according to

25 a rolling calendar that was published by the Eastern

1 at your own practice, and if your own practice didn't

2 meet the standard that was set by some authority, then

3 you had an action plan, you implemented an action plan

4 that would re-audit and bring you up to those national

5 standards. So that's what I understood and that's what

6 I practised with clinical audit.

7 Q. All right.

8 A. You are talking about mortality review.

9 Q. Lest there be no misunderstanding: were you responsible

10 for the mortality meetings?

11 A. I was chairing the audit half-day. For the first

12 hour-ish of that audit half-day, each and every case of

13 death in the Children's Hospital was presented by the

14 consultant and I chaired that meeting.

15 Q. Was Claire Roberts' death discussed at a mortality

16 meeting?

17 A. I have no recollection of her death being discussed, but

18 it would have been practice for her death to be

19 discussed because every child's death -- certainly when

20 I took over as audit facilitator, audit lead person in

21 the children's directorate, I -- my secretary -- sorry,

22 the PICU secretary who I asked to undertake the

23 coordinating role for mortality, she was very fastidious

24 at her job and she would ensure that each and every case

25 was given a date for presentation.

1 Health & Social Care Board. It involved facilitating

2 other projects from other clinicians. It ensured

3 coordinating -- so as audit coordinator, audit

4 facilitator and audit chairman -- to ensure one doctor

5 wasn't repeating the work of another doctor, that they

6 could get together to make sure that the clinical audit

7 department of the Royal Trust, at that stage, wasn't

8 overwhelmed with requests for chart reviews and pulling

9 charts and the secretarial and clerical duties that that

10 audit department ... I believe Dr O'Connor had said --

11 and I agree with him -- it was a little bit

12 under-resourced, to put it mildly, in those days. So we

13 had to make sure that the projects were coordinated to

14 make sure we didn't completely overwhelm the Trust's

15 ability to meet the demand.

16 Q. And in terms of auditing the mortality cases, how were

17 those cases selected for audit?

18 A. Number one, they weren't audited. Clinical audit is, as

19 I've already described, you pick a national standard,

20 whatever that may be, Caesarean sections, whatever your

21 area is, and you compare your own practice to the

22 practice that's in publication. Obviously, you want to

23 get a good guideline, the NICE guidelines, or some other

24 important standard that you would pick. You would audit

25 through a series of statistical analyses, you would look

1 Q. You would know quite quickly if a death had not been

2 reviewed at a mortality meeting, wouldn't you, because

3 there are only so many deaths per year and so many

4 deaths considered?

5 A. The PICU secretary took on that role and responsibility

6 for me.

7 Q. Is it possible that her death was not discussed at

8 a mortality meeting?

9 A. Well, anything's possible.

10 Q. All right --

11 A. But it was my and her particular business to ensure that

12 each and every death was discussed in a systematic way.

13 THE CHAIRMAN: Is that every death in PICU or every death of

14 a child?

15 A. Most deaths will occur in PICU, some deaths occur in

16 A&E, and very rarely would a death occur on the wards.

17 Mostly, the children would be brought, however briefly,

18 to intensive care before they died.

19 MR STEWART: Is there any way of establishing whether or not

20 her case was discussed at a mortality meeting?

21 A. The PICU secretary would keep a record of every case

22 that was presented.

23 Q. Because the inquiry has been keen to find out and has

24 entered into correspondence and has asked people, and

25 first of all, with the exception of Dr McKaigue, who

1 believes he recalls being present at a mortality meeting  
2 where her case was discussed, Doctors Steen, Webb,  
3 Herron, Sands, Bartholome, can't recall, and nor can  
4 you. Have you yourself made any attempt to find the  
5 PICU secretary?

6 A. My PICU secretary retired this summer and she --  
7 I believe the Trust asked her to look into her records  
8 to see if the death of Claire was discussed at the  
9 audit, and I don't believe she was able to find that.  
10 But then, you'll have to remember the context. I took  
11 over as clinical audit lead, as you already know,  
12 in December 1996. I quickly realised that I was going  
13 to be very busy coordinating and facilitating the  
14 audits, so at some stage after December 1996 I asked the  
15 PICU secretary to undertake -- I don't know who did it  
16 before, the previous audit facilitator. But she at some  
17 stage then, in 1997, started maintaining a record and  
18 coordinating the actual mortality reviews.

19 So if a presentation was in late 1996 or very early  
20 1997, then it may be that she hadn't really got up to  
21 speed in that role. For instance, she would, I believe,  
22 have asked her line manager before -- a doctor can ask  
23 a secretary to take on a different role or an increased  
24 role, but the secretary may well, not very politely, say  
25 that she is not able to take on that extra role without

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1 manager to ensure that she wasn't taking on a role that  
2 wasn't supported by the Trust.

3 THE CHAIRMAN: Doctor --

4 A. I don't know when she actually started recording.

5 THE CHAIRMAN: Let's assume for the moment that Claire's  
6 death was reviewed at one of these meetings. What would  
7 that review entail?

8 A. The review in generic terms?

9 THE CHAIRMAN: If you can explain what would have been  
10 reviewed -- would the presentation have been by  
11 Dr Steen?

12 A. The presentation was by the person who knew the patient  
13 best or the person present at the time of the patient's  
14 death.

15 THE CHAIRMAN: That immediately begs the question -- because  
16 Dr Steen was the named consultant, but did not see  
17 Claire until she was in PICU. On the other hand,  
18 Dr Webb, who was not the named consultant, had actively  
19 intervened and had seen Claire a number of times.

20 A. Yes.

21 THE CHAIRMAN: Who would that lead to do the presentation?

22 A. Well, as I say, she wasn't the only case where there may  
23 have been one or more -- more than one consultant  
24 involved and even the lead consultant ... If I am on  
25 tonight, my name goes on the chart as the admitting

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1 her line manager authorising the increased duties and  
2 whatever goes along with that.

3 Q. Would it be fair to assume that a mortality meeting  
4 would not occur until after the autopsy report was  
5 available?

6 A. I believe it was the practice of the PICU secretary to  
7 wait for all the reports to be finalised. It's very  
8 embarrassing for the clinician and for others to be  
9 present at a meeting when the final outcome is --  
10 particularly if you remember the mortality was a review  
11 of the death, it wasn't an investigation into the death.  
12 It was a review of the finality or the final statements,  
13 reports.

14 Q. The autopsy report in Claire Roberts' case became  
15 available towards the middle of February of 1997.

16 A. Yes.

17 Q. And if the mortality meeting awaited the receipt of that  
18 report, the meeting would presumably have been towards  
19 the end of February or into March 1997. Therefore, the  
20 PICU secretary would have recorded her death being  
21 reviewed.

22 A. Well, as I said a few moments ago, the PICU secretary,  
23 I asked to take over that role -- I believe there was  
24 a period before she took on that role where she had to  
25 sort out some administrative niceties with her line

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1 consultant, but I may not have much clinical  
2 responsibility for that patient next week when the  
3 patient may die, but I will be nominated as the  
4 admitting consultant.

5 THE CHAIRMAN: Who does the presentation?

6 A. The first thing my secretary, I believe, would have done  
7 would be to go through the chart and find all the names  
8 of the consultants and then track down to see -- and  
9 I believe -- I remember there being times when she would  
10 come to me and say -- I'm not talking about Claire  
11 because I can't remember, but I do remember other cases  
12 where there were a multitude of consultants involved in  
13 a patient's care and I would work through her and the  
14 different consultants to work out which one of them  
15 would take on the responsibility of presenting and it  
16 was usually done very amicably.

17 THE CHAIRMAN: So the presentation would either be done, in  
18 all probability, by either Dr Webb or Dr Steen?

19 A. Yes.

20 THE CHAIRMAN: Okay. And what does that presentation go  
21 into?

22 A. The presentation, in generic terms, usually would follow  
23 the pattern of the -- a chronological discourse of the  
24 patient's past medical history, reason for presentation  
25 for the final illness, as it were, and then the issues

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1 around the death and the cause of death, any X-rays,  
2 CT scans, blood results and investigations and autopsy  
3 reports or coroners' inquests reports would all be  
4 presented in order. That's the usual --

5 THE CHAIRMAN: Right. If in the course of that it emerges  
6 that for instance Dr Bartholome was called to see  
7 Claire, couldn't see her because she was so busy and  
8 there was a gap of about three hours or so, is that the  
9 sort of thing that would come out at a review?

10 A. It may well come out, but remember the review is really  
11 following the investigation, it's an element of  
12 postgraduate learning that is done to a mixed audience  
13 of cardiologists, neurologists, nephrologists,  
14 anaesthetists, whoever is present then. So it's  
15 a mishmash of 20 or 30 --

16 THE CHAIRMAN: Pathologists?

17 A. Pathologists. My PICU secretary would invite the  
18 pathologist if there was an autopsy report.

19 THE CHAIRMAN: So if Dr Steen or Dr Webb was under the  
20 impression that encephalitis was a contributory cause of  
21 Claire's death then Dr Herron as the pathologist would  
22 be able to say, "That's not right because the evidence  
23 of encephalitis which we found on the autopsy report  
24 shows that it wasn't nearly at the level which would be  
25 required for it to be a contributory cause".

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1 one of the things that was passed on to me, was to say  
2 that there should be no minute kept of the meeting, of  
3 each case.

4 THE CHAIRMAN: Is that still the position?

5 A. There's currently guidance coming through from the  
6 Trust. We had a presentation at the last audit meeting  
7 but one, where a doctor presented the guidelines that  
8 are under consultation at the moment to minute the  
9 mortality aspect of the meetings.

10 THE CHAIRMAN: Thank you.

11 MR UBEROI: Sir, may I just say at this point, if you're  
12 establishing a clearer picture of these mortality  
13 meetings, I don't know whether you wish to establish  
14 with this witness where the notes would have been during  
15 the presentation, how many copies of the notes there  
16 were in the presentation? I don't know if that's the  
17 sort of factual evidence which you're interested in.

18 THE CHAIRMAN: Clinical notes and records?

19 MR UBEROI: Yes.

20 THE CHAIRMAN: Presumably whoever did the presentation would  
21 have worked their way through the clinical notes and  
22 records.

23 A. Yes, as I said my secretary was particularly fastidious.  
24 She didn't want to get any complaint that some of the  
25 notes weren't present. So she would wait until all the

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1 A. Right.

2 THE CHAIRMAN: That's the sort of thing that would be  
3 discussed? Except the problem is that nobody can  
4 remember any such discussion at all.

5 A. Yes.

6 THE CHAIRMAN: Is that the sort of exchange which we've been  
7 told can sometimes spark a fairly lively and fairly  
8 blunt debate between the various people who were or were  
9 not involved in the treatment of the child?

10 A. Well, I worked in Toronto for two years in the late 80s,  
11 and the grand rounds and the mortality presentations  
12 were, as you describe, a bear pit. They were very open  
13 and very occasionally led to clinical disagreement and a  
14 heated exchange of views. My role as the audit  
15 facilitator and chairman of this particular meeting was  
16 to ensure that a reasoned set of discussions did take  
17 place. I wouldn't say they were heated, but there was  
18 certainly an exchange of views and it was my job to make  
19 sure that everybody didn't speak at once and also to  
20 keep time. It would be usual to have two to three  
21 presentations in that first hour of the audit half-day.

22 THE CHAIRMAN: Do I understand it correctly that the  
23 discussions are deliberately not minuted in order to  
24 encourage free expression?

25 A. Well, when I took over as audit coordinator, that was

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1 notes were filed in chronological order, all the  
2 investigations were all collated, and she worked hard to  
3 make sure -- and it was hard work to make sure that the  
4 relevant clinicians, including the pathologist, was  
5 there on that particular day. Everybody had different  
6 duties that day. As I say, I was the chairman and lead  
7 of the audit, but it may be I was on for PICU that audit  
8 day so I would have had clinical responsibilities and  
9 I wouldn't have been able to chair either the start of  
10 the meeting or the end of the meeting.

11 THE CHAIRMAN: Right, but the presentation can only make  
12 sense if the person who does the presentation has worked  
13 his or her way through the reports and records so that  
14 the presentation is as full and complete as it needs to  
15 be.

16 A. That was the way the PICU secretary organised it and  
17 that was the way the clinicians wanted it to be  
18 organised.

19 THE CHAIRMAN: When you get to the meeting -- and let's  
20 suppose here it is Dr Steen; it doesn't matter whether  
21 it was Dr Steen or Dr Webb -- that person will have the  
22 records to hand, will they?

23 A. The PICU secretary ensured that the records were there  
24 for the consultant.

25 THE CHAIRMAN: Will anybody have copies of them?

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1 A. No. It was very -- I don't remember any cases presented  
2 where copies were handed out to the clinicians present.  
3 THE CHAIRMAN: Okay.  
4 A. Very often an acetate was made of a summary of the  
5 patient. In those days, we didn't all have Powerpoint  
6 back in the mid-1990s. It was a teaching, education  
7 centre that we used in the hospital, the function room,  
8 and, at some stage in the 1990s, a Powerpoint projector  
9 was purchased and doctors usually summarised slides,  
10 a slide show of their case.  
11 THE CHAIRMAN: Mr Fortune?  
12 MR FORTUNE: Sir, Dr Taylor's just referred to the  
13 last-but-one audit meeting when a set of guidelines in  
14 draft was presented. It may be interesting for you to  
15 find out when that last-but-one audit meeting was and  
16 whether it has any connection in time to the fact that  
17 you've been sitting for many weeks now.  
18 THE CHAIRMAN: Can you help on that, doctor?  
19 A. I believe the Trust is being proactive to ensure that  
20 things are being documented in a way that perhaps  
21 pre-empts the inquiry.  
22 THE CHAIRMAN: Does that come out -- is that within the  
23 Belfast Trust --  
24 A. I'm not -- I don't know that for certain. That's my  
25 presumption.

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1 "medical audit meeting"?  
2 A. Sorry?  
3 MR UBEROI: Can we see the document that's being referred to  
4 in fairness to the witness?  
5 MR STEWART: All right. I will come to that in just  
6 a second. If I may ask you two questions first. If,  
7 at the mortality meeting, only the person presenting the  
8 case has the notes and records, how can other people  
9 examine the case in any meaningful way?  
10 A. Because sir, with great respect, it's not an examination  
11 of the death; it's a review of the cause of the death  
12 in the Children's Hospital so that the doctors may learn  
13 that the case has been concluded and this is the final  
14 outcome of the cause of death. That helps to educate  
15 the doctors present that a child with diabetes or  
16 hyponatraemia has died within the hospital.  
17 Q. The reason I ask is that a proper examination of the  
18 notes in this case would have revealed two potentially  
19 serious medication overdoses. What is the point of  
20 having a mortality meeting when people don't have the  
21 opportunity to look for the causes of death from the  
22 notes?  
23 A. Well, sir, there are other methods of investigating  
24 death in a hospital. They were being very -- evolved  
25 and formative and, obviously, inadequate back in 1996,

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1 THE CHAIRMAN: That could come from -- if they're  
2 pre-empting anything here, great. They don't need to  
3 wait for a report from me. That's one option. The  
4 other possibility is that it is coming from either the  
5 department centrally, the Department of Health, or  
6 alternatively from any one of the Royal Colleges or the  
7 GMC.  
8 A. I can't illuminate you any further. I just know I was  
9 present at an audit meeting and a doctor presented the  
10 draft guidelines to suggest that -- and there was  
11 a range of debate again; the consultants don't sit  
12 quietly. There was a range of debate about keeping the  
13 status quo, not recording the minutes. Because this  
14 is -- I have to state quite clearly to you, sir, that  
15 the mortality section of audit is not an audit of the  
16 clinical records, it is not an investigation of the  
17 death; it is a review following the completion of any  
18 investigation that has been undertaken and the finality  
19 is presented to the consultants for the purposes of  
20 learning from that death.  
21 MR UBEROI: Our LiveNote has frozen. I don't know if  
22 I might send out a plea for some assistance.  
23 MR STEWART: If there is a misunderstanding between the  
24 terms "mortality meeting" and "audit", is it because  
25 mortality meetings are conducted under the heading of

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1 but a serious adverse incident will now be triggered by  
2 such a case, I believe, as Claire and Adam. That would  
3 involve an investigation of those notes. Following that  
4 investigation internally, they will go on to be reviewed  
5 externally.  
6 Q. May we confine ourselves to 1996?  
7 A. Yes, sir.  
8 Q. What review of Claire's notes would have been conducted  
9 in 1996 to see if everything was all right or lessons  
10 could be learned?  
11 A. Well, it wasn't during the mortality meeting --  
12 Q. Right.  
13 A. -- because that was not convened. The people coming to  
14 the audit half-day were not the people who were trained  
15 and experienced and given up to exploring such matters.  
16 THE CHAIRMAN: Sorry --  
17 A. It was a review of the death.  
18 THE CHAIRMAN: I'm a bit lost then because I can't  
19 understand. If it's not an investigation, it's  
20 a review, as bald as that, how anybody gets excited at  
21 these meetings. If I understand you correctly, you're  
22 not challenging what was done or not done, it's simply  
23 a report to a meeting that a child has died and this is  
24 the cause of death.  
25 A. That's correct.

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1 THE CHAIRMAN: So what's to get excited about?  
2 A. I can give you some examples of things that did change  
3 because of these mortality meetings, and there are  
4 several that I remember during my short time as the  
5 audit lead. One was -- and it has already been referred  
6 to I think in a private witness statement from  
7 Dr Shields.

8 Several cases came through, if you like, to say as  
9 a cluster of deaths around meningococcal disease,  
10 meningitis. These were reported during that and the  
11 cause of death was known. When we frequently have to  
12 phone the coroner following the tragic death of a child  
13 with meningitis -- and it's very rarely in my experience  
14 that the coroner requests that there is a coroner's case  
15 involved. Nearly always the advice, in my experience,  
16 is to complete a death certificate and not go down the  
17 coronial system. Those cases are brought for review  
18 at the mortality meeting outside the coronial system.  
19 Any adverse event that occurred during that is clarified  
20 by the clinicians involved in that case. The  
21 paediatrician would review what antibiotics were given,  
22 what treatment was given. We, in intensive care, would  
23 look to make sure that the patient was adequately  
24 treated in intensive care. Then they would be presented  
25 at the mortality review.

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1 THE CHAIRMAN: Okay, thank you.  
2 A. There are other cases such as children who were born  
3 with congenital abnormalities and I arranged for the  
4 neonatologists and the obstetricians to meet with us in  
5 a joint meeting so that we could work together to make  
6 sure that mummies were told that their child had  
7 a potentially fatal birth defect and so that the  
8 obstetrician would work with the neonatologist, who  
9 would be initially resuscitating that baby and then the  
10 baby would come to us for, perhaps, surgery. For it all  
11 to work together, a joint audit review mortality  
12 meeting -- I facilitated to make sure that we were all  
13 making sure that these children got the best chance of  
14 survival.

15 THE CHAIRMAN: Is this an extended spin-off from a mortality  
16 review in the first place?

17 A. This is all related to mortality. The children that we  
18 present at mortality, people would say this child died  
19 with a 50 per cent mortality of a very serious  
20 congenital defect. Some doctor would say, "But the  
21 mummy was very upset, maybe the information she had been  
22 given during antenatal care by the midwife or by the  
23 obstetrician hadn't prepared her adequately", and that  
24 would be brought through from people attending the  
25 meeting, and to make things better, even if we couldn't

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1 During a discourse of that review, people would  
2 perhaps say, "I remember previous deaths similar to  
3 this", and maybe putting the system together, doctors in  
4 community practice would say, "I'm meeting mummies who  
5 are concerned about their child developing a rash and  
6 developing neck stiffness". So they would want to know  
7 what they could tell their parents.

8 THE CHAIRMAN: That's --

9 A. And together -- we got together and made  
10 a Northern Ireland guideline.

11 THE CHAIRMAN: On meningococcal disease?

12 A. On meningococcal disease. That was part of my sick  
13 child liaison group, which you've asked about. Not long  
14 after those cases were brought to the mortality review,  
15 not having undergone serious adverse incident reviews,  
16 but clearly where practice was -- deaths occurred and  
17 perhaps practice -- whether in primary care, whether in  
18 recognition of the illness or whether in the hospital  
19 care -- did the patient move smoothly through the A&E,  
20 and the theatre and the intensive care, those were  
21 reviewed, put through as a guideline and subjected, as  
22 you can see, to a clinical audit project where we looked  
23 at the standards to see if the guideline was actually  
24 making any difference. And I believe we did reduce our  
25 mortality with a very serious paediatric condition.

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1 impact or improve survival of the babies, at least we  
2 could better inform the clinicians and the parents of  
3 future infants.

4 So I believe that the mortality review did make big  
5 differences to the quality of care and perhaps even  
6 survival of children, not only in the paediatric  
7 hospital, but also in the regional maternity hospital.  
8 That was during my time as tenure.

9 THE CHAIRMAN: Right. Mr Fortune?

10 MR FORTUNE: Sir, do forgive me. You said a few moments ago  
11 that you were lost. I thought I was the only one who  
12 was lost. If I look at Dr McKaigue's witness statement,  
13 about which we will hear tomorrow when he gives  
14 evidence, WS156/2, at page 6. At the top in the second  
15 paragraph, Dr McKaigue refers to Dr Steen presenting  
16 Claire's death at the audit meeting at which he,  
17 Dr McKaigue, was present. And if you go down to  
18 question 24:

19 "I cannot recall if the pathologist was present at  
20 the audit meeting when Claire's death was presented."

21 At 26, Dr McKaigue says:

22 "When Dr Taylor was audit coordinator in the Royal,  
23 his role at audit meetings was as a facilitator. This  
24 did not exclude him from contributing to discussions."

25 My question to you, sir, and ultimately to

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1 Dr Taylor, is: is Dr McKaigue talking about the  
2 mortality meeting or something completely different, or  
3 is the meeting known by more than one name, and if so,  
4 is it minuted? To that extent, I'm totally lost.

5 MR STEWART: May I assist perhaps? 305-011-591.

6 MR UBEROI: [Inaudible: no microphone] interject as well?  
7 I'm not really sure anyone is lost. The witness has  
8 offered his evidence, which is effectively that there  
9 were the clinical audit meetings and the mortality  
10 meetings were a sub-section of that. He has been very  
11 clear on that and he has just offered you some examples  
12 of some of the things that came from them. I'm lost as  
13 to why Mr Fortune is lost.

14 MR FORTUNE: Before the blind leads the blind, what was  
15 discussed at a clinical audit meeting that wasn't  
16 discussed at a mortality meeting, or vice versa, and  
17 were there records provided to all the clinicians at one  
18 or other?

19 MR UBEROI: Dr Taylor has offered his evidence on precisely  
20 that point, his definition of what the clinical audit  
21 aspect of things was, and he has very been clear on the  
22 fact that the clinical audit was not the same as the  
23 investigation into a death. He has talked about the  
24 benchmarking process and how clinical audit involves the  
25 recognition and benchmarking of trends. That's the

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1 A. Approximately an hour, depending on the amount of cases.  
2 Q. Each?  
3 A. No, the whole element of mortality would last an hour.  
4 Q. So that would be no matter whether there was one death  
5 to discuss or four? It would last an hour?  
6 A. I don't think there was ever just one.  
7 Q. Okay. How many would be on average?  
8 A. Two to three is my memory.  
9 Q. And that would all be done in the space of an hour?  
10 A. I wouldn't put on any more than about three, certainly.  
11 But one would look at them in advance and if there was  
12 no -- if the child had died after a complex illness and  
13 there was no controversy or difficulties that one would  
14 expect to be ... I don't know how to put this, but if  
15 they were going to be short cases presented, one would  
16 have some anticipatory knowledge of what would be  
17 a quick case and what would tend to take a lot longer.  
18 And as I said, perhaps babies born in the neonatal  
19 nursery with major congenital defects who were known to  
20 be unlikely to survive, then perhaps the meeting  
21 wouldn't take very, very long. Having said that, we did  
22 get some surprises and perhaps areas did open up many  
23 times that -- although this baby was expected to die,  
24 some doctor or nurse would say, "But that's not what  
25 mummy was told", and that would lead us to then

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1 evidence.

2 MR STEWART: This document is the minute of the first  
3 meeting you chaired as audit coordinator on 10 December  
4 1996. This was shared with us by the DLS on the basis  
5 that this may well have been the meeting at which  
6 Claire's case was discussed, although it seems unlikely.

7 THE CHAIRMAN: Even if it's not, it's a minute of an audit  
8 meeting.

9 MR STEWART: Yes, indeed, and it's useful because it starts  
10 off with Dr Shields handing over the role of audit  
11 coordinator to Dr Taylor. And following that,  
12 a discussion ensued about the future running of the  
13 audit programme, with it being noted that the audit  
14 meetings should start as usual with the mortality  
15 meeting:

16 "Each case presentation should have a time limit and  
17 the consultant supervising the case should have the  
18 opportunity to express problem areas in the management  
19 of the case in a non-hostile environment and those  
20 presenting cases should indicate to Dr Taylor how long  
21 they will require."

22 So that's the type of format of a meeting. You've  
23 had the mortality discussions first.

24 A. Yes.

25 Q. How long would they have lasted?

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1 investigate a better way of educating not only the  
2 paediatricians because we don't come in contact with  
3 pregnant women very often, but very often then ...  
4 I got a feeling from those present that to take this any  
5 further forward -- and that certainly Dr Hicks was very  
6 supportive of a joint audit with the Royal Maternity  
7 Hospital consultants, which would include obstetricians,  
8 midwives and neonatologists, because without putting  
9 them all together, the messages do not get back.

10 THE CHAIRMAN: Does that lead on to point 2 then:  
11 "The directorate should continue doing three or four  
12 multi-professional audits each year and would encourage  
13 the team approach to audit."

14 A. Every audit was multi-professional. Medical audit  
15 changed to clinical audit before my taking over as the  
16 clinical audit lead. So during and before my time it  
17 was very open for all to attend the nursing --  
18 I remember specialist nurses coming for pain, doing an  
19 audit on our pain management to ensure that our quality  
20 of pain management, post-operative pain, was as good as  
21 the national standards, which were published at the  
22 time. I remember other specialist nurses in diabetic  
23 care and asthmatic care coming and being welcomed.  
24 I remember pinning the audit agenda on the noticeboard,  
25 the education noticeboard, well in advance of each

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1 audit, putting it on the door of the education room in  
2 advance -- two or three days, a week, in advance of the  
3 audit meeting. I went round personally contacting  
4 individuals outside the medical fraternity to make sure  
5 that it was open to all.

6 Having said that, nursing very often used the audit  
7 half-day in my perception, my experience, to conduct  
8 their own in-service training, so theatres would  
9 obviously not work unless there was an emergency during  
10 an audit half-day, and that gave theatre managers the  
11 opportunity to get nurses trained on new diathermy  
12 machines, fire training, moving and handling training.  
13 So the nursing established -- undertook their own form  
14 of in-service education and review of their practices  
15 outside the clinical audit meeting and I had no control  
16 over that.

17 THE CHAIRMAN: Okay, thank you.

18 MR STEWART: What about the final section of paragraph 2?

19 "In addition, it is important that each unit  
20 continues to do the case note review audit."

21 A. Yes.

22 Q. What case notes were reviewed?

23 A. Well, this was again started by Professor Shields before  
24 I took over as audit coordinator, and Professor Shields  
25 had very kindly given me the template from the Royal

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1 College of Paediatrics and Child Health template for  
2 case note review. It was a couple of A4 pages where  
3 doctors in that ward would undertake a random selection  
4 so that we weren't picking on any particular doctor or  
5 nurse. And they would sit down in a group and  
6 I actually timetabled an event once or twice a year for  
7 each unit to sit down and we did it in anaesthesia where  
8 we got the Royal College of Anaesthetists template for  
9 anaesthetic record review and that a random selection of  
10 case notes or anaesthetic records were reviewed by the  
11 clinicians encountering that case note or that medical  
12 record. Then the results of that were handed to me and  
13 I sent them on over to the clinical audit department.  
14 That was a continuous process. I have to say that after  
15 each case note review audit was undertaken, the quality  
16 of case notes did improve for the next few months, and  
17 then they tended to slip perhaps back again into not so  
18 good. So it was a good way of improving the clinical  
19 record note-keeping in my view.

20 Q. Would a death case have had the case notes reviewed  
21 in that way?

22 A. No, the case notes review -- you're talking about  
23 a serious adverse incident review?

24 Q. I'm talking about Claire Roberts' case.

25 A. That should have triggered -- but in those days the

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1 system was not as mature as it is now -- a serious  
2 adverse incident review of her case notes.

3 Q. Is there any evidence that Claire Roberts' case was  
4 subjected to a case note review, an adverse incident  
5 review, a clinical audit or any other form of review,  
6 investigation or appraisal to your knowledge?

7 MR UBEROI: Can I interrupt [inaudible: no microphone]  
8 concern at this point? Dr Taylor is here offering  
9 factual evidence and I'm sure, he hopes, helpful  
10 evidence on the system as it was. There's a danger of  
11 him being cross-examined in a fashion which would  
12 suggest he is responsible for the system. He's not.  
13 He's working within it. He has placed his hand up in  
14 order to be the chair of the paediatric audit committee,  
15 which is what he is here offering evidence about. But  
16 I would express that note of caution if that line of  
17 cross-examination is going to be pursued in response to  
18 his answers about what the system was.

19 THE CHAIRMAN: But he's part of that system.

20 MR UBEROI: He is.

21 THE CHAIRMAN: And I think it's legitimate to ask --  
22 because, sorry, let me put it this way as a variation on  
23 what Mr Stewart said. I don't think anyone will  
24 doubt -- and I don't think even Mr and Mrs Roberts will  
25 doubt, despite their experience -- that there is an

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1 awful lot of good work done in the Children's Hospital.  
2 And if you develop guidelines about meningococcal  
3 disease, that's great, that will help treat children and  
4 save lives in the future. This inquiry will not  
5 conclude a report that everything goes wrong in the  
6 Children's Hospital. It clearly doesn't, doctor, and  
7 I don't want that message, misunderstanding or  
8 misrepresentation of the inquiry to get out.

9 What we're looking at, in very crude terms -- and  
10 I'm sure this is too simplistic -- is: what went wrong  
11 in the cases of Adam and Claire and Raychel, as a start.  
12 And, secondly, what happened afterwards.

13 We are going into this because it helps us to  
14 understand what is supposed to happen afterwards and how  
15 lessons are learnt and how mistakes are spotted and how  
16 practices improve. We've got out of this inquiry over  
17 the last number of weeks a lot of evidence about what  
18 went wrong in Claire's treatment, which did not even  
19 come out at the inquest and which certainly did not come  
20 out in 1996. But the second aspect about what happened  
21 afterwards is almost a vacuum. And the parents have  
22 said this repeatedly -- not just the Roberts, but other  
23 parents as well have said this -- when things go wrong  
24 they can understand, we're all imperfect, we all make  
25 mistakes, but what reassurance do they have or do other

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1 parents have that the same things will not happen again?  
2 So when Mr Stewart was asking you since you were  
3 part of the system from late 1996 -- part of the system  
4 anyway, but you took on the role of audit coordinator  
5 and when that system develops and continues and  
6 improves, where is the evidence that anything positive  
7 happened after Claire died to make it less likely that  
8 another child would die in the same or similar  
9 circumstances?  
10 A. Well, there's no evidence.  
11 THE CHAIRMAN: There isn't any evidence, is there? And  
12 that's really the problem. The problem isn't that there  
13 weren't systems in place, the problem isn't that there  
14 was nothing which could have been done. Nobody can ever  
15 say in Claire's case, "Look, that's just one of those  
16 things that happens and we couldn't have done any more  
17 or any better", because I'm afraid from the weeks of  
18 evidence we've heard, Claire's case is full of mistakes.  
19 A. Yes.  
20 THE CHAIRMAN: And I suspect the real tragedy is that, as  
21 was put in Adam as case, as you may have heard, that  
22 sometimes you just get the rather inelegant comparison  
23 to a piece of cheese and sometimes the skewer goes right  
24 through all the holes. And that's a disastrous result  
25 where in other circumstances where people make mistakes,

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1 don't like, but we know what they mean.  
2 THE CHAIRMAN: Something short of death.  
3 A. I would rather 100 near misses be picked up than one  
4 mortality. The pharmacists now, in every third or  
5 fourth clinical meeting, present the outcomes of the  
6 serious adverse incident reviews. So they're presented  
7 during clinical audit; they're not part of mortality,  
8 they are administration of drug errors, they are  
9 prescription errors. So you say the drug errors that  
10 were present in Claire's chart weren't reviewed, and  
11 I see no evidence that they were reviewed. But today,  
12 and for the last few years, a group consisting of  
13 a consultant anaesthetist, a pharmacist and a nurse sit  
14 down and they get every single adverse -- IRI is what  
15 they're called -- report. It's just changed to an  
16 online system rather than a paper system in the Trust  
17 and that was updated at the last audit meeting as well.  
18 So every adverse incident is collated, they are put  
19 into a tabular form so that prescription errors -- which  
20 are usually caused by a doctor -- and administration  
21 errors -- which are usually caused by nursing -- are all  
22 collated. They may or may not have led to patient harm,  
23 they may have been very minor rather than a drug dosage  
24 being wrong, but perhaps it was mixed up in salt water  
25 instead of pure water, if you know what I mean, sterile

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1 as they inevitably will, those mistakes are picked up  
2 somewhere along the way, hopefully before the child dies  
3 or at least after the child dies to make sure it doesn't  
4 happen again. That's the governance issue. Where is  
5 the evidence that anything was picked up at all? And  
6 there doesn't seem to be any. Or where is the  
7 reassurance that something like this won't happen again?  
8 And I'm afraid it's not there either.  
9 A. Well, I believe there has been changes made. I believe,  
10 after the Kennedy report in Bristol, that we did change  
11 the culture significantly. I remember presenting the  
12 Kennedy -- not the 1997 recommendations. I remember  
13 photocopying the recommendations that were pertinent.  
14 Sentinel cases -- reporting of sentinel cases was a key  
15 aspect, and I recollect photocopying them, putting them  
16 on to acetates and presenting it during the audit meeting  
17 that serious cases had to be reviewed a la --  
18 post-Bristol. The governance term wasn't even known.  
19 I did not know about governance until after Bristol.  
20 Then we come into an era where serious adverse  
21 incident reporting was part of the systems in place  
22 in the Royal Trust in 1996, but it wasn't always  
23 utilised. What's happening now is that serious cases  
24 are reviewed, not only mortality, but the numbers of  
25 near misses, which is a term that the risk managers

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1 water. So those are recorded as adverse incidents.  
2 They may be near misses. The number of mortality cases  
3 is obviously very small in relation to the number of  
4 total adverse incidents that are reported. And  
5 I believe the system still is not perfect, but it is  
6 much better now -- and I believe that Claire's drug  
7 errors would have been picked up in 2010 and beyond that  
8 weren't picked up in 1996. And to me it's a source of  
9 great regret that I didn't preside over a better system,  
10 that pharmacists were present on the ward rounds,  
11 pharmacists were present on the wards, and they are very  
12 helpful to me and my colleagues when it comes to  
13 prescribing drugs that we're not familiar with. That  
14 has changed.  
15 Audit is not really a benefit in terms of mortality  
16 review. Audit is a system, as I've explained, of  
17 looking at the macro -- looking at the larger numbers of  
18 patients coming through the service and comparing that  
19 to national standards. CEMACH is also present now --  
20 the Confidentiality Enquiry into Maternal and Child  
21 Health deaths, CEMACH -- and those are presented online.  
22 PICANet, which paediatric intensive care funds,  
23 records all the deaths -- records every patient coming  
24 into PICU. You can go online to PICANet.org.uk and you  
25 can download the latest report which gives you the

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1 paediatric mortality of PICU, which is the main  
2 mortality of the Children's Hospital in  
3 Northern Ireland, and compare our results against  
4 a standardised mortality rate. So in other words,  
5 a risk-adjusted score is given for every PICU in the  
6 country. We're coded as ZB. It's available to the lay  
7 public, you can check to see what is our observed  
8 mortality, so the numbers of death we observe, no  
9 greater than the deaths that would be expected according  
10 to the degree of severity. And we are hovering around  
11 the 1 mark, which means that our observed mortality is  
12 no greater than the observed. And that gives me great  
13 confidence in dealing with the public and with my  
14 patients to say: when your child is looked after in our  
15 hospital, particularly PICU, the risk of death in this  
16 hospital is no greater or less than if that child was  
17 treated in Sheffield or Birmingham or one of the London  
18 teaching hospitals. That detail is available online and  
19 it took a big effort for our trust to move from our  
20 home-grown computerised coding system into a truly  
21 nationwide system where the mortality of each case is  
22 plotted on a curve and we're well on the mark.

23 Paediatric cardiac babies are reviewed and you'll  
24 have heard recently that there was a few outliers on the  
25 deaths from that and that triggered an external review.

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1 A. I believe I produced a few audit minutes, mortality  
2 minutes were part of that, where I did write down  
3 lessons that had been learned.

4 Q. I've come across an example from before your time as  
5 well.

6 A. It may well have happened during Professor Shields' time  
7 as well.

8 Q. 305-011-574. This is from March 1995. It's the  
9 paediatric medical audit meeting, "Topic: mortality".  
10 Points of note:  
11 "Three cases were presented. Decisions. Action."  
12 And there's a neat distillation of a point:  
13 "If a child presents dead on arrival, the senior  
14 house officer on duty must complete the appropriate  
15 protocol form ..."

16 Efforts were made in relation to 1995, earlier, to  
17 distil it, yet it's still not been possible to trace  
18 anything that might relate to Claire.

19 A. No.

20 Q. Can I ask you, moving on from audit, about your  
21 subsequent work a number of years later with the working  
22 party in relation to hyponatraemia in children, the  
23 Department of Health working party. That's in your CV  
24 as part of your national work and you're on the  
25 committee from September 2001 to January 2002. Why were

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1 And that concluded that Belfast was safe to provide  
2 paediatric cardiac surgery, but not sustainable.

3 THE CHAIRMAN: Because of numbers?

4 A. That was -- well, you can read the report. I don't want  
5 to go into that. But the external review was triggered  
6 because of two deaths, which made Belfast just outside  
7 the curve, which triggered an automatic external review.  
8 So what I'm trying to say -- it's a very long answer to  
9 a very short question -- is I believe the systems were  
10 inadequate back in 1995 and 1996. I believe a lot has  
11 changed and a lot of hard work has gone into trying to  
12 prevent such cases.

13 THE CHAIRMAN: Okay, thank you.

14 A. I believe we're nearly there, but I don't think --

15 THE CHAIRMAN: The reality is you won't ever quite be there.  
16 It's impossible to get there.

17 A. It's impossible, it's a continuing process of quality  
18 improvement.

19 THE CHAIRMAN: Thank you very much, doctor. That's very  
20 helpful.

21 MR STEWART: Just one more audit point, if I may, and  
22 that is: when the minutes of the paediatric directorate  
23 clinical audit meeting with the mortality meetings were  
24 produced, did they ever make reference to the lessons  
25 learned from the mortality discussions?

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1 you put forward or chosen or why did you volunteer for  
2 membership of that working party?

3 A. I can't remember who asked me to sit on it, but I didn't  
4 volunteer for it; I was asked to sit on it. It might  
5 have been Dr Carson, but I can't remember. I wouldn't  
6 like to put him on the spot if he doesn't agree with me.

7 Q. Did you produce and did you prepare to present  
8 a Powerpoint presentation to the Department of Health  
9 hyponatraemia working party on hyponatraemia in the  
10 Royal Belfast Hospital for Sick Children, a teaching  
11 aid?

12 A. Yes, I remember that.

13 Q. I believe that you did not, in fact, present it.

14 A. No. I was a bit disappointed in that. I thought  
15 I could get some -- I think that was sent to  
16 Paul Darragh, by email, a week before the first meeting,  
17 18 September, and it was compiled over the summer  
18 months, July and August. Raychel obviously died  
19 in June. So over July and August, I attempted to get as  
20 much information as I could possibly get to try and  
21 illuminate the hyponatraemia working party about the  
22 incidents of hyponatraemia within our intensive care  
23 unit. And that's what the first draft was. I was  
24 a little bit disappointed that some of my work, albeit  
25 an early draft stage, wasn't taken up.

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1 Q. Let's go to that inquiry. It's 007-051-100. There you  
2 are e-mailing Paul Darragh at the Department of Health  
3 on 18 September saying:  
4 "Here are some draft documents for your  
5 consideration in advance of the meeting on  
6 26 September." That's the week following.  
7 A. Yes.  
8 Q. Then you attach to it, 101 -- this is the Powerpoint  
9 presentation teaching aid:  
10 "Hyponatraemia working party, Department of Health  
11 2001."  
12 On the next page, 102:  
13 "Background. Dilutional hyponatraemia has been  
14 documented in otherwise healthy children following  
15 routine elective surgery. If unrecognised, it can lead  
16 to seizures, cerebral oedema and death."  
17 It's quoting Arieff there.  
18 The next, 103:  
19 "Incidence of hyponatraemia in the Royal Belfast  
20 Hospital for Sick Children."  
21 And we've got the deaths represented by bars in all  
22 of the years, 1991 to 2001, excepting 1995, the year  
23 that Adam Strain died, and 1996, the year that  
24 Claire Roberts died. How do you explain your omission  
25 of these two cases from your incidences of

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1 continue. The PAS is basically administrative. It  
2 allows every patient who is admitted to be entered by  
3 the admissions secretary on their arrival in the  
4 hospital: their name, age, date of birth, hospital  
5 number. Sticky labels are then printed from that to be  
6 held in the patient's chart and a new chart is produced  
7 or the old chart is found and brought to the ward.  
8 The PAS allows every patient to be tracked through  
9 the system, multiple admissions, discharges from  
10 outpatient clinics, discharges from hospital, and death.  
11 But unfortunately, the PAS does not contain important  
12 data such as blood test results, sodiums or clinical  
13 codes; it's purely an administrative system. So that's  
14 not really of much use to me, although you can get  
15 sometimes rough statistics about the number of  
16 admissions in a hospital over a month or a year coming  
17 to casualty or coming to outpatients. But that's that  
18 first -- and that's been around for years. But it's not  
19 really integrated into the clinical management of the  
20 patient, if you know what I'm trying to say.  
21 The second system is the clinical coding system,  
22 which is the one I think you're alluding to. Clinical  
23 coding, to me, was a system run by, I think it was  
24 a company called CHKS. It was administered by a senior  
25 coding manager -- to my knowledge, at that time, his

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1 hyponatraemia?  
2 A. I've explained it in my written evidence. I don't know  
3 if you've got the reference to that to help ...  
4 Q. You based, as I understand your witness statement, this  
5 graph on evidence gleaned from a PICU computer database.  
6 A. Yes.  
7 Q. And you chose not to use the hospital computer database;  
8 is that correct?  
9 A. What do you mean? I think I've explained it in my  
10 written evidence. There's --  
11 MR UBEROI: What the witness is alluding to is witness  
12 statement 157/2, page 2. Beginning at 4(a). Perhaps  
13 one might ask if the next page could be put up in split  
14 screen so the full answer is there.  
15 THE CHAIRMAN: Sure.  
16 MR UBEROI: Thank you.  
17 MR STEWART: Perhaps you just tell us rather than reading  
18 out your witness statement.  
19 A. I would have known of three different ways of  
20 interrogating computer data. In the time I had  
21 available, I obviously couldn't pull hundreds of charts  
22 from PICU. There's the PAS, Patient Administration  
23 System, which is --  
24 Q. That's the hospital system?  
25 A. It's one of the hospital systems, if you let me

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1 name was Danny McWilliams -- and a paediatric clinical  
2 coder called Margaret Newell. They entered sets of  
3 clinical codes on to a huge computer in the main  
4 hospital and it included paediatric adult --  
5 Q. May I interrupt you to show you what they coded for  
6 Claire? That's at 302-153-003. This is what was coded  
7 on the hospital PAS computer system in relation to  
8 Claire. If you run down there, you'll see the words  
9 "hypoosmolality" and "hyponatraemia" occur. So there  
10 she is, and hyponatraemia is correctly coded alongside  
11 her.  
12 A. Well, you said that was the Patient Administration  
13 System.  
14 Q. Yes.  
15 A. I didn't understand the Patient Administration System to  
16 be useful for that. I believed that was the clinical  
17 coding system that did that. They're two separate  
18 systems.  
19 MR UBEROI: May I rise at this point to really raise  
20 a procedural point? If Dr Taylor's being cross-examined  
21 on the mechanism by which the data was sourced,  
22 certainly it was my understanding that we've submitted  
23 some of the documentation which, effectively, the PICU  
24 secretary produced. And I stand to be corrected, but  
25 I don't believe it's yet been circulated. It's a fairly

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1 major redaction process to do so. So there's a slight  
2 conflict in my mind if the witness is being  
3 cross-examined on this point, the fact that relevant  
4 documentation has been submitted by him, which has yet  
5 to be circulated.  
6 THE CHAIRMAN: But I think the problem about the  
7 documentation is that it has to be virtually completely  
8 redacted, doesn't it? Because as provided to us, it had  
9 the names of many, many other children.  
10 MR UBEROI: I think that's right, sir, but it does exist,  
11 and if you're able to see things from my point of  
12 view --  
13 THE CHAIRMAN: I think maybe there's just a fairly direct  
14 point that can be raised about this.  
15 MR STEWART: The most direct point is this: given your  
16 involvement with Adam Strain in 1995 and going through  
17 the inquest in 1996 and being told in 1997 that the  
18 medical negligence suit against the hospital in relation  
19 to your care of this patient had now settled, how  
20 could you forget that there was a death in 1995 of  
21 a patient in the Royal Belfast Hospital for Sick  
22 Children from hyponatraemia?  
23 A. Well, the system I used for collating the draft form of  
24 the bar chart was provided by the PICU secretary. I've  
25 sent the original records that she collated from her

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1 at that chart, that it's wrong.  
2 A. I went by the data that was given to me at that time.  
3 THE CHAIRMAN: Okay, thank you.  
4 MR STEWART: Thank you.  
5 MR FORTUNE: Sir, can I ask my learned friend to bring up  
6 007-051-102? It's the Powerpoint presentation.  
7 THE CHAIRMAN: It's the first page.  
8 MR FORTUNE: Yes. I'm a little concerned about the  
9 references to Arieff in 1998 and the BMJ in 2001, which  
10 may seem to suggest that dilutional hyponatraemia came  
11 to be the subject of comment in those years when,  
12 of course, we all know that the Arieff paper was  
13 published in the British Medical Journal in May 1992.  
14 It may not be a good point, but it's a curious point.  
15 THE CHAIRMAN: Yes, I understand.  
16 MR UBEROI: Well, this is a presentation put together in  
17 2001 and it's citing different and more recent articles.  
18 There's no mystery to that at all.  
19 THE CHAIRMAN: Okay.  
20 Before you finish, doctor, I asked you before lunch  
21 about the confidence that Doctors Steen and Webb might  
22 have had in the early hours of 23 October 1996 about the  
23 cause of Claire's death. And you told me that in the  
24 mid-1990s there had been an unhappy number of deaths  
25 arising out of encephalitis.

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1 computerised database in PICU. In that search that she  
2 kindly did for me in August to prepare that chart, there  
3 were no hypokalaemic -- hyponatraemic deaths coded for  
4 1995 or 1996.  
5 MR STEWART: Answer the question: how could you forget?  
6 A. Because the --  
7 MR UBEROI: He must be allowed to finish, please.  
8 THE CHAIRMAN: Well, did you forget, doctor?  
9 A. I collated the data for that bar chart from the data the  
10 secretary had collated for me from the PICU database.  
11 THE CHAIRMAN: Let me ask it in another way: as you were  
12 part of the working party which produced very widely  
13 praised guidelines, did it not strike you in your  
14 preparatory work for this that there was one particular  
15 death missing from the record which you were presenting  
16 for this talk and that was the death of Adam Strain?  
17 A. I don't know why I excluded that. As I said, the  
18 reason -- the bar chart was prepared from data provided  
19 by the PICU secretary in her haste to produce a chart.  
20 THE CHAIRMAN: I understand, doctor, how in some  
21 circumstances you get -- you use an assistant or  
22 a secretary who will give you the information and you  
23 bring that forward. But this is not a typical scenario  
24 of you bringing the information forward. This is  
25 a scenario in which you know yourself, just by looking

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1 A. You might have misinterpreted what I meant, sir, which  
2 was to say that children could die and change condition  
3 very quickly and it was my recollection that children  
4 with meningitis and, potentially, encephalitis could go  
5 from a situation of being relatively well to being  
6 moribund --  
7 THE CHAIRMAN: Right.  
8 A. -- and even dying.  
9 THE CHAIRMAN: Then I asked you about the figures which were  
10 contained in a letter, which I showed you and which is  
11 now -- I don't know if it's available.  
12 A. I remember reading it.  
13 THE CHAIRMAN: It has now been distributed to everybody,  
14 I think. It's 302-174-001. If you bring up 002 as  
15 well, please. When I asked you about this --  
16 do you have it yet? It's 302-174-001. I think the  
17 parties have it. Okay. We'll get it put up on the  
18 screen subsequently. This gives the total number of  
19 deaths by primary diagnosis in the Children's Hospital  
20 in 1995 and 1996. When I asked you about this earlier,  
21 doctor, before everybody else had seen it, I think you  
22 took me to the second page, which is "meningococcal  
23 septicaemia".  
24 A. Yes.  
25 THE CHAIRMAN: And then "meningococcaemia unspecified". But

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1 septicaemia is something quite different from what  
2 Claire had, isn't it?  
3 A. Well, yes. Again, I apologise for that. Perhaps what  
4 you're misinterpreting was that children with suspected  
5 sepsis or infective processes could move from  
6 a relatively stable -- I was talking more generically,  
7 I believe, than specifically about Claire.  
8 THE CHAIRMAN: I was looking to see where in 1995 and 1996  
9 children with encephalitis or some meningitis featured  
10 in these records of deaths, of the primary diagnosis of  
11 deaths, and what we have in fact is septicaemia, three  
12 septicaemia cases in 1995 and one unspecified in 1996;  
13 is that right?  
14 A. Yes. Of course, meningococcaemia is an organism that  
15 affects both the meninges of the brain and the blood  
16 systems. So the primary diagnosis may well have been  
17 septicaemia, but there may well have been meningitis  
18 co-existing.  
19 THE CHAIRMAN: Just for the record, there are no  
20 encephalitis meningitis deaths in 1995 or 1996.  
21 A. No, sir, not as a primary diagnosis.  
22 THE CHAIRMAN: What about status epilepticus?  
23 A. Not listed as a primary diagnosis on this page.  
24 THE CHAIRMAN: In any death for two years? Okay. No more  
25 questions?

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1 because she was being prepared for her second set of  
2 brainstem tests, so I wouldn't have been giving any  
3 drugs that could have made me look at previous drugs  
4 from that point of view. I believe the only drug I gave  
5 her was DDAVP, which was to slow down her urinary  
6 output.  
7 MR McCREA: Does that mean you don't recall looking at the  
8 notes in relation to the prescription?  
9 A. I don't recall. But I'm not trying to give you  
10 a picture of my normal practice.  
11 MR McCREA: During the course of the day of 23 October 1996,  
12 did you speak with either Dr Webb or Dr Steen as to what  
13 had happened to Claire while she was on the ward, why  
14 she was in PICU?  
15 A. I can't remember.  
16 MR McCREA: Well, did you meet with Dr Webb and Dr Steen  
17 during the course of that day?  
18 A. I don't remember. I didn't make a note of it and  
19 I can't remember.  
20 MR McCREA: Do you even recall her being there in PICU?  
21 A. No.  
22 THE CHAIRMAN: I think, just before you sit down, Mr McCrea,  
23 you helpfully passed a message to Mr Stewart earlier  
24 suggesting I was probably wrong -- in fact I was  
25 certainly wrong -- this morning by suggesting that the

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1 MR STEWART: No, sir.  
2 THE CHAIRMAN: Are there any more questions for Dr Taylor?  
3 MR McCREA: Yes. The first question really was: were you  
4 aware that Claire's original sodium level on 21 October  
5 was 132 and that it had fallen to 121?  
6 A. I'm not sure if I was aware of that. I can't remember.  
7 MR McCREA: Okay. Did anyone draw to your attention or did  
8 you examine Claire's notes and records to see what  
9 medication she had in fact been given on the 22nd?  
10 A. I can't remember those details.  
11 MR McCREA: In particular, can you remember examining the  
12 prescription notes themselves?  
13 A. I can't remember examining them.  
14 MR McCREA: You can't remember? Would you have had to --  
15 A. -- examine the PICU records that were available.  
16 MR McCREA: I'm talking about the midazolam, phenytoin and  
17 sodium valproate.  
18 A. I can't remember.  
19 MR McCREA: Would you normally have looked at those while in  
20 PICU to see what anaesthetics or what drugs you can  
21 provide and what you can't provide where there's any  
22 conflict between what medication you wish to give and  
23 what the child has been given?  
24 A. Well, yes, that would be important, but in fact she  
25 wasn't receiving any medication for sedation that day

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1 discussion about "no reference to coroner and a brain  
2 only post-mortem was before either of the brainstem  
3 tests".  
4 MR McCREA: That's right, it was after the second brainstem  
5 test.  
6 THE CHAIRMAN: So that would be in keeping with the normal  
7 practice that you were aware of?  
8 A. That would be very unusual to try to speak to the  
9 coroner. He won't let you speak to him until  
10 [OVERSPEAKING].  
11 THE CHAIRMAN: I was entirely wrong and I apologise to  
12 everyone for that. That came after the second brainstem  
13 test, but at that stage, you would expect the consultant  
14 from PICU to be involved in the discussion.  
15 A. If we were doing the other set of brainstem tests, the  
16 PICU consultant and the paediatrician or the neurologist  
17 would take part in it. So if you were intimately  
18 involved in the decision-making process, yes.  
19 THE CHAIRMAN: Thank you. Mr McAlinden?  
20 MR McALINDEN: Mr Chairman, just in relation to that point,  
21 I have consulted with Dr McKaigue in relation to this  
22 issue, and he will be giving evidence tomorrow, but just  
23 to alert the inquiry at this stage.  
24 His evidence was that after the CT scan report came  
25 back, he initiated a discussion with Dr Webb and

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1 Dr Steen in relation to the issue of a referral to  
2 the coroner.  
3 THE CHAIRMAN: Thank you very much.  
4 Before Mr Uberoi, are there any questions from  
5 anybody else? Mr Uberoi?  
6 MR UBEROI: No questions from me, thank you.  
7 THE CHAIRMAN: Dr Taylor, thank you again for coming back to  
8 help the inquiry.  
9 (The witness withdrew)  
10 Ladies and gentlemen, we'll take a break now. We'll  
11 start Mr Walby at about 3.35.  
12 (3.23 pm)  
13 (A short break)  
14 (3.47 pm)  
15 MR PETER WALBY (called)  
16 Questions from MR STEWART  
17 THE CHAIRMAN: If you can live with this, I wanted to sit  
18 until about 4.45 today, and then we'll pick up your  
19 evidence tomorrow morning.  
20 A. That's all right.  
21 THE CHAIRMAN: Thank you very much.  
22 MR STEWART: Mr Walby, you have provided the inquiry with  
23 three witness statements: WS176/1, 2 and 3. Are you  
24 content that they should be adopted by the inquiry as  
25 your formal evidence?

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1 the litigation management office. Was in that in  
2 succession to Dr George Murnaghan?  
3 A. When he left to go to Dublin, his job was not replaced  
4 by one person, and many of the different jobs that  
5 he had were split into different posts.  
6 Q. Yes.  
7 A. So they created a post, which had part of his work, and  
8 I applied for that.  
9 Q. And what part of his work was that?  
10 A. It was the -- his directorate had been initially called  
11 "risk and litigation management" and risk was peeled off  
12 that, and I was not involved in that. I was involved in  
13 primarily dealing with employers' and occupiers'  
14 liability cases, clinical negligence cases and liaison  
15 with the coroner for inquests and preparation of witness  
16 statements.  
17 Q. Did Dr Murnaghan train you, did you learn the ropes  
18 under him?  
19 A. No, there was a gap. He left in the summer of 1998 and  
20 the medical director, Dr Carson, acted as caretaker  
21 until they decided what to do, and I was interviewed  
22 in November 1998 and appointed to start work on  
23 1 January 1999. So I arrived without anybody in post.  
24 Q. I see. And what were the circumstances of  
25 Dr Murnaghan's resignation?

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1 A. I am.  
2 Q. Thank you. You have also provided us with a copy of  
3 your CV, which starts at page 311-009-001.  
4 A. May I highlight an error, which I --  
5 Q. Yes, please.  
6 A. I prepared this CV with my first witness statement and,  
7 over the weekend, just in preparing to come, on page 2,  
8 could I ask you -- where it says the period  
9 "1 January 1983 to 31 December 2009", that should be  
10 2008. Then three lines up from the bottom, where it  
11 says "2007 to 2009" that then should be 2008. That  
12 means I started my part-time job on 1 January 2009,  
13 rather than 2010.  
14 THE CHAIRMAN: Thank you.  
15 MR STEWART: So I see that from 1999 to 2007, indeed at the  
16 time when Claire Roberts was admitted to hospital, 1990  
17 to 1996, you were at that time serving as clinical  
18 director yourself --  
19 A. Yes.  
20 Q. -- in the otolaryngology directorate.  
21 A. That's correct.  
22 Q. Did you gain clinical governance experience there, such  
23 as it was, at that time?  
24 A. Yes.  
25 Q. Then you went to work as associate medical director in

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1 A. He applied to become registrar of the College of  
2 Physicians of Ireland in Dublin. So he left to do that.  
3 Q. You said that really you were then involved in  
4 litigation for the occupiers' liability and employers'  
5 liability --  
6 A. Yes.  
7 Q. -- and in relation to clinical negligence claims?  
8 A. Yes.  
9 Q. So your work was all focused on the defence side of  
10 litigation as opposed to bringing cases on behalf of the  
11 Trust?  
12 A. Yes.  
13 Q. And we have a copy of your job description, which is at  
14 WS176/1, page 13. There you are responsible to the  
15 chief executive directly, but you also reported to the  
16 medical director. So you have close lines of  
17 communication with the very highest levels of clinical  
18 governance in the Trust. And your main duties were set  
19 out at 1 to 10. Number 1:  
20 "To be a member of the Trust's clinical governance  
21 steering group, ensuring that the Trust's clinical  
22 governance duties and responsibilities are promoted and  
23 implemented."  
24 What did that encompass?  
25 A. Well, I recollect that that was primarily to bring the

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1 statistics from the three areas that I was talking about  
2 earlier to this group, to give listings of numbers of  
3 cases of various varieties, and how they'd been dealt  
4 with.

5 Q. Were you bringing information to them about lessons  
6 learned from them or simply statistics about cases  
7 handled, processed, won, lost, settled?

8 A. At the start, in my first year, it was literally  
9 process, but you'll see elsewhere in my first witness  
10 statement, where you ask me, within the first year  
11 in the post I realised that there was a gap and that  
12 lessons learned from clinical negligence cases were not  
13 disseminated. So it was my practice from 2000 to write  
14 a clinical summary of every clinical negligence case  
15 where payment of damages was made, which indicated  
16 we were at fault, and that summary was then circulated  
17 to the clinical directorates and later what was called  
18 the governance managers in the Trust, but they weren't  
19 called that in 2000.

20 Q. Did you adopt the same practice in relation to inquests?

21 A. Inquests were slightly different in that the cases  
22 often -- learning had taken place before an inquest was  
23 held. I would know from having been part of the process  
24 of running up to an inquest what had been occurring.  
25 But just prior to inquests, it became my practice to

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1 people asking me for -- e-mails asking for information  
2 in the days -- at the time the inquest was being heard.  
3 The medical director received the verdict and he knew  
4 about it and you've read where he talks about how he  
5 wishes he had arranged a root-cause analysis and he  
6 gives the reasons why he didn't. The department were  
7 sitting at the inquest, the police were sitting at the  
8 inquest, so my routine didn't occur in Claire Roberts'  
9 case because of that scenario. And it was also then --  
10 not complicated, but in addition, because at the end of  
11 the inquest, counsel for the Roberts family had raised  
12 a number of issues which the coroner did not think were  
13 appropriate to be dealt with during his inquest, and he  
14 suggested that they were more in the realms of the  
15 hospital's complaints department.

16 So I, at the end of the inquest, went and had a not  
17 very long, but a brief conversation with Mr and  
18 Mrs Roberts and I invited them to take that up at the  
19 chief executive's office, the areas that they wanted to  
20 go into further. So that was as far as I went.

21 Q. Forgive me, but I would have thought that, given the  
22 level of public interest, the fact that this inquiry was  
23 being established and the fact that the coroner might  
24 have made or forbidden questions that might have touched  
25 upon medical negligence, that you might have thought

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1 send a short synopsis to both corporate affairs and the  
2 medical director to alert the Trust that this inquest  
3 was up and coming. And after the inquest, I would  
4 report in a similar way to those two people to say what  
5 had happened and what was the outcome and if there were  
6 concerns that had been expressed by the coroner as to  
7 learning that needed to take place from what had  
8 happened during an inquest.

9 Q. But was there a more detailed, more medical, more  
10 clinical synopsis of lessons learned than just what you  
11 might circulate to the press officer or up the line to  
12 the medical director?

13 A. It could be quite detailed in that -- the press officer  
14 sounds as if it's going rather outside the medical, but  
15 it was a route to the chief executive's office in that  
16 the director of corporate affairs liaised closely with  
17 the chief executive's office. And therefore -- but it  
18 gave a lot of information to the medical director about  
19 the case, but not in great detail.

20 Q. Did you, after the inquest in Claire Roberts' case,  
21 prepare such a synopsis for the medical director?

22 A. No, I didn't.

23 Q. I was racking my brains and couldn't remember seeing  
24 one. Why was that?

25 A. It was so widely known. You'll see that there were

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1 this was an ideal opportunity to inform the medical  
2 director of what you had seen at the inquest.

3 A. No. You have used the words "medical negligence".  
4 I didn't use the word -- I said "complaints". And  
5 herein lies a difficulty in that you have heard how  
6 Dr Murnaghan was planning to settle the Adam Strain case  
7 without going near the clinicians. I had it in my mind  
8 at the end of the inquest that we had not handled it  
9 well and should the Roberts bring a clinical negligence  
10 case, the Trust would be settling it. I have to say  
11 that the damages are awarded for the death of a child  
12 are statutory and they're a small amount and it's  
13 embarrassing that that's the situation. It adds insult  
14 to injury, the fact that parents lose a child and, when  
15 they bring a case, there normally will be no discussion  
16 of it because the case will be settled out of court --  
17 because in this case I would have felt that we were  
18 in the wrong. And worse still, if you bring a clinical  
19 negligence claim, if you have previously initiated  
20 a complaint through the Health Service, the rules state  
21 that the complaint investigation stops once a clinical  
22 negligence case is embarked upon.

23 So the Roberts family were in some difficulty that  
24 if they brought a negligence claim, they weren't going  
25 to be able to make a complaint, it wouldn't be dealt with.

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1 Q. But conversely, had they made a complaint formally under  
2 your system, you'd have been obligated, by virtue of the  
3 rules of good clinical governance, to mount an  
4 immediate, full and thorough investigation, wouldn't  
5 you?

6 A. And you'll see from my file that I e-mailed  
7 Pauline Webb, who's in charge of the complaints  
8 department, saying: expect to be hearing from the  
9 Roberts family. In that e-mail, I counselled her to be  
10 aware that she should probably only be dealing with the  
11 Roberts family case, but that indeed I was aware, from  
12 counsel for the family, that they would have a lot of  
13 questions about the Adam Strain case, and I just set  
14 down a warning to her that it was maybe -- you need to  
15 be careful to deal with the Claire Roberts complaint and  
16 that there was a distinct possibility that Mr O'Hara  
17 would be taking the case under his umbrella and  
18 therefore the wider envelope would be dealt soon enough  
19 with in another form.

20 THE CHAIRMAN: Can I just go back one bit? This might help  
21 to short circuit some issues for me, and also for you,  
22 Mr Walby. You said a few moments ago that:

23 "After the inquest, we had it in mind that we hadn't  
24 handled it well and would be settling any claim brought  
25 by the Roberts family."

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1 Q. I see. Just to go down to paragraph 3, your duty to:

2 "Assist the medical director, the director of  
3 nursing and clinical directors in ensuring that all  
4 aspects of clinical governance are embraced by  
5 management and membership of clinical directorates."

6 How did you go about assisting the medical director  
7 in ensuring that all aspects of clinical governance were  
8 embraced?

9 A. This is a job description, which I probably put aside  
10 once I had got into the post and, as you'll see, all the  
11 things that I told you that I thought about the job  
12 I was taking on are on the second page. So these are  
13 listed and I suspect this was a catch-all, this was to  
14 cover a number of general areas. It really falls into  
15 number 1 as well, I think it's to ... The clinical  
16 governance throughout the Trust. So it was making sure  
17 that I couldn't exclude myself from any particular area,  
18 but I don't -- it didn't mean anything particular.

19 Q. So the first six main duties are really more honoured  
20 in the breach than the observance, are they?

21 A. No, that wouldn't quite be right in that 5 and 6 were  
22 ones which it later became clear that the work involved  
23 in that was just -- just couldn't possibly be undertaken  
24 in the post. I was a full-time consultant ENT surgeon  
25 and I was doing this in extra sessions.

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1 What --

2 A. If a claim had come in --

3 THE CHAIRMAN: What I want to ask you is: can you summarise  
4 succinctly what it was that you believed that the Royal  
5 had not handled well and would therefore be settling  
6 a claim for --

7 A. The failure to do a blood test on Tuesday morning.

8 THE CHAIRMAN: Thank you.

9 MR STEWART: Anything else?

10 A. No, that's why I would have settled the claim. I think  
11 the claim would have been settled on that point alone.

12 Q. Just to revert to your contact with Pauline Webb at that  
13 stage, why didn't you, given that you expected a claim  
14 to be made, likely to be made, warn somebody to start an  
15 investigation process?

16 A. Well, the medical director dealt with that. I would not  
17 have embarked on an investigation myself at all. In any  
18 inquest, I would not have done that; that would have  
19 been dealt with by the area of the Trust where the  
20 patient episode occurred. And the medical director was  
21 well on top of this case, the Trust was acutely alert to  
22 what was happening. Therefore, as the medical director,  
23 Dr McBride, in his statement has been saying, he thought  
24 of these things, but decided that he wouldn't take it  
25 further forward.

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1 Q. Right.

2 A. Whereas in number 6, I did --

3 THE CHAIRMAN: Can I ask you how many extra sessions?

4 A. Three initially.

5 THE CHAIRMAN: That's effectively a day and a half, is it?

6 A. Yes.

7 THE CHAIRMAN: Right, thank you.

8 A. Number 6. Initially, number 6 just involved reporting  
9 the figures to the department of where we were with  
10 junior doctors and trying to get junior doctors' hours  
11 reduced. At early stages, there was not great impetus  
12 to get them reduced, but when the junior doctors' hours  
13 issue started to come up and the junior doctors'  
14 hours -- it could be seen in numbers of years ahead, the  
15 numbers of hours would have to be reduced drastically  
16 because of the hours that they worked. It meant that  
17 very radical solutions were going to be required by the  
18 Trust to get the hours down to the number required. And  
19 therefore, number 6 and number 5, which was to a process  
20 that was coming in to do with regulation,  
21 self-regulation of consultants mainly, those two were  
22 hived off and another consultant in the Trust took on  
23 board 5 and 6.

24 MR STEWART: The effective process of professional  
25 self-regulation referred to in paragraph 5, does that

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1 mean doctors reporting adverse clinical incidents with  
2 which they've been personally involved?

3 A. Yes. I think it would do in that I know, when I retired  
4 as a consultant ENT surgeon, by that stage I was having  
5 an annual appraisal with my clinical director and  
6 certainly to that would be brought any complaints that  
7 had been made about you or any adverse incidents or  
8 anything. So there was a form for the clinical director  
9 to discuss with you any areas about your practice that  
10 maybe could be improved.

11 Q. Is there an implication from the wording of number 5  
12 that the process that preceded was somehow ineffective?

13 A. Yes.

14 Q. Number 7 over the page, page 14, is:  
15 "To provide a claims investigation and management  
16 service on behalf of the Trust in relation to claims of  
17 litigation ..."

18 We've discussed that. Number 8:  
19 "To assist Her Majesty's Coroner with enquiries and  
20 the preparation of statements prior to inquests."

21 Can you describe a little about how much of your  
22 time that took up?

23 A. It took up quite a lot of time. When I started on  
24 1 January 1999, Dr Carson, who had been dealing with  
25 this over the six or seven months before, after

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1 fall under that in that they weren't part of my  
2 mainstream job at all, but occasionally I would be asked  
3 to do that, normally by the medical director, if  
4 something had come up.

5 Q. And so although such correspondence came to your  
6 attention not because a formal complaint had been  
7 triggered, you nonetheless dealt with it as if it were  
8 a formal complaint, did you?

9 A. It could come from various parts of the hospital, but  
10 certainly if the complaints department asked for my  
11 input, I would give it. I can't think of any occasion  
12 where I refused.

13 Q. I suppose really my question is: would you deal with  
14 that contact under the complaints procedure rules of  
15 engagement, as it were?

16 A. As I said, the only time that I would get involved in  
17 this would be way down the -- I was never part of  
18 initiating or developing a complaints investigation.  
19 It would really be being asked to scan, as an  
20 independent person who hadn't been involved in the  
21 building up of things -- as you can see, there's been  
22 talk about a number of people viewing drafts of papers  
23 and making changes to them. If a number of people make  
24 changes to drafts, sometimes if you come afresh and look  
25 at it, there are non sequiturs, things are left out,

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1 Dr Murnaghan had left, I think there had been  
2 a particular backlog that had developed in dealing with  
3 the coroner, and therefore I was asked for the first  
4 three months to concentrate purely on the coroner's  
5 work. That's all I did in the office at that stage to  
6 do with inquests and the run-up to them.

7 Q. Dr Murnaghan described himself as a link or  
8 a facilitator between the Trust and the coroner; did you  
9 see yourself in the same role?

10 A. Yes, absolutely. I heard the word "agent" used this  
11 morning, "an agent of the coroner", and of course that's  
12 not correct. I was doing things at the coroner's  
13 direction, but not as his agent.

14 Q. Yes. But your duty was to assist him?

15 A. Yes.

16 Q. And also to assist with complaints management where  
17 appropriate. Can I ask you: did you only deem a matter  
18 a complaint if it was initiated under the complaints  
19 procedure?

20 A. Yes. I would get occasionally asked to vet a letter,  
21 or -- it was very peripheral. There would be  
22 a circumstance where I might be asked to get  
23 peripherally involved at a late stage. And, I would  
24 have to say, the comments that I made on the letter to  
25 the Roberts in January 2005, they really would almost

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1 things have been dropped, and therefore I think I was  
2 often used as a proof reader, to tell you the truth.

3 Q. Paragraph 10. A duty was:  
4 "To liaise with Trust solicitors, to give advice and  
5 support to staff involved in litigation, coroner's cases  
6 or the complaint process."

7 What type of support are we talking about?

8 A. This was support -- you've heard over the last couple of  
9 days -- and it has brought it home to me -- that all the  
10 clinicians, all the four doctors who gave evidence  
11 at the Claire Roberts inquest, all consultants by that  
12 stage, none of them had ever given evidence at an  
13 inquest before. I know Dr Webb had made one inquest  
14 statement in the Adam Strain case, but it demonstrates  
15 to you how rare it is in a doctor's career that he  
16 actually gets caught up in the coronial process. There  
17 may be some, and there are some specialties -- I suspect  
18 A&E and intensive care anaesthetists will be used to  
19 making witness statements for the coroner, but most  
20 other doctors don't. And therefore, there's a certain  
21 amount of naivety in how they would prepare them.  
22 Therefore, I became experienced in guiding them and  
23 supporting them because often they were anxious about  
24 what was up and coming.

25 And it wasn't just doctors, it was nurses.

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1 Occasionally, it could be technicians if something had  
2 gone wrong with equipment. Basically, an inquest  
3 statement could be demanded from any hospital employee.  
4 Therefore, I was there to provide support and explain  
5 what the process was about.

6 Q. So would you have seen yourself as providing a service  
7 to those staff members who needed a bit of support when  
8 going to the inquest?

9 A. Yes. Yes, indeed, it did.

10 Q. Would they have relied upon you?

11 A. I hope they looked upon it -- they were relying on me.  
12 That's what I was trying to do.

13 Q. They were a bit out of their depth and you were  
14 a practised campaigner and you were able to shepherd  
15 them in the right direction.

16 A. Yes.

17 Q. Did you see any conflict or tension between the support  
18 you gave to staff, your duty to support staff, and your  
19 duty to assist the coroner in the preparation of  
20 statements?

21 A. Clearly, you could get that wrong, and therefore I was  
22 indeed conscious, not of a tension, but I was there to  
23 assist the coroner and if some flat stones needed to be  
24 upturned and something unpleasant was underneath them,  
25 I was there to do that and I did do that.

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1 support. I'm not sure -- maybe I haven't answered the  
2 question.

3 Q. Can I ask to look at page 139-151-001? This is an  
4 e-mail that you, I think, sent to Michael McBride,  
5 16 December 2004. This is in relation to the letter  
6 that Mr McBride is going to send to Mr and Mrs Roberts.  
7 And you report that you've in fact reported the death to  
8 the coroner and so forth. In the second paragraph:

9 "I think the letter to Mr and Mrs Roberts should  
10 come from your office rather than mine, given its  
11 adversarial name."

12 So can I suggest that that at least shows you were  
13 alive to the responsibility that out there, amongst  
14 those who perhaps don't know you, there is a perception  
15 that, on the one hand, the litigation management office  
16 might be defensive of the Trust whereas the medical  
17 director might be more straightforward?

18 A. I was well aware that -- the litigation management  
19 office name covered all the work I was doing for  
20 the coroner as well. And of course there's no  
21 litigation involved in coroners' work. So it was  
22 a catch-all title for the office, but it didn't sit well  
23 with the coroner's work. You'd have had to have created  
24 a rather more complicated title for the office. When  
25 Dr McBride had written his letter, I can't just remember

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1 THE CHAIRMAN: It's a question of where you draw the line  
2 between supporting staff and providing the coroner with  
3 the relevant assistance.

4 A. That's why I'm hoping you're going to give me enough  
5 time to go through in detail every amendment I made to  
6 each of the seven statements which we've got in total  
7 here.

8 THE CHAIRMAN: We'll go through as many as we need to,  
9 Mr Walby.

10 A. Thank you.

11 MR STEWART: You counted rather more than I have. Even  
12 though you may not have perceived a tension or  
13 a conflict, do you think others might have perceived  
14 a difficulty there for you between acquitting your duty  
15 to the coroner to get those statements and supporting  
16 the staff when they are out of their depth? Do you  
17 think other people might have seen that there was  
18 a difficulty there?

19 A. Well, if they knew me, they would know that the way  
20 I would be performing the duty that I had to do what was  
21 required as regarding witness statements for the coroner  
22 and they knew me -- I had been around the hospital for  
23 a long time and therefore I was well experienced at all  
24 levels in most parts of the hospital and I was  
25 well-known. So I was in a good position to be providing

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1 the mechanics of it, but I remember there was an issue  
2 of it being printed out and he would sign it, and  
3 I suggested that really a letter coming from him on  
4 paper that was headed "Litigation management office" did  
5 not give the right measure of tone to the parents of  
6 Claire.

7 Q. Tone? They might not trust it. The "litigation  
8 management office" sounds like a defensive litigation  
9 type thing. It might be better, is what you mean, if it  
10 came from the medical director.

11 A. Well, it was going to be coming from the medical  
12 director anyway. It literally was the paper it's  
13 printed on. That's what this was about. I had no part  
14 in the drafting of that letter. So it literally was  
15 a presentational comment that I was making.

16 Q. It's a question about presentation I put to you.

17 A. It was to do with presentation.

18 Q. Yes. Because your duties were not only to the Trust,  
19 but they also were, of course, to the coroner himself.  
20 I'm referring to the duty imposed upon you as all other  
21 doctors by the GMC and the 2001 edition of Good Medical  
22 Practice. I would ask that that be brought up at  
23 314-014-014. At paragraph 32, just to place in context  
24 the various duties by which you were bound at that time:  
25 "Similarly, you must assist the coroner by

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1 responding to enquiries and by offering all relevant  
2 information to an inquest or inquiry into a patient's  
3 death. Only where your evidence may lead to criminal  
4 proceedings being taken against you are you entitled to  
5 remain silent."

6 So do you accept that you did have duties at that  
7 time both to the Trust and to the coroner?

8 A. Yes.

9 Q. Can I ask about the time that UTV broadcast its  
10 documentary programme on hyponatraemia? Do you remember  
11 that time?

12 A. I do.

13 Q. Did you watch the programme when it was broadcast?

14 A. I did.

15 Q. What sort of stir did it cause? Did it cause a stir in  
16 the hospital?

17 THE CHAIRMAN: Sorry, Mr Walby, you'd have known about it in  
18 advance, wouldn't you?

19 A. I did, yes.

20 MR STEWART: I was going to ask you about the preparatory --

21 A. Well, there appears -- what I didn't know was that there  
22 was correspondence between the Trust solicitors and the  
23 Trust about the programme and whether it should be  
24 broadcast in the form it was. I only was sent that  
25 correspondence around about the time of the broadcast

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1 itself, within a day or two before it, whereas there had  
2 been ongoing communications, which I was not involved in  
3 at all.

4 Q. This was a letter from Mr George Brangam, Trust  
5 solicitor, to the producers, I think, of the programme.  
6 For the sake of completeness, we can bring it up at  
7 137-005-001. 7 October -- that's about a fortnight,  
8 I think, before the date of broadcast. There's debate  
9 about the perceived unacceptable behaviour from  
10 Mr Trevor Birney, and then:

11 "Mr George Brangam, the Trust solicitor, requires an  
12 [in the third paragraph] an unqualified retraction of an  
13 allegation that the Trust had perhaps misled  
14 the coroner."

15 Then it goes on to indicate that:

16 "If you do so, the Trust reserves the right to take  
17 legal action against you unless an unqualified  
18 retraction is made [and so forth]."

19 Would you not have normally been liaising with the  
20 Trust solicitor yourself?

21 A. I was only one area of the Trust that liaised with the  
22 Trust solicitors. The personnel department had a lot of  
23 dealings with the Trust solicitors to do with personnel  
24 and disciplinary matters. There was a lot of dealing  
25 with the Trust solicitors by the estates department to

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1 do with contracts and things. The chief executive's  
2 office will have had direct dealings with the Trust  
3 solicitors. So there were a number of different  
4 areas -- and in fact the complaints department would  
5 have also liaised with the Trust solicitors. So  
6 although the office that I was associate medical  
7 director of at that stage has that title, in fact it was  
8 a small proportion or only a portion of the work.

9 THE CHAIRMAN: It's only one route from the Trust to the  
10 solicitors?

11 A. Yes.

12 THE CHAIRMAN: Right.

13 MR STEWART: So your work then really was just inquests and  
14 defence work?

15 A. Yes. That's why I'm saying this came out of sight of  
16 me. This came as copy correspondence.

17 THE CHAIRMAN: So there's a whole lot of other issues like  
18 employment issues, family cases, for instance, that  
19 won't go through you at all? There's a whole lot of  
20 areas that you literally have nothing to do with?

21 A. Nothing to do with, yes.

22 MR STEWART: So we know that in the immediate aftermath of  
23 the broadcast, considerable disquiet was expressed, and  
24 the department wrote a letter to Mr McBride asking that  
25 all documents relating to the other cases, the other

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1 three deaths, be secured and kept safe.

2 A. Yes, I think that was a letter to the chairman --

3 Q. The chairman, yes.

4 A. -- I think.

5 Q. It appears at 137-002-001. You're quite right, the it  
6 was addressed to the chair. This is in relation to Lucy  
7 Crawford, Raychel Ferguson and Adam Strain. It says:

8 "The department is currently considering how it  
9 should respond to the allegations made in the programme.  
10 Without prejudice to that, there is a need to ensure  
11 that all relevant records and documents are secured so  
12 that, if necessary, they can be made available for  
13 independent examination. To that end, I am writing to  
14 you to take whatever steps are necessary to ensure and  
15 keep safe all documentation within the custody or  
16 control of the Trust, its employees, servants or agents,  
17 including drafts and information in electronic format."

18 This includes practically everything they can think  
19 of, even legal advice received by the Trust in  
20 connection to the cases. Was this sort of information  
21 sent down to you?

22 A. A copy came to me, yes.

23 Q. Did it come to you before you heard about the case of  
24 Claire Roberts?

25 A. Yes.

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1 Q. So as soon as you heard about the case of  
2 Claire Roberts, you thought "that links in with this"?  
3 Did you then think that you should secure all  
4 documentation relating to Claire Roberts?  
5 A. Well, if you remember, Claire Roberts' notes came to me  
6 in December 2004, and I held on to those notes until  
7 I left in March, by and large. So they came to the  
8 office. So the documentation in relation to  
9 Claire Roberts was secured.  
10 Q. Did you seek out computer records?  
11 A. No.  
12 Q. Coding records?  
13 A. No.  
14 Q. Did you make a search for audit records, mortality  
15 records?  
16 A. No.  
17 Q. Neuroscience grand round records?  
18 A. No.  
19 Q. So did you take any steps to locate and secure  
20 documentation apart from the file you were given?  
21 A. No, but I have to say you would need to run down the  
22 list again, but I didn't do that in terms of Lucy  
23 Crawford, Raychel Ferguson or Adam Strain, the list of  
24 things you have just listed. A lot of those came later,  
25 looking for those.

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1 direction?  
2 A. I have to say that I only made sure that I had the  
3 medical records. There are lots of subsidiary  
4 departments of the hospital of which records I now know  
5 I did not recover, such as neuropathology file notes.  
6 Q. At the time there was -- correct me if I'm wrong --  
7 considerable advice in how you should go about an  
8 investigation into an adverse clinical incident, and  
9 that advice encompassed the sort of documentation you  
10 should locate and secure as part of an investigation;  
11 isn't that correct?  
12 A. Yes.  
13 Q. I could take you to some of the directives if you  
14 wanted, but it's clear that in 2004 there was readily  
15 available advice as to how to go about an investigation.  
16 Even though you were directed to get the documentation,  
17 you say you didn't. Can you say how that squares with  
18 your duties in relation to clinical governance?  
19 A. Well, this instruction from the department was to hold  
20 it all -- the bottom line of that -- and retain it. So  
21 I only obtained, as I say -- in the case of Adam Strain  
22 there were clinical notes and a medical negligence file  
23 and an inquest file. In Raychel Ferguson, there were  
24 the notes and inquest file and a medical negligence  
25 file. But if I'm right, we didn't have all three in all

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1 THE CHAIRMAN: Let's take the third bullet point under "this  
2 should include":  
3 "All notes of meetings or discussions concerning  
4 each case."  
5 If Adam's case or Lucy's or Raychel's was discussed  
6 at a grand round or at an audit meeting of any sort,  
7 then that would be a meeting which concerned the case,  
8 wouldn't it?  
9 A. You're absolutely right. You know what I did with this  
10 letter, I sent it immediately to the Trust solicitor and  
11 said, "What do we do here?". The Trust solicitor then  
12 arranged to meet the medical director to discuss how  
13 this would be dealt with and I attended that meeting.  
14 At that stage in relation to Claire Roberts, of course,  
15 there was no inquest file.  
16 THE CHAIRMAN: Yes.  
17 A. But there was developing what was called a "media file"  
18 because of the UTV programme. So it was a discussion of  
19 what do we need to keep, and it was in terms of those  
20 three children. Not "keep", we were keeping everything  
21 but securing.  
22 MR STEWART: Were you given a direction by the medical  
23 director to locate and secure documentation?  
24 A. Yes.  
25 Q. And what steps did you take to comply with that

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1 three cases. We had an inquest file and notes on  
2 Lucy Crawford. I don't think a clinical negligence case  
3 involved the Belfast Trust in Lucy Crawford. There was  
4 one, but it didn't involve the Belfast Trust. So those  
5 are the materials that I had secured.  
6 Q. Yes. I was going to suggest to you that it's hard to  
7 conceive of a more formal and a more forthright  
8 departmental requirement than:  
9 "Now requires you to take whatever steps are  
10 necessary to secure and keep safe all documentation".  
11 That is really about as strong as it gets, isn't it?  
12 A. Well, yes.  
13 Q. And indeed, you had, as you said, your media file.  
14 I think you called it the Insight file; is that right?  
15 A. No, we tended to call it the media file, and I tended to  
16 use -- I have notes, "I put it in the Insight file", but  
17 in fact the file in the office remained labelled the  
18 "media file", but it's the same file.  
19 Q. WS177/1, page 54.  
20 MR FORTUNE: Is this file 141?  
21 MR STEWART: This comes from Dr Rooney's witness statement.  
22 I wonder if it's the same one. You can see, top  
23 right-hand corner, it looks like your initials, "APW"?  
24 A. This is a page from my file, my media file, I suspect.  
25 Q. You're 176, though. It has been circularised to

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1 Nichola Rooney, we can see at the top, there, and  
2 Dympna Curley.  
3 A. The writing on the top right-hand corner is mine, so  
4 that's a copy that came to me.  
5 Q. Yes:  
6 "This is about a query fourth hyponatraemia case.  
7 Place in the Insight file, please."  
8 A. Yes. And that's the media file.  
9 Q. So in November, after the letter requiring the  
10 documentation to be secured, you knew this was a fourth  
11 case and you were filing them together.  
12 A. No. Well, I put it in the Insight file because I had --  
13 if we read at the bottom, this is the e-mail from  
14 Dr McBride to Heather Steen, number 2. That is  
15 indicating -- and I think at a hospital meeting I must  
16 have heard, "It looks like there may be another case of  
17 hyponatraemia", and therefore no names were mentioned  
18 and I just heard the -- and then when this e-mail came  
19 to me, I had no file to put it in because I didn't have  
20 a name. That's a note -- the blanked out is the  
21 secretary's name -- asking the secretary:  
22 "This is a about a query fourth hyponatraemia case.  
23 Please place in the Insight file."  
24 Because we had nowhere else to put it at the time.  
25 Q. Yes.

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1 alert to it. But I haven't seen that. I think there  
2 had been an earlier one in 2004, but this one arrives  
3 from the department two weeks before and he realises on  
4 reading that, that if a matter of serious public concern  
5 is coming up, and this indeed was Claire Roberts'  
6 inquest, that for that reason it should be reported to  
7 the department.  
8 Q. Okay. Just to correct you, the circular that we're  
9 talking about here, 2006, is dated 20 March 2006.  
10 A. Yes, eight days before. Did I say 14?  
11 Q. In fact, it was not a fresh instruction in this regard  
12 but it merely repeats the content of circular HSS(PPM)  
13 of June 2004.  
14 A. I think I said that.  
15 Q. Yes. So what I'm asking you is: did you not think in  
16 2004 that you should report it to the department then?  
17 A. As I said, I have never reported anything to the  
18 department. Dr McBride, I think in his witness  
19 statement, has said: yes, indeed he thinks it should  
20 have been reported to the department then.  
21 Q. Because the criteria for reporting under the 2006  
22 circular is identical to the criteria under the 2004  
23 circular.  
24 A. Yes.  
25 Q. And if you reckoned in 2006 it should be reported, why

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1 A. And you'll see in what eventually becomes the  
2 Claire Roberts coroner's file, there's another reference  
3 to the first time it becomes clear that the name is  
4 Claire Roberts. There's -- somewhere I have a margin  
5 note saying, "This is the fourth case". And by that  
6 stage it goes -- that page gets put into what becomes  
7 the Claire Roberts inquest file because we now know the  
8 name of the patient to attach it to. That page really  
9 could have been moved into the inquest file.  
10 Q. At that time in 2004, were you aware of the  
11 responsibility of the Trust to report an adverse  
12 clinical incident such as Claire's to the department?  
13 A. Incident reporting to the department was not -- I would  
14 have known that that is something that the Trust should  
15 be doing, but you know, I didn't report an incident to  
16 the department in my career, so I had no knowledge of  
17 the detailed pathway as to how one did that. So it  
18 wasn't part of my role, but I did know that incidents  
19 would be reported to the department.  
20 Q. I asked because subsequently it was you who suggested to  
21 Dr McBride that it should be reported. That is at  
22 139-052-001.  
23 A. Yes. Isn't this interesting? This circular HSS(PPM)  
24 2/2006 was issued two weeks before, so it clearly had  
25 just arrived on Dr McBride's desk, so he was clearly

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1 didn't you do so -- were you aware of the 2004 circular?  
2 A. I knew that there was the need to report incidents to  
3 the department. As I say, never having initiated the  
4 procedure or been involved in it, I can't say that  
5 I would have kept that circular to hand because it would  
6 have been something that would have been dealt with by  
7 the medical director's office.  
8 Q. So it wasn't your responsibility, is that what you're  
9 saying?  
10 A. That sounds as if I'm ducking it, but on the other hand,  
11 if a serious incident happened, I would make sure the  
12 medical director's office knew about it and they would  
13 then take it further. So it's not as if I'm making  
14 light of it. It was a very important document.  
15 THE CHAIRMAN: Don't worry about that, Mr Walby.  
16 I understand the position. If a serious adverse  
17 incident is reported to Dr McBride's office then, in  
18 essence, you're entitled to assume that he will report  
19 that to the department.  
20 A. Yes.  
21 THE CHAIRMAN: It's not ducking it. If ten people in the  
22 Trust know that there's a serious adverse incident, then  
23 it's ridiculous to have ten reports going to the  
24 department. But it is important to have one report  
25 going to the department.

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1 A. Yes, it is.

2 MR STEWART: So the next question is: if you could have or

3 did appreciate in 2004 that no report had been sent by

4 the medical director, would you not then have suggested

5 that perhaps it should be sent?

6 A. Well, if you remember, in 2004, we've got the Roberts

7 family reporting the death of their daughter and the

8 coroner is being advised that this is a death that he

9 might want to investigate. So we're at an early stage

10 of matters. But certainly, as 2005 progresses, and the

11 Trust becomes more aware of the problems that had

12 occurred in that case -- Professor Young has highlighted

13 them for the Trust -- but the fact is sometime around

14 that stage it indeed could have been and should have

15 been reported to the department.

16 Q. Indeed because the department makes the point in the

17 circular that it's important that action be taken. It

18 expects:

19 "... urgent action to be taken to investigate and

20 manage the adverse incident."

21 It goes on to say that in fact:

22 "The department may, in independent reviews, provide

23 guidance in relation to determining specialist input

24 into such reviews."

25 So there would have been a real reason why the

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1 because -- why we didn't have it. Unfortunately,

2 someone has had the wit to remove that "severe" from the

3 version that went to the department. This was modified

4 by Mrs Champion, as it seemed to have been her role at

5 that stage to have been forwarding that. So I apologise

6 for having made that mistake. It was quite wrong. But

7 it has been corrected before ... A lot of my very --

8 almost identical wording goes to the department.

9 Q. I was going to draw your attention to something in the

10 middle paragraph, the paragraph commencing:

11 "Following the UTV Insight programme in October 2004

12 into paediatric deaths from hyponatraemia,

13 Claire Roberts' parents contacted the hospital and,

14 after a review of the notes, it was considered in

15 retrospect that the known hyponatraemia, which was

16 treated, may have had a part to play in the medical

17 condition leading to death, and after a meeting with the

18 family, the death was reported to the coroner."

19 "In retrospect, it was considered that the known

20 hyponatraemia, which was treated, may have had a part to

21 play in the medical condition."

22 Was it not known at the time and was it not recorded

23 in the notes at the time?

24 A. I don't think that the -- you are drawing me into

25 clinical matters, but I don't think that the clinicians

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1 department should have been notified.

2 A. I agree.

3 Q. Can I ask --

4 THE CHAIRMAN: Sorry, can you just give me that reference,

5 Mr Stewart, that you were quoting from?

6 MR STEWART: WS061/2, page 422. That is --

7 THE CHAIRMAN: Mr McKee, is it?

8 MR STEWART: Yes. That is the 2004 circular. In 2005,

9 a further circular is sent out, reiterating the need to

10 comply. That appears at WS068/1, page 251. And then

11 the circular is sent out in its final -- in this case,

12 essentially unchanged -- version in 2006. And that

13 appears at, as does this document, 139-045-002.

14 Can we go back to that last page we were looking at?

15 This is the account, is it, dated 28 March 2006, from

16 you to McGinley. McGinley was the press office; is that

17 right?

18 A. It is, and it contains a serious mistake.

19 Q. Could you perhaps highlight that for us?

20 A. Yes. I have written there, why I know not:

21 "She had severe learning disability."

22 We know that's not the case. I haven't written it

23 anywhere else, but in that -- fortunately -- and I don't

24 know how it came to light, but I only quite recently saw

25 the SAI that had been submitted to the department

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1 at the time did feel that the hyponatraemia was ...

2 Where is it?

3 Q. It says here:

4 "After a review of the notes --

5 A. "Played a part in the medical condition."

6 I think they felt that the cause of death that was

7 written on the death certificate did not lead you to

8 believe that that's what they were considering and that

9 the SIADH, which causes hyponatraemia, was a consequence

10 of these.

11 Q. This was a conclusion of the review of the notes?

12 A. Yes. Whose review -- is this my review of the notes?

13 Q. It's written by you.

14 A. Yes, okay.

15 THE CHAIRMAN: The information which you have to write this

16 note is what, the collected statements which are going

17 to the inquest, which is due to be heard reasonably

18 soon?

19 A. Yes.

20 THE CHAIRMAN: Okay.

21 A. This is a month or two in advance of the inquest.

22 THE CHAIRMAN: Yes. And just before Mr Stewart continues

23 his line of questioning, when you say:

24 "The known hyponatraemia, which was treated ..."

25 Is that a reference to Dr Stewart and his

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1 intervention between 11 and 11.30 on the Tuesday night?

2 A. Yes.

3 THE CHAIRMAN: Thank you.

4 MR STEWART: Because what you had at that time, if you were

5 basing your view on the notes, and they contained

6 references to hyponatraemia in the discharge, in PICU,

7 in Allen Ward, and it's also clinically coded with

8 hyponatraemia being a condition, you also had Dr Webb's

9 witness statement that you had obtained from him for

10 the coroner.

11 A. Yes.

12 Q. And you had that at 091-008-053. In the middle of the

13 page is the paragraph:

14 "Claire's hyponatraemia led to her developing

15 cerebral oedema (swelling) and then brain herniation.

16 The swollen brain will herniate down, resulting in

17 brainstem compression and cardiorespiratory arrest."

18 If your information is based upon the case notes and

19 what the clinicians are telling you, I would suggest to

20 you that it would not be correct to say that in

21 retrospect it's only apparent that hyponatraemia played

22 a part in her death, but that it must have been apparent

23 at the time too.

24 A. Yes, that is right, but I think my sense there is that

25 the hyponatraemia is as a consequence of SIADH and not

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1 I do think that it's rather inappropriate for

2 a statement to be made to a witness that he is trying to

3 mislead the department or his medical director

4 in relation to the serious matter of submitting an SAI.

5 The statement, when analysed properly and carefully, is

6 clearly consistent with what actually occurred in this

7 case.

8 There was a review of the records by

9 Professor Young. At the time Professor Young reviewed

10 the records, he formed the opinion that hyponatraemia

11 may well have played a part in the death of the deceased

12 and, as a result of that, the case was referred to the

13 coroner. In essence, that's what that statement in this

14 letter says and, in essence, there is no actual

15 misleading content in that statement.

16 THE CHAIRMAN: Okay.

17 MR STEWART: The suggestion from this is that it was only in

18 retrospect that this was known and that it was somehow

19 not known at the time.

20 MR McALINDEN: It is quite clear. It really is "in

21 retrospect" because the review by Professor Young

22 occurred in retrospect. It was that that triggered

23 the investigation.

24 THE CHAIRMAN: That is undoubtedly correct. It is correct

25 to say:

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1 as a consequence of overloading with fifth-normal

2 saline.

3 Q. Let's just go back to the page and have a look at your

4 wording again. Back one page:

5 "After a review of the notes, it was considered in

6 retrospect that the known hyponatraemia, which was

7 treated, may have had a part to play in the medical

8 condition leading to death."

9 I suggest to you that that misleads.

10 A. I've written too long a sentence. I'm having some

11 difficulty dissecting it here.

12 THE CHAIRMAN: Let's break it up:

13 "Following the UTV programme, Claire Roberts'

14 parents contacted the hospital."

15 Let's put a full stop there:

16 "After a review of the notes, it was considered in

17 retrospect that the known hyponatraemia, which was

18 treated, may have had a part to play in the medical

19 condition leading to death."

20 Full stop. So it's that middle segment of that

21 four-line paragraph that Mr Stewart is asking you about.

22 A. I think that's correct.

23 THE CHAIRMAN: And the question is: is that correct?

24 Mr McAlinden?

25 MR McALINDEN: I'm reluctant to interfere at this stage, but

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1 "After a review of the notes by Professor Young, it

2 was considered in retrospect ..."

3 That's entirely accurate.

4 MR McALINDEN: Yes. And also my learned friend then raised

5 an issue in relation to Dr Webb's statement. Dr Webb's

6 statement was obviously obtained after the referral to

7 the coroner because the statement was a statement

8 obtained for the purpose of the inquest. So it could

9 not be the case that Dr Webb's statement was in some way

10 contemporaneous with the events.

11 THE CHAIRMAN: Sorry, there are two separate issues. One is

12 if that is referring only to what has happened from

13 2004, then it's undoubtedly correct that it was

14 considered in retrospect and that the known

15 hyponatraemia may have had a part to play in Claire's

16 death; okay?

17 MR McALINDEN: Yes.

18 THE CHAIRMAN: Let's go back to 1996, which I think was the

19 gist of Mr Stewart's question. He was querying the

20 inclusion of the words "in retrospect".

21 The question is: was it known at the time or was it

22 considered at the time that hyponatraemia may have had

23 a part to play in the medical condition leading to

24 death? And I think the gist of Mr Stewart's question

25 is that when you go through a series of entries in the

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1 medical notes and records and the documentation from  
2 that time, that wasn't just known in retrospect from the  
3 work of Professor Young and others from 2004 onwards,  
4 but it was also recognised at different points in the  
5 notes in 1996.

6 I accept the first part is that, if I read your  
7 sentence as, "after a review of the notes by  
8 Professor Young", that's correct.

9 A. That's what I'm meaning.

10 THE CHAIRMAN: Let me ask you to take it one step further.

11 If we go back to the 1996 notes, October 1996, is it not  
12 also apparent that there was, to put it at a minimum,  
13 some recognition by some of those involved that  
14 hyponatraemia was present in Claire and that this may  
15 have had a part to play in the condition which led to  
16 her death?

17 A. That's correct. What causes the hyponatraemia is an  
18 additional matter.

19 THE CHAIRMAN: Yes. Okay. I've got that point.

20 MR STEWART: Why put in the two words "in retrospect"?

21 Because if you hadn't put those in, it would have read:

22 "After a review of the notes, it was considered that  
23 the known hyponatraemia, which was treated, may have had  
24 a part to play in the medical condition."

25 THE CHAIRMAN: I think the answer to that, to be fair to the

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1 witness, is that that's a reference to the review of the  
2 notes by Professor Young in 2006. But there's perhaps  
3 two separate issues.

4 In any event, it's 4.50, Mr Stewart. If you're  
5 in the middle of something, we'll finish it, if we can  
6 do it briefly. Otherwise, we'll adjourn until tomorrow  
7 morning.

8 MR STEWART: Just a couple more questions, if I may, on this  
9 particular area.

10 When the notification of the serious adverse  
11 incident was made then to the department, and that  
12 appears at 302-164-003, and as you've already told us,  
13 the wording of that is essentially taken from that last  
14 document we looked at, which was your briefing to the  
15 press office.

16 A. Yes.

17 Q. Was this a conventional way of drafting a serious  
18 adverse incident report for the Department of Health, to  
19 work it out first in a press release?

20 A. Well, the email went, I think, to both parties. I think  
21 it went to the medical director as well. I can't  
22 remember the circumstances on why I would have aimed  
23 at ... You'll need to take me back as to ... Was the  
24 email to McGinley and copied to McBride?

25 Q. It went to June Champion.

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1 A. The medical director then forwarded to June Champion and  
2 instructed her to deal with it as an SAI.

3 THE CHAIRMAN: Can we go back to the previous page for one  
4 second, please? It goes to McGinley with a cc Michael  
5 McBride. And then it goes from Dr McBride to  
6 Ms Champion.

7 A. That is just serendipity. I could have put both those  
8 names on the heading line -- I just never did that.  
9 I sent it to one person and copied it to another. It  
10 could have been -- it needed to go of equal importance  
11 to both.

12 THE CHAIRMAN: But it has the effect of going to both, so  
13 that's not an issue.

14 A. And the medical director then did indeed think that  
15 an SAI was needed and he chose to use my e-mail as the  
16 source of a lot of the information. But that was  
17 outside my knowledge. It wasn't my plan. I was happy  
18 with it, but it wasn't my plan.

19 THE CHAIRMAN: And that shows, in a sense, what we have  
20 talked about a few minutes ago: that if you report  
21 something like this to Dr McBride, he takes the  
22 responsibility of reporting to the department?

23 A. Yes.

24 MR STEWART: And he does that, and can we go please,  
25 finally, to 139-046-001? This is Michael McBride giving

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1 information to all:

2 "The department has been informed as per the  
3 circular of 2006 and has requested a further background  
4 briefing which I will provide."

5 Did you provide that?

6 A. No, I ... This is Michael McBride saying he is going to  
7 provide something.

8 Q. Yes. Did you ever see it?

9 A. No, I didn't see his --

10 Q. Did it exist? Did he provide a further background  
11 briefing?

12 A. I don't know.

13 THE CHAIRMAN: I don't want the name that's redacted in the  
14 recipients of that email, but can I take it that the  
15 redaction is --

16 A. My secretary.

17 THE CHAIRMAN: So in fact that goes to you?

18 A. Yes.

19 THE CHAIRMAN: Thank you.

20 MR STEWART: Indeed, we know it goes to you because your  
21 initials are at the top and there's a line that you have  
22 drawn from the reference to the circular of 2006, that's  
23 the circular about informing the department, and you've  
24 entered a comment there. Can you read it out, please?

25 A. Yes. This circular, you see, is dated February 2006 and

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1 I didn't think that I had seen it and I asked my  
2 secretary to get me a copy of it. You'll see that there  
3 is a copy, a blank copy, of the SAI and this circular in  
4 the coroner's file, which I obtained after I knew that  
5 this is what Dr McBride was doing. I got the circular  
6 and made this note to myself, which reads:  
7 "Having seen this circular, it seems a bit  
8 heavy-handed for this case."  
9 Q. "For this case"?  
10 A. "For this case." But this was, in my innocence, not  
11 being aware that the reason for reporting this was  
12 basically so that the department and the minister would  
13 know what's going on. It was being done a bit above my  
14 pay station and really I now see that indeed the  
15 department does need to know about things which will  
16 have public interest. That's why I made that note.  
17 Q. This is a case of a child's death from hyponatraemia, of  
18 a care management problem, of an inquest, of a public  
19 inquiry, of politicians being involved, and you're  
20 saying: it's a bit heavy-handed for this case.  
21 A. What I thought was heavy-handed was submitting an SAI  
22 just before the inquest. It was basically saying it  
23 could have been submitted much earlier, once I had read  
24 it. So it's a throwaway line in my e-mail, but you  
25 wanted to know my thinking and that was my thinking when

1 I read that, that I thought submitting an SAI for the  
2 public aspect of it, to the department, was maybe  
3 inappropriate, that it should have been done earlier.  
4 MR STEWART: Sir, thank you.  
5 THE CHAIRMAN: Thank you. Mr Walby, can you convenience us  
6 tomorrow morning?  
7 A. Yes, indeed.  
8 THE CHAIRMAN: Thank you very much. I'll leave you to  
9 discuss timetabling tomorrow. I'm content to pick up  
10 with Mr Walby if that suits. We've got Dr Murnaghan and  
11 Dr McKaigue. Maybe you could have some discussions and  
12 work out some sort of prospective timetable between you.  
13 Okay, thank you very much. Tomorrow morning at  
14 10 o'clock.  
15 (4.57 pm)  
16 (The hearing adjourned until 10.00 the following day)  
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