

(9.30 am)

(Delay in proceedings)

(9.50 am)

THE CHAIRMAN: Good morning. You'll be pleased to know that we have got a slightly shorter day than yesterday. Professor Neville has to leave by 1.15 and Dr Scott-Jupp is only available by video link from 2.30 to 4.30, so we won't be here until 6.30.

Professor Neville, you're still under oath.
Thank you very much.

PROFESSOR BRIAN NEVILLE (continued)

Questions from MS ANYADIKE-DANES (continued)

MS ANYADIKE-DANES: Good morning.

Professor Neville, can I just confirm with you that you have received certain documents? Have you received two witness statements that incorporate reports from Professor Young?

A. Yes.

Q. Have you received a report from Dr MacFaul that deals with those reports?

A. Yes, I have.

Q. And did you receive the transcripts for Dr Webb on Friday and yesterday?

A. Yes, I did.

routine need to restrict fluid intake in encephalopathy and to use fluid with a higher sodium content than Solution No. 18."

Do you have a view as to what the practice was in terms of the treatment of encephalopathy at 1996 and the use of fluids, low-sodium fluids, and any need to restrict their use?

A. Yes. Although I see that one of the major handbooks had giving 0.18 per cent salt, it's quite clear that that required caution and that you would be watching the sodium level and making quite sure that it was not dropping further. And if it was, you should certainly increase the dose of salt so that you were giving either half normal or normal saline. So that, I think, is just giving the normal amount. That, of course, was not followed up because of the lack of doing the sodium on the next morning.

Q. But if I ask you what the knowledge and practice was in 1996. I think what you said is, in 1996, that you would be watching carefully and monitoring and so on, but what I am trying to find out is if you have reached a view that the child has an acute encephalopathy, then in 1996 what was known about how you manage fluids and administer fluids in those circumstances?

A. Well, it had been described for at least 20 years, the

Q. Thank you. Then I wonder if I can take you first to the witness statement of Professor Young. The reference is 178/2. You can see at page 2 of that, at (b), which is a reference to a part of an earlier report of Dr MacFaul, where he is dealing with the treatment of cerebral oedema, in particular the need to act presumptively and restrict fluids in certain circumstances.

A. Yes.

Q. The criticism that's made, apart from the obvious one that he referred to an earlier edition of Forfar & Arneil, the third edition, which was 1984, although at the time of Claire's administration there was a more recent edition than that, but the criticism that's being made is that his reference to:

"In many cases, treatment of cerebral oedema is required to be presumptive. Fluid should be restricted to 60 per cent of estimated daily requirements. Low sodium-containing infusions are contraindicated."

That's one. And then if we go to page 4, then one sees the comment that Professor Young has made having gone through the report and made reference to the materials. He says:

"In reality, in 1996 there simply was not any general or widespread understanding that there was a

problem of giving low-solute fluids to these children.

So I would have, with that particular indication, been really quite careful about what should have been given and I would have given a higher amount. But in fact, if the lower amount, the 0.18 per cent solution, if given, would have been given overnight and then rapidly, I hope, corrected because of a drop in sodium. That's what I would have expected to happen.

THE CHAIRMAN: Sorry, professor, when you say it had been described for at least 20 years, where had it been described? Because the point that Professor Young is making in this paragraph is he is saying there wasn't any general or widespread understanding and he also then cites Dr Scott-Jupp as saying that, as late as 2003, textbooks and handbooks were still recommending hypotonic saline. So if Professor Young is wrong, he suggests also that Dr Scott-Jupp is wrong. So where had it been described for the previous 20 years?

A. Yes, there's a series of descriptions, which are actually quoted by himself. There's a Scott paper in 1965, there's a Worthly paper in 1986. There's another paper by Aines in 1987. And this was really saying that there was overwhelming evidence that the treatment of symptomatic hyponatraemia with hypertonic saline was associated with survival and recovery.

1 THE CHAIRMAN: Apart from disagreeing with Professor Young,
2 do you disagree with Dr Scott-Jupp?
3 A. Could I have ...
4 THE CHAIRMAN: It's the next few lines beyond the bit that's
5 in yellow. It's now being extended for you. You'll see
6 how he finishes that paragraph. In essence, the point
7 Professor Young is making is that there may have been
8 units or places where your position and Dr MacFaul's
9 position is correct, but that was far from being
10 universal.
11 A. No, I think that's probably true.
12 THE CHAIRMAN: That's the curious change in the contents of
13 the textbook.
14 A. Yes.
15 THE CHAIRMAN: What had been in the textbook before was then
16 removed.
17 A. Yes. Well, the textbook is rather peculiarly sort of
18 phrased in that 1992 to 1994 sort of ... By saying
19 homeostasis rather than saying precisely what the
20 requirements are.
21 THE CHAIRMAN: But then doesn't Professor Young make the
22 point that when it's pointed out to Dr MacFaul that he
23 is quoting from the wrong edition of the textbook, he's
24 quoting from the edition which came out subsequent to
25 Claire's death, and then Dr MacFaul says, yes, but the

1 from the use of otherwise standard volumes of
2 low-solute/sodium intravenous fluid."
3 And then he goes on in (5) to say:
4 "The guidance provided in both editions in respect
5 of investigation, fluid management and other aspects is
6 otherwise essentially the same. The later edition
7 however requires the user to refer to separate chapters:
8 (a) on fluid, electrolyte and acid-base disturbance --
9 the section on low sodium and water intoxication and
10 SIADH; (b) on endocrine disorders -- syndrome of
11 inappropriate secretion of antidiuretic hormone; (c) on
12 disorders of the central nervous system in the section
13 dealing with raised intracranial pressure in focal
14 ischaemic brain insult."
15 Then he finally concludes that:
16 "The latter edition later expands the neurology
17 section on management of raised intracranial pressure by
18 pressure monitoring, but removes a specific warning on
19 usage of [Solution No. 18]."
20 Are you able to assist with that in whether what is
21 being indicated in that later edition is in fact
22 pointing to a change in practice or recommending
23 a change in practice from that which was being advocated
24 by the earlier edition or whether it is framing the
25 practice in a slightly different way? That's the thing

1 various doctors here would have been trained at the time
2 when the earlier edition was out and Professor Young
3 makes a point that if they hadn't kept up-to-date with
4 the new edition, they'd be criticised, so it's a bit of
5 a double standard to criticise them backwards.
6 A. I think his understanding, Dr MacFaul's understanding,
7 is that that homeostatic mechanism was what was leading
8 the requirement and so that it would in fact be, if
9 required, a higher amount of sodium. But of course, it
10 isn't explicit.
11 MS ANYADIKE-DANES: Can I put to you that part of his
12 report, just so that maybe that assists you to look at
13 it as you speak to it. It's 238-004-001. This is
14 Dr MacFaul's report. If you see under "Reasoning",
15 if we take from the later edition under (4):
16 "The later edition confines its advice in the
17 section on acute encephalopathy on fluid management to
18 the maintenance of homeostasis and to the use of fluid
19 restriction in hyponatraemia. Maintenance of
20 homeostasis implies connection and management of
21 hyponatraemia associated with water overload and/or
22 SIADH by adjustment of the intravenous fluid regime and
23 the guidance implicates inappropriate intravenous fluid
24 management in the production of hyponatraemia by which
25 is implied (but not stated in the later edition) change

1 that I think we need your guidance on.
2 A. I think this is reinforcing the change that was
3 previously put forward and I think it's making it quite
4 clear that you have to look at the individual child and
5 look at the results that are being obtained from that
6 child at suitable intervals in order to manage the child
7 so that ... But that if you have a hyponatraemic damage
8 potentially occurring and if you have that because the
9 child is of reduced consciousness, then I think you
10 would almost quite clearly be very careful in increasing
11 the quantity of fluids.
12 Q. Can I ask it in this way: the reason for all of that, as
13 I understand it, is because it was believed that there
14 was a connection or there was a risk posed if, for
15 children like that, you continued to administer them low
16 sodium fluids.
17 A. Absolutely.
18 Q. What I want to ask you is: in between the two editions,
19 had there been any change in the received understanding
20 of the risk of administering low-sodium fluids to
21 children who presented with those sort of neurological
22 conditions?
23 A. Not in my view, no.
24 Q. Not in your view, but was that known and accepted in the
25 paediatric neurological community, if I can put it that

1 way?

2 A. Well, I sort of thought it was well-known and that

3 low-solute fluids were not given and was surprised that

4 this sequence of events was being described then.

5 Q. When you say you thought it was well-known, is that

6 what was being taught in your department or your

7 hospital and being administered and practised?

8 A. Absolutely, yes, it was.

9 Q. So far as you know from your colleagues, was that what

10 they were doing?

11 A. Yes.

12 Q. A final question in relation to the various texts.

13 I think it goes back to the point where you were saying

14 that a range of concerns and presentations are being

15 addressed in detail so that you can match those to the

16 conditions of your particular patient, if I can put it

17 that way.

18 A. Yes.

19 Q. At 238-004-008, Dr MacFaul has produced a tabular

20 version of -- the points going down the left-hand side

21 are the things that would appear to be of concern or at

22 least potential concern in Claire's case, and which are

23 relevant for seeing whether there were changes between

24 the editions. And then along the top he has the three

25 Forfar & Arneil editions and there's a paper by

1 systemic circulation is well filled and that large

2 volumes of hypoosmolar fluids are not given."

3 Are you familiar with that particular paper?

4 A. Yes, I am. I am a close colleague of Dr Kirkham's.

5 Q. Ah. Does that paper provide the support for the

6 argument, so far as you are concerned, for the argument

7 that Professor Young is advancing, which is that there

8 wasn't a common knowledge or appreciation that in

9 children with neurological conditions, restriction to

10 60 per cent of daily requirements or that use of

11 Solution No. 18, he says, was prohibited? It's not

12 entirely clear that that's how Dr MacFaul was putting

13 it. I think he was talking about a situation of acute

14 encephalopathy. In any event, can you help by your

15 understanding of what Professor Kirkham is addressing

16 in that paper?

17 A. I think she had been particularly influenced by the

18 study in pyogenic meningitis which was done by

19 Dr P Singhi. That was a controlled trial in which she

20 had found that the death rate was higher in those who

21 had restricted fluids and thus she abandoned the trial

22 early. So that, I think, was really quite a signal

23 event in that. These were, of course, children who had

24 a pyogenic infection so that they were febrile and

25 really somewhat differently unwell, but nevertheless it

1 Professor Kirkham at 2001, which Professor Young seems

2 to think has given some support for the way he perceived

3 matters.

4 I presume the "Y" indicates "yes", ie whether those

5 texts are recommending what is set down in the left-hand

6 side. You've had an opportunity to look at this. Would

7 you be in broad agreement with what is set out there?

8 A. Yes, I would.

9 Q. Then on the issue in relation to Professor Kirkham, we

10 find it at witness statement 178/2, page 7. We're back

11 to Professor Young's statement. He refers to this paper

12 by Professor Kirkham in a review of non-traumatic coma

13 in children that was published in 2001. The part that

14 he cites from it is particularly in relation to salt

15 wasting. You can see the quotation at the bottom of

16 page 7 and it goes on into page 8:

17 "Fluid management can be very difficult and should

18 be tailored for the individual patient's needs. There

19 is considerable controversy over fluid restriction,

20 which has been shown to be potentially harmful in

21 patients with subarachnoid haemorrhage and meningitis.

22 The syndrome of inappropriate secretion of ADH, for

23 which fluid restriction is indicated, is relatively

24 rare; instead, intracranial diabetes insipidus may

25 require careful management. It is essential that the

1 was that that pulled people away from fluid restriction.

2 I think that during the time that they were looking

3 at this child, which would be in the 1980s [sic], it was

4 relatively common practice to reduce fluids and that has

5 somewhat --

6 Q. Claire is 1996.

7 A. No, sorry, 1996. Sorry. And I think that that has

8 somewhat faded into being extremely careful about

9 restriction. But that was being used at that time.

10 Q. Okay. So is it that in the mid-1990s the position was

11 a fairly general approach to restrict fluids in cases

12 where you had children who had neurological problems, if

13 I can put it that way?

14 A. Yes.

15 Q. And since then, the more common approach now is to watch

16 and monitor carefully and see what is actually happening

17 to the child's serum sodium levels?

18 A. Yes.

19 Q. Would that be a --

20 A. Yes.

21 Q. And that might involve a restriction, it might involve

22 using fluids with higher sodium content, but it's all in

23 response to the measurement of the child's particular

24 condition?

25 A. Yes. It would certainly involve the use of higher

1 quantities of sodium, but it would be less usually,
2 I think, of fluid restriction.
3 Q. But if you're going to have that kind of regime, then it
4 means that you are taking your blood tests more
5 regularly.
6 A. Indeed.
7 Q. And monitoring their serum sodium levels more regularly?
8 A. That's right.
9 Q. Thank you. Just on that point, I wonder if you could
10 help with this, because I think what Dr MacFaul went on
11 to say was that it wasn't just because Claire had a low
12 sodium level, it's what a low sodium level should have
13 been understood to mean in a child of her presentation,
14 and this is one of the things that I put to Dr Webb, and
15 I think that there was a disagreement, I'm not sure that
16 he accepted it. Can I pull up the transcript of
17 Dr MacFaul's evidence of 13 November, page 75? It
18 really starts at line 23 and perhaps we can pull up page
19 76 alongside it.
20 So as you know, Dr Webb was under a misunderstanding
21 about when the blood tests had been taken that produced
22 the serum sodium result of 132. He thought in his
23 evidence that that blood test had been taken round about
24 8 o'clock that morning for the ward round that morning.
25 So a lot of his -- well, we'll go into the significance

13

1 child is receiving low-solute fluids of full quantities,
2 that it will drop really quite fast.
3 Q. So then the 132 is not to be seen as just a low level,
4 slightly out of range, as you would for any other child,
5 if you've got a child who has got acute encephalopathy
6 132 is significant?
7 A. Yes.
8 Q. I had asked Dr Webb -- as a result of that, I put to him
9 what else he might have been doing at 2 o'clock. We'll
10 go to his evidence in a minute, but while we're on this
11 page 76, it might be helpful to have your views.
12 Dr MacFaul goes on to say that when Dr Webb saw
13 Claire:
14 "The range of blood investigations which had been
15 carried out was limited."
16 He claims that the guidance in the textbooks, both
17 the third edition and fourth edition, and also the
18 relevant edition of the Nelson textbook and the
19 paediatric neurology textbooks all include a range of
20 investigations, which he says should have been done.
21 And it's over the page where he says what they should
22 be:
23 "Further blood tests. Another blood test should
24 have been done for liver function tests, for blood
25 ammonia, possibly toxins. If that had been done, that

15

1 of that later, but in any event his assessment of Claire
2 is predicated by that belief.
3 A. I understand that.
4 Q. "Let's assume that you also were in that situation, so
5 assume for the moment that it's right and it's
6 understood somehow that a result of 132 comes from the
7 morning. It's low-ish, but not necessarily on its own
8 particularly concerning."
9 And Dr MacFaul goes on to answer in this way, and
10 this is where I'd like your comment:
11 "The view that I've expressed is that for a general
12 paediatrician in a child without encephalopathy, it is
13 not particularly significant [that is the level of 132].
14 But I have also taken the view that, for a paediatric
15 neurologist where there is acute encephalopathy, even
16 a measurement of 132 should have been a red flag that
17 this common and very serious complication of
18 hyponatraemia was evolving because it is well recognised
19 ... So I believe his action should have been, when he
20 saw Claire, to have taken the steps to deal with it
21 already, even on a figure of 132."
22 A. Yes, I've written that in my original report and I don't
23 use a red flag, but I do say that it is something that
24 should be taken serious note of because it's very likely
25 to be on the way down and it's very likely that if the

14

1 would have necessarily produced the blood sodium level
2 even if you weren't thinking at 2 o'clock that you
3 needed to do that because you already had a value from
4 8 o'clock in the morning."
5 Can you express a view as to whether you think that
6 a full blood workup, I suppose that's effectively what
7 he's saying, should have been done at 2 o'clock as part
8 of the practice?
9 A. Yes, I think so. I think it could have been done
10 earlier.
11 Q. And if it hadn't been done earlier?
12 A. Then it would have been done then.
13 Q. Is that just because that's out of your experience
14 and/or because that's what the textbooks that were in
15 current use at that time would have indicated?
16 A. Yes, I think so, for an encephalopathy of uncertain
17 origin that would be the minimum.
18 MR SEPTON: Sir, I don't understand the witness's answer to
19 my learned friend's question. She put an option and the
20 answer was yes, so which of the two options is the
21 witness actually alighting on?
22 MS ANYADIKE-DANES: There were two, although they could
23 amount to the same thing. I was asking whether you are
24 of the view that those sorts of tests should have been
25 carried out because that is what comes out of your

16

1 experience, and I suppose I could have said and/or is it
2 because that's what the current textbooks would have
3 been advocating?
4 A. I would have said yes to both.
5 Q. Thank you.
6 THE CHAIRMAN: Sorry, you also said, professor, that you
7 think these tests could have been done earlier. I mean,
8 it's self-evident that they could have been done
9 earlier. Are you saying they should have been done
10 earlier?
11 A. Yes, I would.
12 MS ANYADIKE-DANES: Mr Chairman, I want to refer to the
13 transcript from yesterday, and I'm conscious I'm looking
14 at a draft and it may be that some others are too. I'll
15 give a page number and my junior will tell me if I've
16 got the right page. It's page 22.
17 Sorry, can we try at page 55? I beg your pardon.
18 THE CHAIRMAN: What's the point you're looking for?
19 MS ANYADIKE-DANES: I'm going to put to him what Dr Webb
20 said in response to that very question that I put to
21 Professor Neville.
22 THE CHAIRMAN: Is that not it at page 55, line 12, about the
23 lack of testing?
24 MS ANYADIKE-DANES: Yes. So it goes on to page 56 really.
25 You see the bottom line, that just says "the range of

17

1 "Some people take a broad sweep and do a lot of
2 blood tests and others target their investigations to
3 the most likely diagnosis."
4 MS ANYADIKE-DANES: No, that wasn't quite where I wanted to
5 go. Line 11:
6 "Well, I think you have to think about what you're
7 looking for when you do your investigations. So in some
8 people with a viral infection, it's quite likely that
9 the liver enzymes will be slightly elevated, but it
10 doesn't help you any further really."
11 And then it goes on to a slightly different point,
12 which is how persuaded he was by his own differential
13 diagnosis. When I put that same point to you, you were
14 of the view that a full blood workup should have been
15 done earlier, but if not done earlier, certainly then.
16 This is Dr Webb's response to that. Can you comment?
17 A. They're not complicated tests, liver function tests, and
18 they would give a clear idea of whether this liver is
19 seriously deranged, mildly deranged or okay.
20 Q. Sorry, if I pause you there. Why would you think there
21 was anything wrong with her liver from what you'd seen
22 at the time?
23 A. It's perfectly possible that this is a primarily liver
24 start for the problem --
25 Q. Do you mean there's nothing --

19

1 blood investigations". If we go on to page 56, I think
2 that'll help us.
3 About line 10, and there I'm citing literally what
4 I put to you. If we go to page 57, I think we will get
5 his answer.
6 Then the question culminates in:
7 "Do you accept that you should have asked for more
8 blood tests?"
9 The answer to which is:
10 "No, I don't."
11 Then his explanation starts at line 9:
12 "Because you are talking about the accepted practice
13 at that time. The textbook essentially comments that
14 these are tests that may be helpful. They're not
15 prescriptive tests and I had no evidence that Claire had
16 evidence of liver damage, she had a normal glucose and
17 I had no reason to think that she had ingested
18 toxins ... I think it's most unlikely that she would
19 have given the supervision that she had."
20 I ask him:
21 "Why don't you simply do them as part of
22 a broad-based approach?"
23 And I think he says ... This isn't quite the same
24 as mine, so I'm trying to find ...
25 THE CHAIRMAN: He says:

18

1 A. -- with a hyperaemic presentation. So it is a perfectly
2 reasonable question to ask.
3 Q. So does that mean there's nothing in her presentation
4 which would exclude it?
5 A. No.
6 Q. And if she did have that, what would that lead you to
7 start doing?
8 A. Well, you'd be thinking of trying to reduce the ammonia
9 level by a number of techniques.
10 Q. And if you don't do that and you don't treat it because
11 you don't presume that it's there, what is the
12 consequence of that?
13 A. It's another reason for not knowing what you're doing.
14 Q. I appreciate that as a general point, but if it's left
15 untreated what is the consequence of her having a liver
16 problem, if I can put it that way, that's causing her
17 presentation?
18 A. It automatically puts it into a much higher group of
19 seriousness of problems and would indicate a need for,
20 presumably, greater care and earlier ventilation and
21 things of that sort.
22 Q. Does that mean that she was at risk in some way by, if
23 she had that condition, that condition not being
24 treated?
25 A. Yes. It's not saying that it's very easy to treat.

20

1 That's for sure.

2 Q. Well, he says that the liver enzymes will be slightly

3 elevated, but then he goes on to say:

4 "That doesn't help you any further really."

5 Can you understand what that means?

6 A. It's a matter of whether you speculate or whether you do

7 the test. I would do the test.

8 Q. In relation to toxins, he's not convinced that that

9 would have assisted at all because he says there's no

10 evidence that she ingested any toxins.

11 A. No, and I would sort of tend to agree with that in terms

12 of the fluctuation that she had, which suggested that

13 she wasn't going acutely into more severe coma.

14 Q. Can I ask you about the fluctuations because actually

15 that was one of the things that Dr Webb used --

16 obviously, the presentation of the child diagnostically.

17 He said firstly she was recorded as having seemed

18 a little brighter at midnight. By that time, she had

19 been on her fluids since about 8 o'clock in the evening,

20 I think.

21 Then I think the nursing staff thought she was

22 a little brighter first thing in the morning, although

23 by the time the parents got there, they did not think

24 she was any brighter and I think, to some extent, the

25 nursing staff and certainly Dr Sands, although he hadn't

21

1 brighter at midnight, and then the nurses' view first

2 thing in the morning -- and I think the nurses' have

3 reflected that in their notes -- that she did seem a

4 little better in the morning.

5 So she appears to fluctuate and that's the

6 information that he had. And you're right, by the time

7 he got there at 2 pm, he had information that diazepam

8 had been administered rectally at 12.15 and she did seem

9 to have some positive effect from that. And that then

10 diminishes and recedes and she returns to her state.

11 A. Yes.

12 Q. So what I'm asking you is: is that kind of presentation

13 relevant and was it appropriate, reasonable, for him to

14 use that as fortifying his view that he was really

15 dealing with non-convulsive status epilepticus?

16 A. My point would be that it was unlikely that it was

17 a toxin.

18 Q. Sorry?

19 A. My point would be that it was unlikely that it was

20 a toxin.

21 Q. Right.

22 A. I think the chances of it being non-convulsive status

23 are quite small, but they're present.

24 Q. And why do you think, just so that we understand the

25 reasoning of it, that that kind of improvement and

23

1 seen her to make a comparison, he was concerned about

2 her presentation.

3 But that ability for her to seem a little brighter

4 and then not, he took some comfort from that, that

5 what -- not comfort, but he used it as part of his

6 analysis of her condition to reach the view that what he

7 was dealing with here was a non-convulsive

8 status epilepticus.

9 A. Yes.

10 Q. Do those differences that he was informed about and

11 would have known, therefore, when he came at 2 pm, are

12 they relevant as part of identifying her underlying

13 condition?

14 A. They're not, that she was anarthric and unsteady and

15 then she became normal. So there's certainly not that

16 sort of difference between the recovery after giving an

17 anticonvulsant.

18 Q. Well, sorry, she hadn't actually had any anticonvulsant

19 at all until she got the diazepam at 12.15.

20 A. No, sure.

21 Q. He does say that he was informed that she was a little

22 better after that, or at least there was some

23 improvement, and I'll come to that in a minute. But the

24 point that I was asking you about, the specific thing he

25 mentioned, was the recorded fact that she was a little

22

1 falling away does not reinforce a view of non-convulsive

2 status epilepticus?

3 A. Because it isn't fluctuating between getting close to

4 normal and then going severely off again; it's much less

5 than that.

6 THE CHAIRMAN: So if the fluctuation was like that, that's

7 more significant than if the fluctuation was within

8 a narrower range?

9 A. It's much more significant if she's fluctuating between

10 being fully awake and then being unconscious. That's

11 much more like what would happen in non-convulsive

12 status.

13 MS ANYADIKE-DANES: And just while we're hovering around

14 that area, Dr Webb had the view that Claire had suffered

15 a convulsive seizure on the Monday of her admission and

16 that he got that information -- he says that the mother

17 told him ... Well, he wasn't clear whether he was being

18 given that information by the grandparents when he

19 examined Claire at 2 pm. By the time he examined Claire

20 in the presence of her mother at 5, her mother was

21 describing something to him, which he interpreted as

22 a convulsive seizure on the Monday. You've read

23 Claire's notes. Is there anything that is at least

24 recorded that would give you the view that she had

25 suffered a convulsive seizure on the Monday?

24

1 A. She certainly had an episode and whether that was
2 a seizure or a sort of dystonic attack is quite
3 difficult. But the ones that involved one side of the
4 body would almost certainly be a seizure.
5 Q. Let's be clear that we're talking about the same thing.
6 You are quite right, there is a record of attacks that
7 relates to the Tuesday, which does describe episodes,
8 the first of which is recorded at 3.25.
9 A. Yes.
10 Q. What Dr Webb was talking about is her date of admission,
11 which was on the Monday.
12 A. Yes.
13 Q. And what I'm asking you is: have you seen any evidence
14 that, on admission, any of the history taken indicated
15 that she had sustained a convulsive seizure?
16 A. I'm really not sure. Sorry.
17 Q. Perhaps, in fairness, I should take you to the notes.
18 If we go to 090-011-013. That is the referral from the
19 GP. There's a reference to her tone increasing.
20 A. Yes.
21 Q. You see that there is a difference between the right and
22 the left side. Then there's a query from the GP, he's
23 querying a further fit or querying an underlying
24 infection. So that seemed to be the information from
25 there.

25

1 asked about it because --
2 Q. Well, we see Dr Webb's view of it in his witness
3 statement 138/1, page 38, and I think it's in answer
4 to (g). He refers to focal seizures. He didn't
5 indicate this at 2 o'clock because he wasn't quite clear
6 on the position, but he does then describe them as focal
7 seizures in his 5 o'clock note.
8 A. Yes.
9 Q. And he says:
10 "The focal seizures described included focal
11 stiffening of Claire's right side. This clearly had
12 been repeated on more than one occasion and, from the
13 description, I considered it to be seizure activity.
14 I believed that Claire was presenting with seizures that
15 were symptomatic of an intercurrent viral infection and
16 this infection could potentially have included
17 involvement of Claire's meninges and brain."
18 He's a little more specific there than he was,
19 I think, when he was giving his evidence. In his
20 evidence, he relied more on the history that Mrs Roberts
21 gave him. But there, that description of the stiffening
22 of one side or other, does that connote to you
23 a convulsive seizure?
24 A. I have thought that there were likely to be two
25 different sorts of attacks and I agree that the ones

27

1 Then if one looks at the record at A&E, 090-012-014,
2 it's a bit difficult to read perhaps. Up at the top,
3 there's the history of the epilepsy and so forth. Then:
4 "Speech very slurred, hardly speaking. On
5 examination, drowsy and tired. No neck stiffness."
6 Then it goes on to describe left and right-hand
7 side:
8 "No apparent limb weakness. Tone increased."
9 Then just very briefly, if we go on to 090-022-050.
10 This is the note taken by the registrar to admit her.
11 If you go down to the history and if we go over the page
12 to 051, there we have what she can do and then ...
13 Power is not assessed, but tone is and reflexes are ...
14 A. Yes.
15 Q. "Not responding to parents' voice. Intermittently
16 responding to deep pain."
17 Then just to close that off, 090-022-052, that ends
18 up with the impression of Dr O'Hare. All those details
19 about the differential movements on left and right side
20 may indicate things to you which obviously don't
21 indicate it to me, but having been taken through those
22 three records by the clinicians, do you see evidence, if
23 you were simply drawing it from the notes, of Claire
24 having sustained a convulsive seizure?
25 A. No, I can't see any evidence. That's why I sort of

26

1 that involve the right side, provided they're accurately
2 described, are likely to be seizures. They're of course
3 highly likely to be provoked by having a low sodium
4 level rather than --
5 Q. Sorry, I want to be clear on your evidence. Because
6 when I took you through those descriptions of the
7 difference between the left and right side, in her
8 medical notes and records, which were taken by the GP,
9 the description by the GP, the description in A&E, and
10 the description by the registrar, when you looked at
11 those you answered me to say that you didn't think that
12 that indicated to you a convulsive seizure.
13 A. No. When I was --
14 Q. Is there a difference between that and what is described
15 here then?
16 A. Well, there are, I think, probably two different sorts
17 of attacks. One is a dystonic extension attack, which
18 may well not be seizural, and the other is the
19 right-sided, if it is right, stiffening. And they're in
20 small number, and I don't know that they're of any great
21 note, quite honestly. They are not proof of anything.
22 Q. They may not be to you, but they're part of what Dr Webb
23 used, part of the general history of Claire to try and
24 formulate a view as to what was causing her
25 presentation --

28

1 A. Yes, I understand.
2 Q. -- and how he should plan her treatment.
3 A. Yes.
4 Q. But I want to make sure that I am not misunderstanding
5 your evidence. Are you saying that the descriptions in
6 the medical notes and records that I took you to --
7 forget this for the moment -- do those connote to you
8 seizure activity? Do you want to see them again?
9 A. Yes, I think that one or two may be and the other one or
10 two may not be. It's very difficult to be sure of that.
11 Q. Right. Well --
12 A. And I hope that's what I said before.
13 THE CHAIRMAN: It is.
14 MS ANYADIKE-DANES: Yes.
15 I think the most detailed one is taken by Dr O'Hare,
16 090-022-051. She starts with the tone:
17 "Upper limbs: cogwheel rigidity, tone elevated for
18 the left-hand side; cogwheel rigidity for the right.
19 Lower limbs: tone increased for the right, tone
20 increased for the left."
21 Then she deals with the reflexes. Does that connote
22 stiffening of any sort?
23 A. Yes, it does, but it doesn't indicate a seizure.
24 Q. That doesn't?
25 A. No.

29

1 history of Claire's presentation endorsed my opinion
2 that she had recurrence of epileptic seizures with an
3 intercurrent viral infection."
4 So it may be that I have put you on the wrong lines
5 because I don't think that Dr Webb is claiming that he
6 got that view of Claire from the medical notes and
7 records, but he got it from the mother.
8 If his conclusion from her description is correct
9 that there was that kind of stiffening -- and "focal"
10 means, I presume, identified to a particular place as
11 opposed to general -- if that's the case, would that
12 connote to you seizure activity or potential seizure
13 activity?
14 A. Yes, it would.
15 Q. Yes. And you said that you don't think that that's
16 particularly relevant. Why is it that you don't think
17 that's particularly relevant?
18 A. Well, it would be a relatively common feature of
19 somebody who has hyponatraemia, particularly as the
20 sodium is dropping quite fast.
21 MR SEPHTON: I'm sorry to interrupt. I wonder if the doctor
22 could help us on what evidence there was that Claire was
23 suffering from hyponatraemia on the Monday afternoon.
24 THE CHAIRMAN: When she was at home?
25 MR SEPHTON: Yes. The story is, as I understand it, Dr Webb

31

1 Q. Right. Then if we go back to what Dr Webb was saying,
2 which is at 138/1 at page 38 at (g), does this
3 description accord -- because it may be that Dr Webb is
4 actually getting this from Mrs Roberts and is not saying
5 that he's getting it from the medical notes and records.
6 But does this description accord with the medical notes
7 and records?
8 A. Well, of course it does really matter where they came
9 from. I hadn't quite realised where the potential
10 source was.
11 Q. I think if we go to page 19 on this, maybe that'll help.
12 If you look at 14(b):
13 "After speaking to Claire's mother [so it does
14 appear it's coming from the mother], state whether you
15 had a clear picture from the lead into yesterday's
16 episodes."
17 That's how he described them in his clinical note at
18 2 o'clock:
19 "Describe that picture and describe where it is
20 recorded ..."
21 And so on. He says:
22 "Following my discussion with Claire's mother, I
23 felt more certain that Claire had experienced focal
24 seizures affecting her right side on the day of
25 admission. I did not record the exact timing. The

30

1 sees Mrs Roberts on Tuesday afternoon at 5 o'clock.
2 He's trying to find out from her what "yesterday's
3 seizure activity" was. "Yesterday" must have been the
4 Monday.
5 THE CHAIRMAN: Yes.
6 MR SEPHTON: So I want to know from the doctor why he says
7 that seizure activity on the Monday was probably caused
8 by hyponatraemia and that her sodium level was dropping
9 fast.
10 A. Of course, the level was done at something like
11 9 o'clock, I think, wasn't it? So that it would
12 have ... The problem about that is how fast it had been
13 dropping beforehand --
14 THE CHAIRMAN: Yes.
15 A. -- and how long she had been unwell with this disorder.
16 THE CHAIRMAN: I think the point of the intervention is that
17 that is an unknown --
18 A. Yes.
19 THE CHAIRMAN: -- for how long she'd been unwell. And the
20 question Mr Sephton is asking, on behalf of Dr Webb, is
21 what evidence there was that Claire was suffering from
22 hyponatraemia on Monday afternoon. Is it not the case
23 that there's no actual evidence that she was suffering
24 from hyponatraemia? There is a possibility that --
25 A. Yes.

32

1 THE CHAIRMAN: -- she was suffering from hyponatraemia. Is
2 the evidence of that possibility the fact that later in
3 the evening she had a reading of 132?
4 A. I think that was partly on the agenda. She had been
5 vomiting, so there was a considerable chance that she
6 was dropping. But I can't be sure.
7 THE CHAIRMAN: If that hyponatraemia was developing, it
8 wasn't because of excess fluid --
9 A. No.
10 THE CHAIRMAN: -- that she was receiving, and it wasn't
11 because of the rate of fluid intake --
12 A. No, it wasn't.
13 THE CHAIRMAN: -- and it wasn't the type of fluid.
14 A. No.
15 THE CHAIRMAN: If hyponatraemia was a possibility at that
16 time, it's from SIADH, is it?
17 A. Yes.
18 MS ANYADIKE-DANES: And if that's a possibility, you would
19 have to do that working back, wouldn't you,
20 Professor Neville --
21 A. Yes.
22 Q. -- because you couldn't possibly have known that at the
23 time, for example, when Dr O'Hare was doing her slightly
24 more detailed examination? She didn't know what the
25 serum sodium levels were and, in fact, the first

33

1 you're giving low-solute sodium or you're giving
2 normal --
3 Q. I'm taking it slightly later than that. I'm taking it
4 from when you appreciate you have 132 and you're then
5 able to engage in that sort of thinking, what that might
6 indicate. What I'm trying to find from you is, if you
7 had joined up the dots to think maybe she might have
8 been on her way to having reduced serum sodium levels,
9 would that affect any decision you made about the
10 continuation of her fluids?
11 A. That would have particularly pushed you in the direction
12 of having either half normal or normal saline.
13 Q. If you had made that connection?
14 A. Yes.
15 Q. But it's not necessarily a connection that might be
16 readily made?
17 A. No.
18 Q. Thank you.
19 THE CHAIRMAN: And that is why the criticism of the doctors
20 on Monday night is quite equivocal, isn't it?
21 A. Mm.
22 THE CHAIRMAN: I'm expressing this very generally,
23 professor, but there seems to be a view that they might
24 have thought about changing the type of fluid or they
25 might have thought about reducing the volume of fluid,

35

1 opportunity for anybody to have really considered that
2 would be when they came through and, in terms of any
3 sort of consultant to take a view on that who actually
4 might know about the implications of that
5 neurologically, it may have been Dr Webb.
6 A. Yes.
7 Q. It could have been somebody earlier, but in any event
8 what you would have to be thinking about was: well, if
9 she was 132 when the bloods were taken at 8 o'clock or
10 shortly thereafter, whenever it was, and she hadn't
11 really received much in the way of fluids, then, as you
12 say, do I posit the proposition that with the vomiting
13 that she'd experienced, that she might have been
14 slightly dropping in her serum sodium levels before she
15 actually was admitted?
16 A. Yes.
17 Q. And if you had reached that view, that that was
18 a possibility, so your 132 is your one point on a graph,
19 which doesn't have any other points, if I can put it
20 that way --
21 A. That's right.
22 Q. -- does that affect what you do when you review her
23 fluids?
24 A. Well, if you were managing it as from the Monday
25 evening, then you would have to decide between whether

34

1 but it would be unfair to be critical in any significant
2 way --
3 A. Yes.
4 THE CHAIRMAN: -- on Monday night.
5 A. Yes.
6 THE CHAIRMAN: The criticism is that when Claire's condition
7 did not improve on Tuesday morning, there should have
8 been more tests.
9 A. Exactly.
10 THE CHAIRMAN: There seems to be a very strong view that
11 there should have been an EEG before presuming that
12 there was non-convulsive status epilepticus --
13 A. Yes.
14 THE CHAIRMAN: -- and that, had these tests been done, the
15 outcome might have been very different.
16 A. Yes, indeed.
17 THE CHAIRMAN: Having said all that, Claire's condition was
18 not easily diagnosed.
19 A. Well, I think a serum sodium would have made quite
20 a difference.
21 THE CHAIRMAN: Sorry, let me put it this way: her condition
22 was not straightforward; it's because it's not
23 straightforward that you do do the tests.
24 A. Yes.
25 THE CHAIRMAN: And you do do the EEG rather than presume

36

1 that there's the rather unusual and unexpected
2 non-convulsive status epilepticus.
3 A. Yes.
4 THE CHAIRMAN: Dr Webb made the point that you can always do
5 more tests and I am sure he's right, but in order not to
6 do more tests you have to have a degree of confidence in
7 your diagnosis, which I think you and the other experts
8 say he couldn't really have had.
9 A. No. Well, he didn't, at that stage, have any clear
10 indication, I think.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: Thank you.
13 If that particular logic had not been worked out to
14 think that her presentation -- because she did have some
15 sort of disturbed state as she was admitted to
16 hospital -- was as a result of her falling serum sodium
17 levels or in part contributed to by that, if it's not
18 that then what else could it have been in your view?
19 A. I think it's most likely that she had an intercurrent
20 viral infection and that she therefore became at risk of
21 developing hyponatraemia. So I think it's likely that
22 she had two things, not just one.
23 Q. Did the two relate to each other in the sense that did
24 the intercurrent viral infection predispose her to
25 responding in a way that her serum sodiums would become

37

1 covering. In the way that you've just described things
2 now, are joining up those particular dots something that
3 would have assisted if an experienced consultant
4 paediatrician had been there, either earlier or at the
5 ward round?
6 A. Yes. I mean, an experienced paediatrician may well know
7 those links, but even so, they would want to know the
8 morning level of sodium so that they could check upon
9 that. I do think it's part of a paediatric
10 neurologist's job to remind everybody that hypotonic
11 solutions have hazards to them.
12 Q. But the process of getting in the evidence so that you
13 could get better guidance from the neurologist might
14 have already started if you've got an experienced
15 paediatrician saying, "We don't seem to have our levels
16 for this morning, we certainly need them for this
17 child".
18 A. Yes.
19 Q. Can I ask you something else related to a query as to
20 what else might be happening, other than what you have
21 just described. It's something that Dr Webb dealt with.
22 On my system, he's dealing with it at page 40. You've
23 written your report about matters to do with raised
24 intracranial pressure, which I am going to ask you about
25 as well. I am citing from your report. I think it's

39

1 lower, or are they completely independent of each other?
2 A. They're probably independent, but of course, unless she
3 is in a state when she is to be given intravenous
4 fluids, you wouldn't really know.
5 Q. And if she was in that state, possibly with those two
6 things happening, what is the impact of that on her
7 having received the normal fluid regime that child would
8 have received in those days, which is the Solution No.
9 18? I think her rate was 64 millilitres an hour.
10 A. Well, it would be likely to be a drop in the sodium
11 level of the sort that we see occurring later.
12 Q. I'm just going to ask you another point that's a little
13 bit related to that, but leading on from something the
14 chairman asked you, which is that these things require
15 a little bit of thought to work out what the connections
16 are --
17 A. Yes.
18 Q. -- and to sort of test those against the presentation
19 that you've got and the notes that you've received.
20 A. Yes.
21 Q. Dr Webb doesn't actually come into it until slightly
22 later in the day, if I can put it that way. His view --
23 and I know that it's not necessarily shared by the
24 experts -- is that the fluid management side of things
25 is something that the general paediatric team was

38

1 232-002-006:
2 "I would not agree that non-convulsive
3 status epilepticus was the likely diagnosis because
4 it is not common and epilepsy was not prominent in this
5 child's recent history. In my opinion, non-convulsive
6 status epilepticus needed to be proved by an urgent EEG
7 and another more likely cause of reduced conscious level
8 and poorly-reacting pupils would be cerebral oedema ..."
9 I think it might be the next page. Then:
10 "The reduced conscious level and poor reacting
11 pupils would be cerebral oedema related to hyponatraemia
12 and that should have been considered as a matter of
13 urgency because, in its early stages, it is reversible."
14 And then I ask Dr Webb if he would comment on the
15 point that you have made about the epilepsy not being
16 prominent in Claire's recent history. What he then goes
17 on to say is:
18 "I think a child, who has had epilepsy in early
19 infancy, as I mentioned on Friday, is at very high risk
20 of recurrence of seizures in childhood."
21 And then if we go over the page --
22 THE CHAIRMAN: Do you want to take this bit by bit? Before
23 we go on to the next bit, do you agree with that,
24 professor, that Dr Webb says that a child who has had
25 epilepsy in early infancy is at a very high risk of

40

1 recurrence of seizures later in childhood?

2 A. Yes, there's no doubt that she's at higher risk than

3 otherwise. And by having a low-ish IQ, she will be at

4 higher risk as well. I just thought it was somewhat

5 extraordinary for somebody who'd had previous infantile

6 spasms, which is what I understood was the likely

7 diagnosis from the previous consultant, that she should

8 just drop into having minor status.

9 MS ANYADIKE-DANES: I did put that point to him. I think

10 you see it at 43, I hope, but I'm reading from mine,

11 which is your report, you say:

12 "Her epilepsy had ceased. She was at significantly

13 higher risk of developing epilepsy again [so you do

14 accept that], but the form of epilepsy that she had

15 before, which as I understand it was likely to be

16 infantile spasms, is one which tends to have an end

17 point to it, around 2, 3, 4-ish [years], and then to

18 either go away or persist almost continuously with

19 a different sort of epilepsy. So I think that the

20 chances of it just starting in the middle of something

21 which would be 3 or 4 years away is unlikely."

22 And I asked Dr Webb about that in particular, and on

23 the next page he deals with it. He does not regard her

24 seizures in that way. He says:

25 "In fact, the seizures that she had had -- as an

41

1 Q. Did you have an opportunity then to look at her earlier

2 medical notes and records, Claire's earlier medical

3 notes and records?

4 A. Yes. It was presented here.

5 Q. And so if she had had that kind of infantile spasm, then

6 your view -- and is that out of just your experience or

7 what was in the literature?

8 A. Yes.

9 Q. Your view is that that either peters out after a while

10 or, unfortunately, increases and develops into

11 a different kind of epilepsy?

12 A. No, it is -- well, there's a lot of evidence upon that

13 with particularly the relationship between either being

14 free of the attacks or developing a condition called

15 Lennox-Gastaut Syndrome.

16 Q. And does that mean, so far as you are concerned, Claire

17 just did not fit that pattern?

18 A. No.

19 Q. So what was the likelihood in your view -- and you may

20 not be able to quantify it in that way -- of her

21 actually suffering a recurrent epileptic episode?

22 A. Of her suffering continuous non-convulsive status,

23 relatively small, but certainly it's --

24 Q. But higher than a child who had never had epilepsy

25 before?

43

1 infant, she had multiple different seizures types and

2 she didn't have typical infantile spasms because her EEG

3 didn't follow the pattern that was typical for that. So

4 I'm not sure that Professor Neville is correct when he

5 refers to infantile spasms. It's certainly not a case

6 of infantile spasms and I'm not sure whether he is

7 basing this opinion on his lifetime of experience of

8 epilepsy. But certainly my understanding at the time in

9 1996, from my reading, would have been, in the

10 situation, Claire had a very high risk of recurrence."

11 Can you respond to that?

12 A. Well, the diagnosis that was written down by the

13 consultant was "infantile spasms", so I think that's

14 clear in her writing. It isn't that everybody has to

15 have just spasms, but they can have multiple types of

16 attacks. But these attacks are subsumed, really,

17 I think, within the infantile spasms group. That's

18 where I put it for that purpose.

19 Q. So you could have different sorts of --

20 A. Yes.

21 Q. -- presentations which can all be grouped together as

22 infantile spasms?

23 A. Sure, and you can start off with focal seizures, say, at

24 2 to 3 months, and then you develop spasms a little bit

25 later. That's a relatively common thing to occur.

42

1 A. Higher than another child, yes.

2 Q. And "relatively small", does that mean it's sufficient

3 to keep that in your thinking when you're trying to

4 formulate differential diagnoses?

5 A. It's perfectly reasonable to put it into the group, but

6 you have to think of other things as well. And that

7 seems to be the difficulty.

8 THE CHAIRMAN: He did, didn't he? At 5 o'clock, Dr Webb

9 revised his 2 o'clock approach --

10 A. Yes.

11 THE CHAIRMAN: -- by raising the risk level of encephalitis.

12 A. Yes, that's right.

13 MS ANYADIKE-DANES: Mr Chairman, I was going to go on to

14 a different point and I'm conscious of the time. We

15 started at 9.30 and bearing in mind yesterday was quite

16 a day for the stenographer.

17 THE CHAIRMAN: Okay. 11.15? Thank you.

18 (11.05 am)

19 (A short break)

20 (11.20 am)

21 MS ANYADIKE-DANES: Professor Neville, just to go back to

22 something that you had dealt with earlier --

23 A. Could you possibly speak up?

24 Q. -- but in a slightly different way, that description

25 that Dr Webb had of his take from the history he

44

1 received from Claire's mother, and he had concluded from
2 that that what was happening was that there were these
3 focal seizures and that they were on the Monday, just
4 prior to her admission or maybe on admission, but in any
5 event they were on the Monday.
6 A. Yes.
7 Q. And he regarded those as actual seizures, so convulsive
8 seizures that were evident, if I can put it that way.
9 Let's say that that was correct and that the mother had
10 described something, which could properly be interpreted
11 in that way. In your view, what could have given rise
12 or might have given rise to that?
13 A. She was in an altered state, so she had lost some skills
14 within a somewhat reduced framework, so that she was
15 therefore not well. That's one reason why she might
16 have become unwell at the end and developed some
17 seizures. That's a --
18 Q. Could that kind of illness, whatever was causing her
19 altered state and so on, could that have triggered
20 a seizure of the type that Dr Webb described?
21 A. Well, it depends what he's describing.
22 Q. Let's pull it up.
23 A. Because I don't think it's -- well, sorry.
24 Q. Let's pull it up so you can see it. 138/1, page 38, and
25 I think it's his answer to a question at (g). There

45

1 epilepsy?
2 A. No.
3 Q. This would be an epilepsy born out of, let's put it this
4 way, a slightly vulnerable brain to that sort of thing?
5 A. Yes.
6 Q. She has some sort of viral infection and that is what,
7 in conjunction with that vulnerability, produces the
8 electrical activity that is seen as focal stiffening and
9 seizure?
10 A. Yes.
11 Q. Would that be --
12 A. Yes, that would be right.
13 Q. And that's possible?
14 A. Yes.
15 Q. And if that's what you thought was the case and you're
16 trying to take stock and see how you would plan the
17 treatment and care of Claire, what would you be doing in
18 order to do that, recognising that that's what you think
19 has happened?
20 A. One aspect of that would be to try to treat the
21 seizures. I've said, I think, that doing an ordinary --
22 giving a single dose or multiple doses of one drug, say
23 diazepam, would be an entirely reasonable thing to do.
24 But I would then be looking as to whether that really
25 subsumed the whole illness or was really just a part of

47

1 we are. What he has described there is a focal seizure,
2 including -- that's simply repetition. So there's
3 "focal stiffening of Claire's right side", repeated on
4 more than one occasion. So he interprets that as
5 a seizure.
6 A. Yes.
7 Q. If he had correctly done that, the question I was
8 putting to you is: what could have triggered or given
9 rise to a focal stiffening of Claire's right side, which
10 could be detected on more than one occasion? What could
11 have produced that?
12 A. That would be a seizure disorder which involved,
13 presumably, the left-hand side of the body and would
14 have been because of, indeed, a triggering of that
15 event.
16 Q. That's what I'm asking you. What could trigger it?
17 A. An infection could easily do that.
18 Q. An infection could do that?
19 A. Yes.
20 Q. Could an infection do that irrespective of whether the
21 child had any previous epileptic history?
22 A. Much, much less likely if she hadn't had an epilepsy
23 in the previous time, no. So that would be very
24 surprising, but it's not impossible.
25 Q. So this wouldn't be a recurrence of her infantile

46

1 it and perhaps a relatively minor part. So I think
2 it would turn out to be a relatively minor part in this
3 situation, and so I would then be looking for other
4 reasons as to why this was occurring.
5 Q. If you'd thought that that kind of seizure had been
6 triggered by some sort of viral upset, if I can put it
7 that way, do you address the underlying viral upset or
8 seek to --
9 A. You would, certainly.
10 Q. -- identify what it might be?
11 A. Surely. You would normally be giving the appropriate
12 drugs, which were given in the end in the latter part of
13 Tuesday.
14 THE CHAIRMAN: The acyclovir?
15 A. Acyclovir.
16 MS ANYADIKE-DANES: Earlier?
17 A. You would have thought of giving it earlier, yes. But
18 that's ...
19 MR SEPHTON: I'm sorry, [inaudible] put this to the witness,
20 what the evidence is for the proposition that it was
21 a relatively minor part of the situation, the previous
22 history of seizures on the Monday. Why does he say it's
23 a relatively minor part?
24 MS ANYADIKE-DANES: Yes. You'd characterised it because you
25 thought that a viral upset, given her vulnerable brain,

48

1 had triggered the seizure. If there was a seizure,
2 that is what could have happened. So I had asked you
3 how do you address that as your treatment plan, and you
4 said you would treat the seizure and you thought that
5 administering the diazepam would be a reasonable thing
6 to do. Then you expressed the view that you would then
7 be having to be looking at whether that was the complete
8 picture or something else was going on. Then you went
9 on to say that actually you would have formed the view
10 that a seizure of that sort was a relatively minor part
11 of her condition and so the implied statement is that it
12 was much more important to be getting on and looking at
13 whatever else was wrong with her.
14 A. Yes.
15 Q. And why do you characterise it as a relatively minor
16 part and what would be the evidence that you would have
17 to allow you to reach that view?
18 A. Reduced conscious level, speech being lost, and
19 a dysarthria and an unsteadiness as well. All those
20 things would point to something more, and the issue has
21 been: could that possibly be having non-convulsive
22 status?
23 Q. If I can ask you in this way: firstly, could any of that
24 be the aftermath of a convulsive seizure? I think in
25 some places in her medical records -- and the statements

49

1 non-convulsive in nature, as you have interpreted them
2 to be, but you should be doing other things, certainly
3 if you have no absolute confirmation that the entire
4 problem is to be found in the seizure activity.
5 A. Exactly.
6 Q. Thank you. You've mentioned the possibility that Claire
7 could have suffered both a seizure, convulsion, and at
8 the same time also have non-convulsive
9 status epilepticus. I know that you don't think that is
10 particularly likely, the non-convulsive status, but is
11 it possible --
12 A. Yes, it is.
13 Q. -- in the way that many things that have been discussed
14 are possible for Claire?
15 A. Yes.
16 Q. I had asked Dr Webb about the differences between those
17 two things and I think he had conceded that if you had
18 repeated convulsive activity, so you had
19 status epilepticus as opposed to the non-convulsive
20 type, that was a very serious condition to have had.
21 And I think he thought, though, that if you had
22 non-convulsive status epilepticus, that perhaps was less
23 serious. And I think he indicated that you had more
24 time to deal with that. I think we find that at pages 3
25 and 4 of his evidence yesterday.

51

1 of the clinicians have been -- that she might have been
2 in a postictal state.
3 A. No, I think it's very unlikely that that would persist.
4 I think it wouldn't persist.
5 Q. So if it's --
6 A. So I think when you're looking at these situations
7 you're looking at persisting for up to half an hour or
8 so. It isn't a more prolonged --
9 Q. So if it's not the aftermath of what I was putting to
10 you as a possible seizure, if it's not that, then could
11 it be that the vacancy and the loss of her speech and so
12 forth, that that is all due to what Dr Webb had
13 characterised as non-convulsive status epilepticus?
14 A. There are a number of reasons why it might not be
15 characterised by that, but I can only see one way of
16 finding out, which is to do the EEG.
17 Q. So --
18 A. And the problem is that you're either concentrating just
19 upon this or you're taking a more comprehensive approach
20 of, say, treating non-convulsive status, but actually
21 also searching for yet another cause. And I think it's
22 in that sort of area that we have the difficulty.
23 Q. So if I understand you, I think you would say it's
24 a perfectly proper and reasonable thing to do, to treat
25 the seizures, whether they be convulsive in nature or

50

1 I'm trying to find it.
2 A. I know the area you're referring to.
3 Q. If we see there, if we look at line 10, he's saying:
4 "Non-convulsive status can go on for days and cause
5 no additional damage to the brain. In that sense, it
6 doesn't always cause the concern that you see with
7 convulsive status."
8 Would you accept that as a proposition, first?
9 A. Yes, up to a point, I think. Convulsive
10 status epilepticus is a medical emergency and needs to
11 be dealt with within half an hour, and thus you start
12 working on it after about five minutes. So that's
13 clear. Non-convulsive is of a lesser severity. I think
14 the only thing is that this is an acute situation --
15 Q. Sorry, if you pause there so that people can understand.
16 What do you mean by "this is an acute situation"?
17 A. It has just happened to this child, having been
18 previously completely her normal self. So it therefore
19 requires attention relatively rapidly because you don't
20 really know its significance if it's there. I don't
21 think it's there, but --
22 Q. Let's assume it doesn't ever develop into a breakthrough
23 convulsive seizure that you can actually detect and
24 it is just continuing in the way, for example, Dr Webb
25 thinks that that can go on to days, so you just have

52

1 this electric activity going on in the brain. Can that
2 in and of itself cause damage?

3 A. It can eventually, but we have seen children and young
4 adults who have gone on doing this for weeks on end,
5 which they certainly would not do with convulsive
6 status epilepticus. There is no doubt that there is
7 a difference.

8 Q. What are the dangers and risks that are inherent in the
9 non-convulsive version of status epilepticus?

10 A. I suppose they're partly what's the cause of it and
11 they're partly -- probably the psychiatric risks,
12 really, of being in this altered state for such a long
13 time.

14 Q. Is part of the problem -- I think you were just
15 beginning to say, maybe I interrupted you -- because
16 until you actually confirm that's what you've got, you
17 don't know that what's happening is these sort of
18 sub-clinical seizures?

19 A. No.

20 Q. It could be anything. So until you know for sure that
21 it's the non-convulsive type, which obviously you want
22 to address but isn't perhaps so likely to do any brain
23 damage, until you know that for sure you have always to
24 be concerned about what is the real cause of it and what
25 might it lead to?

53

1 Q. Is there any --

2 A. I mean, it's ... But it's not one in which you're
3 normally given intravenous fluids and --

4 Q. Is there any link between that and the development of
5 SIADH?

6 A. There may be. There may be. But I think it's
7 a relatively minor sort of link.

8 Q. Thank you. Then I wanted to see if you can help us with
9 your view of the sort of factors that Dr Webb says were
10 influencing him and he was taking into consideration
11 when he formulated his differential diagnosis of Claire.

12 In my version, it starts at, I think, 37. I was
13 putting to Dr Webb, as at 2 o'clock, the things that to
14 him had seemed to be most important. One of the things
15 I put to him was the fact that her serum sodium levels,
16 as he thought them to be, were 132 at 8 o'clock that
17 morning. So that, I think, meant that he was not so
18 concerned about the electrolyte position, if I can put
19 it that way.

20 A. Yes.

21 Q. And the other, which he referred to as being diagnostic,
22 I think, is that she had rectal diazepam at 12.15 and
23 had been seen to show some measure of improvement
24 in relation to it. I was suggesting to him that the one
25 had deflected him perhaps from looking further down the

55

1 A. Yes, and even if it were the case, you've still got the
2 issue of hyponatraemia to think about.

3 Q. Yes. Can non-convulsive status epilepticus develop into
4 convulsive status epilepticus, if I can put it that way?

5 A. Yes, it can, yes.

6 Q. Is that a known development?

7 A. Yes, it does, yes. Sometimes, yes.

8 Q. Is that a risk of itself, the fact that that can happen?

9 A. It is a risk, but it's ...

10 THE CHAIRMAN: Is it a rare phenomenon?

11 A. Yes, it's not that common.

12 MS ANYADIKE-DANES: So the more important point is because
13 you don't know why it's happening and you don't know --

14 A. That's right.

15 Q. -- until you do one of the determining tests that that's
16 actually what you're dealing with?

17 A. No, that's right.

18 Q. So I think perhaps it goes back to the chairman's point
19 before, which is: if you're not doing anything further,
20 then that is because you're pretty confident that
21 that is what you've got.

22 A. Yes, it must be, mustn't it?

23 Q. Is there any link between status epilepticus of whatever
24 type and development of hyponatraemia?

25 A. I've not seen it occurring particularly.

54

1 electrolyte line, if I can put it that way, and the
2 other had seemed to confirm his diagnosis of
3 non-convulsive status epilepticus.

4 He agreed that those two things were important and
5 diagnostically significant -- I think that was his
6 term -- and then he went on to say the other things that
7 he had taken into consideration. He said that the
8 fluctuating course or her fluctuating course was one.

9 It starts at about line 19, I think:

10 "She had been brighter at 7 o'clock than she had
11 been at other times, which would have been very much
12 against raised intracranial pressure as a cause."

13 Which was something that you had indicated that
14 maybe people could have started to think about. His
15 view is that there were therefore several factors that
16 militated against raised intracranial pressure.

17 Then I went on to ask him about her being brighter
18 at midnight. He seemed to think that that was also
19 something. And in particular, that 7 o'clock in the
20 morning, he said the significance -- this is his answer:

21 "If you have raised intracranial pressure, the worst
22 time for you is first thing in the morning so, for me,
23 that was significant."

24 Would you accept that, that in terms of your
25 thinking that raised intracranial pressure was something

56

1 that the clinicians might have had in their minds or
2 given some thought to, that the fact that she appeared
3 brighter certainly at 7 o'clock in the morning might be
4 a reason for them not thinking about raised intracranial
5 pressure, at least at that stage?

6 A. I think that's talking about more chronic raised
7 intracranial pressure. This is an acute situation and
8 I don't think the rules apply. I think the other part
9 of this is: do children with this sort of disorder
10 fluctuate? And the idea is they do and they'll vary
11 a bit according to all sorts of things, including if
12 they happen to hyperventilate or something, they may
13 well take their pressure down a bit and they may well be
14 all right for a while.

15 The other thing that you asked about is about
16 papilloedema and papilloedema really doesn't appear for
17 the first 24 hours or so.

18 Q. So the fact that you didn't detect any signs of it
19 shouldn't give you any comfort in particular because --

20 A. No, that's right.

21 Q. -- if you had, that would be a very serious situation
22 indeed?

23 A. That's right, and by the time you've got that, as we
24 said before, you are really close to the end.

25 Q. So what you're trying to do is you're trying to have in

57

1 It's going to go on to the next page. Then he
2 recognises that you have a different view. I asked him:

3 "[The] evidence that allowed you to consider was
4 sufficient ... to start treating Claire for
5 non-convulsive status epilepticus ..."

6 I ask him about -- sorry, I think we've gone to the
7 wrong place. I beg your pardon, it's a bit higher up
8 than I want to be. I'm asking him what is the evidence.
9 He says:

10 "She continues to have vacant staring and poor
11 responsiveness."

12 Then that is what he was really basing his view on,
13 that she was in the condition of non-convulsive
14 status epilepticus.

15 So despite the intervention of the diazepam and her
16 initial slight improvement or response to that,
17 nonetheless she goes back to her previous state and it's
18 really this vacant staring and poor responsiveness, the
19 continuation of that is what allows him to feel that
20 he's got the right diagnosis, it is non-convulsive
21 status epilepticus. Can you respond to that?

22 A. They're very vague, aren't they? And they could mean
23 just not being fully cognizant of what's going on around
24 you. I can't see them as being diagnostic of any
25 specific state.

59

1 mind whether you've got a developing situation that you
2 can stop before it becomes too severe?

3 A. Yes.

4 Q. So it's a matter of bearing in mind the possibility of
5 raised intracranial pressure so that you can do
6 something about it?

7 A. Yes.

8 Q. And you don't particularly want to find that it's a very
9 high level, you're trying to avoid that situation.

10 A. That's right. It will happen in the end, but ...

11 Q. And then in terms of why -- so that's why he didn't form
12 the view that raised intracranial pressure is something
13 he would have considered. To be fair to Dr Webb, I'm
14 not saying that he thought about raised intracranial
15 pressure and discounted it, but those would be the
16 reasons why he would not have thought that that was an
17 appropriate consideration.

18 He then goes on to deal with why he did think
19 non-convulsive status epilepticus -- and why he thought
20 that for so long, really. I think it's at 67. I asked
21 him in relation to 2 o'clock and give him back his own
22 statement:

23 "I must have felt when I saw Claire first at 2 pm
24 on October 22nd that I would have sufficient evidence to
25 treat Claire for non-convulsive status epilepticus."

58

1 Q. Can I ask you whether you formed the view that Claire
2 was in any way deteriorating and, if you did, what are
3 you basing that on?

4 A. Well, I think there is a change in the Glasgow coma
5 scores so that overall, although they move around a bit,
6 they tend to be getting more like 6 than 9 at the
7 beginning of the Tuesday. So they've dropped down.
8 There have been all the arguments about the Glasgow Coma
9 Score, but --

10 Q. How much do you use that as a tool?

11 A. Yes, we do use it, yes, and I think with the sort of
12 group that looks at the ones that ... It's not the
13 Glasgow, it's the Adelaide score or whatever, but it's
14 a similar score. Sorry, where was I?

15 Q. I was asking you if you thought there was -- I'm going
16 to take it in two parts, the deterioration. One is the
17 one over the day, if you like, up until, say, 5 o'clock.

18 A. Yes, sure.

19 Q. And then there's what happens in the evening when
20 there's the slightly different evidence that one has
21 in the evening. If you take the position over the day,
22 the first record of her Glasgow Coma Scale is recorded
23 at 1, no one is entirely sure when they take it, but
24 anyway that's when it's recorded. It's 9 then and it
25 seems to be roughly 7-ish, sometimes going down to

60

1 6-ish, and that's where it is over the course of that
2 afternoon.
3 A. Yes.
4 Q. And having said that, though, there is what he took to
5 be significant, the slight improvement in relation to
6 diazepam. He also says that her level of consciousness,
7 if that's -- I may be using that in a non-technical
8 way -- seems to change in the sense that when he
9 examined her at 2 o'clock he says that she sat up, she
10 seemed to interact with him. So she's not in a constant
11 state, if I can put it that way.
12 A. No.
13 Q. But she is having quite a significant amount of
14 anticonvulsive medication. Apart from the diazepam, she
15 has phenytoin, which turns out to be considerably more
16 than he intended her to have. She has midazolam and she
17 has a midazolam infusion.
18 A. Yes.
19 Q. So she's having quite a bit of medication, but that's
20 her presentation, sometimes a little bit more
21 responsive, other times not. The nurses don't seem to
22 record that in any great detail, they just say she's
23 pale and responding essentially only to pain. But if
24 you take that as the description of her state over the
25 day, then do you have a view as to whether, if she is

61

1 rigidly only to non-convulsive status epilepticus as
2 there isn't the response which he had expected or which
3 he had hoped for. He then revisits it at 5 o'clock,
4 doesn't he?
5 A. Yes. Yes, I see the situation as one in which the
6 hyponatraemia aspect is relatively low on his ...
7 THE CHAIRMAN: It is.
8 A. So I think he has difficulty with -- or had difficulty
9 with that subject, which he's obviously had to revise.
10 THE CHAIRMAN: There is certainly some, subject to whatever
11 further evidence emerges, scope for criticism of
12 Dr Webb, but as you said before, he came back and saw
13 Claire more than once.
14 A. Indeed.
15 THE CHAIRMAN: He was reviewing what drugs she got and
16 he was reviewing what her condition was.
17 A. Yes.
18 THE CHAIRMAN: Your concern is that, while it wasn't all his
19 fault at all, there was inadequate testing of Claire
20 earlier in the day and, if he was the gatekeeper to the
21 EEG, that is something he should have pushed rather more
22 than he did.
23 A. Yes.
24 THE CHAIRMAN: Then you also, I think -- correct me if I'm
25 wrong -- take the view that he really doesn't appreciate

63

1 your patient, you consider she is deteriorating?
2 A. I would have said that the most obvious thing is that
3 she's certainly not improving and that thus she is still
4 requiring a diagnosis. Overall, I think she is probably
5 deteriorating, but I think the most important aspect
6 is that she's just not showing the sort of improvement
7 which you might expect from giving an anticonvulsant.
8 Q. Is that diagnostic itself, the fact that you have taken
9 a view that this is her condition, you treat her with
10 the anticonvulsants that should have improved it, or at
11 least in many cases would, in that case? Does that
12 confirm your differential diagnosis or weaken it? What
13 is the effect of it?
14 A. It weakens it, but it doesn't actually remove the
15 possibility that she just doesn't respond.
16 Q. Yes. Does it increase the need to look for something
17 else though?
18 A. Indeed, it would.
19 THE CHAIRMAN: And he did.
20 A. Pardon?
21 THE CHAIRMAN: And Dr Webb did because that's what prompted
22 Dr Webb to change his view on the risk of encephalitis
23 when he saw her at about 5 o'clock.
24 A. Yes, by giving drugs for that.
25 THE CHAIRMAN: Yes. To be fair to Dr Webb, he doesn't stick

62

1 the risk of hyponatraemia through SIADH.
2 A. No, I think that's right, and should, of course, have
3 insisted upon making exactly certain when these levels
4 were taken and when the next one should be taken.
5 THE CHAIRMAN: Thank you.
6 MS ANYADIKE-DANES: You, I think, have expressed the view
7 that he should have had a broader approach to the
8 possibilities as to what was causing her presentation.
9 A. Yes.
10 Q. In fact, the approach always seems to have been
11 threefold. They move about in terms of perhaps their
12 relative importance. Non-convulsive status epilepticus,
13 probably in the light of Dr Webb's evidence yesterday,
14 remained his prime contender. But from the discussion
15 which Dr Sands had with Dr Webb quite early on the
16 Tuesday, it seems that encephalitis and encephalopathy
17 were also there. Dr Sands would say, "I had thought
18 about encephalitis myself". Dr O'Hare, to be fair to
19 her, had thought about encephalitis also. So the three
20 that are running are non-convulsive status epilepticus,
21 encephalitis and encephalopathy. And encephalopathy
22 being a kind of a broad general thing.
23 At 2 o'clock, Dr Webb is of the view that the
24 encephalitis is probably less significant and he
25 concedes that if it was there at all, maybe he could

64

1 have suggested it was treated. By 5 o'clock, although
2 it hasn't overtaken non-convulsive status epilepticus,
3 it's slightly more significant for him than he had
4 previously thought it might be. But those are still the
5 three areas. Apart from the area that would take you
6 into electrolyte imbalance -- SIADH, hyponatraemia and
7 so forth -- is there any other possibility that should
8 have been in their frame of reckoning, if I can put it
9 that way?

10 A. Apart from hyponatraemia? Well, I suppose the other
11 things that could have been thought about would be the
12 other things that might be revealed by doing a CT scan
13 or an MRI scan, but they were not.

14 Q. Well, now, I can help you with that because I asked
15 Dr Webb about a CT scan. Apparently, Dr Sands in his
16 early conversation on the Tuesday morning, whenever it
17 was on the Tuesday, had spoken to Dr Webb and
18 specifically raised with him two things, apparently.
19 One: should I be arranging a CT scan? Two: should I be
20 administering diazepam? He got a no to the former and
21 a yes to the latter, and I think the no to the former
22 was: not yet, I'll come and see. I think that was
23 effectively his evidence. Ultimately, you know that his
24 view was that he'd wait until the morning and, if she
25 doesn't wake up then, we'll do a CT scan then, which

65

1 by comparing one with the other or not really?

2 A. Oh, I think it would. Sorry, you mean having had it
3 earlier?

4 Q. Yes.

5 A. Earlier than the previous? No, I don't think that would
6 be particularly helpful, no.

7 Q. Her early ones wouldn't be relevant to this?

8 A. No, I don't think so, no. I think performing a CT scan
9 at an interval -- and this was going to be at least
10 24 hours, I think, from the original, wasn't it, from
11 the time that she had originally become unwell --

12 Q. Mm-hm.

13 A. -- even though she hadn't gone into hospital? So
14 I think that was likely to be helpful.

15 Q. She became unwell when she came back from school,
16 really, so that'd be some time in the afternoon of
17 Monday.

18 A. Yes.

19 Q. And his view is -- I think it's first being suggested to
20 him that he might have asked for a CT scan at 2 o'clock
21 when he comes to see Claire.

22 A. Yes.

23 Q. I think that was your view too, if they hadn't done one
24 earlier, that is certainly something that he could have
25 been asking. What he is saying here is that: well,

67

1 might be associated with a lumbar puncture.

2 But on what an early CT scan might disclose, I asked
3 him about that on Friday. So it's 30 November and
4 I think it comes -- the question comes on page 223 at
5 line 25, right down at the bottom:

6 "I thought the yield from a CT scan with the story
7 that I'd been given was going to be very low."

8 In other words, the history that he had taken.

9 So then he goes on to talk about what he thought he
10 might get:

11 "In somebody who has a learning disability and has
12 had a previous history of epilepsy, who has now come in
13 with what we now think are seizures with an intercurrent
14 illness, the yield from a CT scan in that situation
15 would be very small."

16 Well, if I pause there, can you assist with that?

17 A. Yes, I don't quite understand the meaning of this "who
18 has a learning disability and previous history of
19 epilepsy", how that is modifying the situation. There's
20 obviously a point along the CT scan line in which you
21 either are nearly finding it or you are definitely
22 finding, and you just have to choose where you're going
23 to go.

24 Q. If you'd had CT scans of Claire's brain earlier from
25 when she was previously admitted, would that assist you

66

1 given the presentation, he doesn't think he was likely
2 to find much that would have helped. Then he goes on to
3 say:

4 "If it was early encephalitis without fever [which
5 he, I think, conceded was a possibility] in that
6 situation the yield would [also] be small."

7 A. I think it's quite likely it would have been positive
8 in that situation. And of course, we're somewhat
9 ignoring the fact that she would have had another sodium
10 done because I think there was an agreement that she
11 should have had a sodium done at 2 o'clock in the
12 afternoon of the Tuesday.

13 Q. Well, some time in the afternoon, I think he expected
14 that it would happen, but in fact it doesn't seem to.
15 I'm actually just looking at what he calls the yield
16 from the CT scan.

17 A. That would require careful looking, but I think it would
18 be very likely to be positive.

19 THE CHAIRMAN: Sorry, I think for completeness what he was
20 saying -- and I will be corrected if I'm wrong -- was
21 that the CT scan would show if there was a lesion, which
22 he thought was unlikely, which showed there was
23 haemorrhage, which he thought was unlikely -- and was
24 there something else?

25 MS ANYADIKE-DANES: He deals with that at page 225, which is

68

1 where he goes on to talk about that. Firstly, he says:
2 "I wasn't expecting her to deteriorate quickly."
3 At line 12. He goes on at line 14:
4 "I didn't think the yield from a CT scan -- which
5 would involve her leaving the hospital and going over to
6 the adult hospital -- was likely to be high. While I
7 understand the experts have expressed a different view,
8 in fact, the differentials, when you think about them,
9 are extremely unlikely."
10 This is the differential diagnosis that the experts
11 have suggested they might be looking for or considering:
12 "So for example, it's extremely unlikely that she
13 would have had a subarachnoid haemorrhage or a bleed
14 because that's a stroke essentially and it presents very
15 acutely. It's very unlikely she would have had
16 hydrocephalus because that is not detectable with
17 papilloedema. And she didn't have a neurosurgical
18 presentation: there hadn't been a history of trauma or
19 definite focal weakness; she was moving all four limbs."
20 So the upshot of the whole thing is that his view is
21 that for the sorts of things you might be looking for,
22 you're unlikely to have found them on a CT scan.
23 A. Yes, but the one thing that she was likely to have, she
24 did have, and that was found the following day.
25 MR SEPHTON: Can I just ask what the doctor means when he

69

1 suppose it could be arranged by 3 o'clock, just to take
2 that as a stab. How long would it take before a result
3 comes through?
4 A. Oh, they come through immediately. The only question is
5 then getting a radiologist to look at them.
6 THE CHAIRMAN: Okay. Is it something that Dr Webb himself
7 could interpret or does he need a radiologist to
8 interpret it for him?
9 A. He would be a perfectly reasonable person to look at it,
10 but it would require two people to think about it in the
11 context of this particular patient.
12 THE CHAIRMAN: Okay.
13 MS ANYADIKE-DANES: Just in case of Mr Sephton, you are
14 saying that whatever you could reasonably expect or be
15 concerned about was developing, that is something that
16 you believe you would be able to see on a CT scan at
17 2 pm?
18 A. Yes.
19 Q. And if you hadn't done one at 2 because you had been
20 lulled into believing that you were getting a positive
21 response from your anticonvulsant therapy and it was
22 worth pursuing that for a little bit, should one have
23 been done at 5 pm?
24 A. Yes.
25 Q. I have two other areas I want to canvass with you,

71

1 says, "positive". First of all, when does he say
2 a CT scan would have revealed anything and, secondly,
3 what is the thing that that CT scan would have revealed?
4 A. The CT scan would show infilling of the areas around the
5 brain so that it would appear like a full brain, which
6 was ... And that would be, I think, from 24 hours from
7 the beginning of the onset.
8 THE CHAIRMAN: So I think you described this before: in all
9 our brains, there is a space or a gap --
10 A. Yes.
11 THE CHAIRMAN: -- and if you have rising intracranial
12 pressure, that gap is diminishing, is it?
13 A. That's right.
14 THE CHAIRMAN: So a CT scan will show if the gap is
15 diminishing and the stage to which it has reduced?
16 A. That's right.
17 THE CHAIRMAN: And that will indicate to you whether there
18 is a developing problem --
19 A. Sure.
20 THE CHAIRMAN: -- and the stage to which the problem has
21 developed?
22 A. Yes.
23 THE CHAIRMAN: Okay. How quickly would a CT scan be turned
24 around? If Dr Webb had taken the view at 2 o'clock that
25 it was required -- and we don't know how long -- let's

70

1 I think, unless I'm asked to deal with anything else.
2 One is to do with the explanation to parents. Running
3 alongside the whole issue of trying to identify what is
4 the cause of Claire's presentation and what is an
5 appropriate treatment plan to develop for her is
6 actually what the parents know or can or should be told
7 about the condition and the cause of the condition of
8 their daughter. That goes through the whole of the day,
9 really, into the evening and then ultimately, when they
10 come back, when unfortunately Claire has suffered her
11 respiratory collapse, at that stage what they should be
12 told or should have been told by the two consultants,
13 who have had an opportunity apparently to discuss their
14 views before going to speak to the parents. So that's
15 a whole long continuing issue.
16 What I want to ask you is: we know that Dr Steen,
17 the paediatric consultant, did not see the parents
18 during the day, so it's Dr Webb who saw the grandparents
19 at the 2 o'clock examination and Claire's mother at the
20 5 o'clock examination. So there is an interaction.
21 Can you help us with what you think the parents
22 should have been being told or at least what information
23 should have been provided to the junior paediatric staff
24 or the nurses with the intention that that ought to be
25 passed on and explained to the parents? Let's take

72

1 2 o'clock.

2 A. Well, it partly depends upon how sick you think Claire

3 was. There are sort of different views about this, but

4 assuming you thought that she was sick and really quite

5 unwell, you would need them to know that and that you

6 were so far not providing any reasonable explanation --

7 apart from the status epilepticus, which you couldn't

8 easily prove -- for that.

9 So I think that's ... There's no ... It's very

10 difficult to argue very hard from a single level of 132

11 of what more you would make. You could say that there

12 has been some evidence of a low sodium occurring, but

13 you'd have to say, "But we would need to repeat that".

14 Q. Well, this is 1996. It may well be in 2012 there's

15 a fair bit more interaction with the parents or, rather,

16 the amount of information that you give parents may be

17 more now than it was then. But in 1996, on the basis of

18 what Dr Webb thought was the problem -- because it's

19 only fair to judge by his thought process as opposed to

20 what people think he might have thought was the

21 problem -- at that time, 2 o'clock, he thought Claire

22 was in non-convulsive status epilepticus, she'd

23 responded a little bit to the diazepam and then that

24 response had not been continued and he was going to try

25 her on further anticonvulsants. So that's where he is,

73

1 Q. -- when I think he accepted from me that there was a bit

2 of a stocktaking going on as to where things stood and

3 what the implications of that were.

4 A. Yes.

5 Q. And that's when he meets, for the first time, Claire's

6 mother. His view at that stage is that he thinks

7 there's still non-convulsive status epilepticus. It's

8 not entirely sure why she hasn't responded better to the

9 amount of anticonvulsants, although some children don't.

10 He feels that the encephalitis is likely to be slightly

11 more of a problem than he thought it was before, and

12 he's got a regime for that. He thinks that she is

13 unwell, but he thinks he's got a plan, and he expects

14 her to respond and recover. And what then, in those

15 circumstances, should he be communicating to the mother?

16 A. Well, I think he should be communicating that. I think

17 that we are caught up a little bit with where does the

18 CT scan stand in this argument as well because a CT scan

19 would be a pretty regular part -- or an MRI scan -- of

20 the assessment of a child who has encephalitis. So that

21 would be one aspect of what would be planned to be done.

22 I know that it was planned to be done the following day.

23 Q. That presumably was what he would say to them: if she

24 doesn't wake up, we'll do one tomorrow?

25 A. Yes, but in fact you don't wake up that fast from an

75

1 really. It's obviously something he wants to treat, he

2 recognises that she's ill, but he believes that he can

3 formulate a treatment plan to address that. Somebody

4 will correct me if I've got that wrong, but I think

5 that's where he was at 2 o'clock.

6 If that's what you think, you do have a sick child,

7 there's no doubt about it, and Dr Sands thought she was

8 really quite neurologically unwell. What do you think

9 that Claire's parents should have been being told at

10 2 o'clock?

11 A. Well, they should have been told that she was sick, they

12 should have been told that they were treating for

13 a particular disorder of non-convulsive status and that

14 she wasn't so far responding fully appropriately and

15 there would have to be a time limit to that.

16 Q. There would have to be a time limit to that when they

17 would revisit the situation?

18 A. Yes.

19 Q. In fairness to Dr Webb, he does revisit the situation.

20 It's not entirely clear what he does somewhere in the

21 mid-afternoon about the midazolam, but he certainly

22 prescribes that. Exactly what other interaction there

23 is, it's unclear, but he prescribes that. And then he

24 comes back to see Claire at 5 o'clock --

25 A. Yes.

74

1 encephalitis. It's a slower process.

2 THE CHAIRMAN: I think, to be fair to Dr Webb, he has told

3 us what he meant by "if she doesn't wake up", and he

4 doesn't literally mean if she doesn't wake up; he means

5 if she hasn't recovered or isn't clearly on the road to

6 recovery. On its face, "not waking up" means that she's

7 unconscious.

8 A. Sure. I was making a point about the general rule of

9 this thing that you don't get better that swiftly.

10 MS ANYADIKE-DANES: Sorry, that might be a different point.

11 You don't think that you do recover your normal state or

12 are on the way to doing it in that way?

13 A. No, you may never, of course, recover either if you're

14 badly affected by an encephalitis. So there's quite

15 a reasonable chance of coming to greater harm.

16 Q. So if he did think that although maybe not as likely

17 a diagnosis as the non-convulsive status epilepticus,

18 but still worthy of note and worthy of treating, if he

19 did think that, what should he have been telling them

20 about the encephalitis aspect?

21 A. Well, I think he'd have to be warning them that this was

22 only, if you like, partially treatable and that there

23 would be some potential hazard in terms of neurological

24 functioning to how she was going to be afterwards.

25 Q. And if the mother had wanted to know from him because

76

1 they were trying to make arrangements for the evening,
2 on the basis of what he has described, if they'd wanted
3 to know whether they ought to stay that evening, it's
4 obviously an area you have to be very careful of because
5 you don't know what people's arrangements can be and you
6 don't want to make people feel guilty.

7 A. No.

8 Q. But if it can be communicated, would you be
9 communicating that this might be a time when you might
10 be thinking if your arrangements permit for you to stay
11 or, or are you saying it's unlikely that anything very
12 serious will happen in the evening? What are you
13 saying?

14 A. It's very difficult, retrospectively, to actually judge
15 this matter.

16 THE CHAIRMAN: Surely at 5 o'clock if she hasn't responded
17 in the way that he had hoped to the status epilepticus
18 and if he is now factoring in, to a greater degree,
19 encephalitis and he has to warn the parents that this is
20 now more on the horizon than he had thought before, and
21 while he's still hopeful, this can cause long-term
22 damage, that conveys to Mr and Mrs Roberts that things
23 aren't as positive as they might have thought earlier.

24 A. No.

25 THE CHAIRMAN: And they then make their decision about

77

1 to the chairman so that, in his absence, they are able
2 to explain matters to them?

3 A. Mm.

4 Q. He's not her consultant.

5 A. No.

6 Q. Should he have been doing that or is he entitled to
7 expect that because he's attended, usually, by a junior
8 member of the paediatric team, they're keeping their
9 consultant informed and, in due course, that interaction
10 or communication with the parents will be made by the
11 child's own consultant?

12 A. Yes, I mean, it's quite difficult in this situation to
13 know what was actually happening. I would expect to
14 have the opportunity, as the consultant paediatric
15 neurologist, to want to talk with the consultant
16 concerned. So thus, I would normally have done it by
17 that route and we would have got over that problem. If
18 that consultant, the general paediatric consultant, is
19 not available and is just not available, then I think
20 you have to give the thing to the registrars and say,
21 "You'll have to deal with this in this way", and say
22 that they've had warning of the problems, but I'm
23 hopeful that she will improve.

24 Q. But if you have the opportunity, as he did, to speak to
25 the mother, then irrespective of what you think the

79

1 staying or not staying or shifts between them and the
2 grandparents and so on; isn't that right?

3 A. I agree, it's just the severity of the events that
4 happened over that night, which could not be
5 anticipated, particularly from not having the diagnosis.

6 THE CHAIRMAN: But if we're looking at what Dr Webb was
7 thinking, Dr Webb told us yesterday he still thought
8 that Claire was going to improve. In fact, had he not
9 thought that, had he realised how serious the trouble
10 was, he wouldn't have left, which is perfectly
11 consistent with his willingness to become involved
12 throughout that day.

13 A. Yes.

14 MS ANYADIKE-DANES: Dr Webb meets Claire's mother at
15 5 o'clock, but Dr Webb was really coming to, I would
16 imagine, see what was happening in relation to the
17 treatment plan that he had devised for her, not
18 primarily to be making contact with the parents in
19 particular. At least, I don't think that was his
20 evidence.

21 So on the basis that you'd be wanting the parents to
22 know something about what's happening with the child,
23 should he perhaps, in different terms, have been
24 communicating to the junior clinicians and the nursing
25 staff the sort of thing that you've just been explaining

78

1 consultant is going to do thereafter, do you take the
2 opportunity to yourself broach these sorts of matters?

3 A. I think it depends on the circumstances, but I think
4 I would have done.

5 Q. And then I have really just two further areas that I'd
6 like to discuss with you. One is a continuation of this
7 issue of communication with the parents. It happens,
8 actually, at the time when the parents come back into
9 the hospital. Claire has suffered her respiratory
10 collapse and it is quite clear from when the two
11 consultants meet with them that there is no way back, if
12 I can put it that way, and they meet -- it's not
13 entirely clear who meets when, but certainly Dr Steen
14 meets them at least on three occasions before the
15 CT scan that confirms what the position and then, after
16 it, and explains matters to do with the brainstem death
17 test and so forth. She may have met them a third time
18 in the evening.

19 Dr Webb may have met them only on two occasions,
20 before the CT scan and after the CT scan. In any event,
21 it seems clear that it's Dr Steen who does much of the
22 explanation, but he's there.

23 The issue arises in this way: I had asked Dr MacPaul
24 at the stage when it is clear that there is no way back,
25 probably after the CT scan has been received, what he

80

1 thought was an appropriate explanation, a proper
2 explanation to give to the parents. This is what I put
3 to Dr Webb to receive his comment. It's yesterday's
4 evidence. It starts at page 212 and you see what I'm
5 putting to him at line 21. What's in quotations is what
6 Dr MacFaul's explanation is as to what he would have
7 said, and that's the explanation that I put to Dr Webb
8 to get his comment. So you can see:

9 "I would have explained that Claire had suffered
10 brain swelling [and so forth], stopped breathing, and
11 that damaged her brain irretrievably. The brain had
12 swollen from an underlying disease and the complications
13 of that. If that had been diagnosed, then there should
14 have been fluid restriction. If there hasn't been, then
15 that's a matter of fluid management."

16 And he goes on to say:

17 "There is no reference in the discussion to the
18 epilepsy being --

19 Sorry. I think this is a slightly different point.

20 The point that I had put to him really is having
21 recited what Dr MacFaul had said, Dr MacFaul came to the
22 view that really the parents ought to have been told
23 that there was the possibility that her -- you see it on
24 the previous page starting at line 10:

25 " ... the possibility that her fluid management was

81

1 restricted and although I think he concedes that the
2 Solution No. 18 was restricted, but because some of that
3 medication was being given intravenously in normal
4 saline, there wasn't a total restriction on her fluids.
5 But in any event, he did not take the view that she had
6 been overloaded, if I can put it that way, with fluids,
7 and if she hadn't been overloaded then one shouldn't
8 have been explaining to the parents that there was
9 a fluid management issue.

10 A. Yes, but she was not given the appropriate levels of
11 either half-normal or normal saline from whatever
12 stage -- and shall we call that, say, 8 in the morning
13 of the Tuesday?

14 Q. Mm.

15 A. Having got a new sodium level measured, hopefully that
16 would have led to a change in regime. So she had not
17 been given that regime from that time in the morning.
18 But of course, it's very hard to admit that you have
19 made a mistake.

20 Q. Yes, Dr MacFaul conceded that, that that would be hard,
21 but if you were wanting to give them a full explanation,
22 you would have to include that.

23 A. Yes.

24 Q. If one uses the expression "a fluid management problem",
25 does that encompass more than just literally what type

83

1 inadequate."

2 That's what they really should have been told. And
3 if her fluid management was inadequate, that had certain
4 implications because, of course, the fluid management is
5 something that the clinicians have control over.

6 Dr Webb, when I put it to him in that way, had
7 a different view of that and he didn't think that it was
8 right to characterise it in that way, that her fluid
9 management was the problem, which would imply, really,
10 if you work that through, a degree of culpability on the
11 part of the clinicians.

12 Do you have a view as to whether at that stage the
13 parents ought to have been told that part of Claire's
14 condition resulted from fluid management?

15 A. I think it's difficult not to see that that is one
16 aspect of her management which hadn't been taken
17 appropriate care of. So she had really up to 24 hours
18 without having her sodium level performed.

19 Q. In fairness to Dr Webb, part of what he says is that it
20 wasn't clear that there was a fluid management problem
21 because it wasn't clear that she had received too much
22 by way of fluid, too much for a child to receive per
23 hour. I think it's 64 ml an hour was what she was
24 receiving.

25 He then refers to the fact that her fluids were

82

1 of fluid you gave, how much you gave of it and what rate
2 you gave of it? Does fluid management also include the
3 testing of the electrolytes to determine what the
4 administration should be? Is that part of management?

5 A. Yes.

6 Q. So if you wanted to be critical, if I can put it that
7 way, of fluid management, it wouldn't necessarily be
8 confined to whether they should have been giving
9 Solution No. 18 or not at this stage or that stage,
10 it would also be your view that they should have carried
11 out serum sodium tests at certain stages and they simply
12 didn't do that. Is that part of management?

13 A. Yes, and it would be appropriate to the particular
14 occasion, so sometimes it would require only, you know,
15 twice a day, sometimes it might even be more often.

16 Q. Dr Webb then went on to develop the issue as to whether
17 he thought, and if so at what stage, if ever, Claire
18 became fluid overloaded. You may recall from Claire's
19 medical notes and records there is a note that
20 Dr Stewart makes at 11.30. I will pull it up for you
21 very quickly so you can see it. It's at 090-022-056.
22 There we are, you see it on the left hand side.

23 So the serum sodium level has come back of 121.

24 THE CHAIRMAN: This is Tuesday night at about 11.30,
25 professor.

84

1 MS ANYADIKE-DANES: Thank you, Mr Chairman.
2 He's responding to that, and he gets hyponatraemia,
3 because that's 121, and then he's querying the reasons
4 for that. The top query is "fluid overload and low
5 sodium fluids"; the second is "SIADH". His impression
6 is a need to increase the sodium content in fluids, and
7 then he records that he has:
8 "... discussed with the registrar and she says to
9 reduce the fluids to two-thirds of the present value,
10 which is 41 ml per hour, and send urine for osmolality."
11 So the point that I put to him was whether that
12 consideration by Dr Stewart wasn't perhaps indicating
13 that there might have been a fluid overload, or at least
14 he thought there was.
15 A. Mm.
16 Q. And Dr Webb's view of that was, well, he didn't think
17 that there was a fluid overload at 11.30, because he
18 didn't see any evidence at 11.30 that she had been given
19 any more than she should have been given, if I can put
20 it that way.
21 A. Yes. I think the fluid may have been in the wrong
22 space, though, and she required more intravenous high
23 sodium in order to bring up the level. So I think
24 that's -- it's not just a matter of the whole body, it's
25 which space they're filling.

85

1 reduced to 10 or below 10 and just waited before you
2 started the first brainstem death test.
3 A. Yes.
4 Q. And Dr MacFaul was also of the view -- well, he
5 primarily focused on this particular statement in the
6 notes, which is the precursor to doing the brainstem
7 test, and he simply was of the view that he couldn't
8 with confidence say that, given the regime she'd been
9 on. I just want to pull this up. It's 310-020-001.
10 Just to refresh your mind. This is what she's
11 having. I think Dr Aronson's view is that the rectal
12 diazepam isn't having any effect, but he said that the
13 phenytoin has quite a long half-life and she'd had
14 635 milligrams of that at 14.45, and then she'd had
15 an hour's infusion of it at 23.30. Then the midazolam,
16 she'd had 12 milligrams of that when what she should
17 have been having was 3.6. And she's then almost
18 immediately afterwards on an infusion -- I think it is
19 2 ml per hour -- and then that infusion is increased as
20 you can see it there. It looks as if it stops at about
21 3 o'clock. It certainly is not running when they first
22 record her in the paediatric intensive care.
23 Then she's received the sodium valproate, although
24 probably not the infusion of it, but certainly the
25 400 milligrams of the sodium valproate. So that's the

87

1 Q. Then the final area that I would like to deal with with
2 you, or ask you to comment on, starts at the note that
3 Dr Webb makes just before he's going to start the
4 brainstem test. You can see it at 090-022-058. You see
5 there just under "CT, cerebral herniation", there's
6 a line saying:
7 "Under no sedating or paralysing medication."
8 I put that both to Dr Aronson and Dr MacFaul.
9 Dr MacFaul had already addressed that in his report and
10 he thinks that's just an incorrect statement, because
11 she was, she had received anticonvulsant therapy, which
12 would have that effect. Dr Aronson was also of the same
13 view. I think at one stage I had pulled up for you
14 a chart that we had that showed what she was receiving.
15 I think it's --
16 A. She had a 23 level of phenytoin.
17 Q. She had a 23 level of phenytoin --
18 A. And her sodium was 127, I think, or 129.
19 Q. Yes, well, her phenytoin level was 23 at -- well it was
20 recorded being that at 11.30. She had another phenytoin
21 level test taken at about -- it's not entirely clear --
22 3 o'clock, maybe, and that produced 19.2, I think.
23 Dr Aronson's view is although that's within the range,
24 which is 10 to 20, it was so close to the top end of it
25 that in his view, he would have wanted to see that range

86

1 anticonvulsant therapy, and you can see -- well, in this
2 chart we've indicated how that correlates with episodes
3 during the day, but that's not the point. Then you see
4 the respiratory arrest at 3 o'clock and you can see the
5 first brainstem test is taken at 6 in the morning. Both
6 of the doctors felt that that first test should possibly
7 have been postponed, given what was likely to be in her
8 system.
9 So the question for you is: would you have been
10 happy writing in her notes that she was, at 6 am, under
11 no sedating or paralysing medication?
12 A. No, I would have put the appropriate riders to that.
13 Then the question would be: do you actually then do the
14 test or not do the test? And I think ...
15 THE CHAIRMAN: I think you gave evidence about this before,
16 professor, didn't you --
17 A. I did indeed.
18 THE CHAIRMAN: -- on 5 November. You said that the question
19 that we were looking at yesterday about question 1(f) on
20 the form, you thought the answer to that question was
21 correct, and you thought it was not terribly important
22 to have waited for the midazolam to come down.
23 A. I mean, the change in her was absolutely dramatic and
24 remained that way for three hours. The fact that you're
25 going to do it later as well makes it ... This quite

88

1 often happens in the management of these children.
2 THE CHAIRMAN: So this isn't a point that you're
3 particularly concerned about?
4 A. No, I think not.
5 THE CHAIRMAN: Okay.
6 A. I think you'd be -- you'd want to be absolutely sure
7 where you were for the last ... But I think the change
8 is so dramatic and apparently so permanent that it's ...
9 I think it's tough not to just wait because you can go
10 on waiting really quite a long time.
11 MS ANYADIKE-DANES: When you said you'd put a rider in the
12 note, what exactly do you mean by that?
13 A. The phenytoin level was 23 and 23, although it's a bit
14 high, is not one that would normally affect the pupil
15 reactions or the response to pain.
16 Q. I think when Dr MacFaul was dealing with the matter in
17 relation to her electrolytes or her serum sodium levels,
18 which were also slightly out of range --
19 A. Yes, they were. I thought they were -- were they 129?
20 Q. 124 and 125.
21 A. Oh.
22 Q. Oh, 129 and 152, sorry, at the end. That was another
23 child who had that. 129 and 152.
24 A. Okay, that's down a bit, but that doesn't do anything to
25 you --

89

1 well and you have to then keep trying to warm the child
2 and this can get really quite difficult because that is
3 more of a force.
4 THE CHAIRMAN: But the basic position is that the child's
5 position is not reversible --
6 A. No, exactly.
7 THE CHAIRMAN: -- therefore you don't want to keep the
8 parents, who are already going through the most awful
9 time, any longer than needs be?
10 A. That's right.
11 MS ANYADIKE-DANES: Mr Chairman, I don't have any more
12 questions to ask, but I think there are some questions
13 to ask. I wonder if you'd give us five minutes.
14 THE CHAIRMAN: I'll give you no more than five minutes
15 because it turns out that the professor has to leave at
16 1 o'clock, not 1.15, so we've got very limited time.
17 Okay?
18 (12.41 pm)
19 (A short break)
20 (12.46 pm)
21 MS ANYADIKE-DANES: I have two very discrete points to
22 raise.
23 One relates to a statement that you made earlier,
24 Professor Neville, about how the 132 may was lower than
25 the bottom of the range, which is 135, and it may have

91

1 Q. The point I was going to make was following on from how
2 you have just answered the chairman. You said how you
3 could address that is you answer and you put the rider
4 then by giving actually what the level is --
5 A. Yes, exactly.
6 Q. -- on the form.
7 A. Yes.
8 Q. So it's quite clear that you have considered the matter,
9 but your overall view is that it's not affecting or is
10 not likely to affect her in terms of a reversible
11 situation?
12 A. Yes.
13 Q. Is that something that might have been done in relation
14 to her --
15 A. Yes, I think so.
16 Q. -- medication?
17 A. Yes, I think so.
18 Q. You acknowledge what it is, but you go on and do the
19 test because you don't think that waiting will lead to
20 a reversible situation?
21 A. Yes, I think that's right.
22 Q. In fairness, I think none of the experts thought the
23 situation would be reversible; it was their concern
24 about how you adhere to the brainstem death test.
25 A. You can get into a secondary situation of hypothermia as

90

1 indicated a fall. What nobody could know, of course,
2 because it wasn't being measured, is what the rate of
3 that fall might have been.
4 A. Yes.
5 Q. And the question that I have for you is: once that 132
6 level was received and then communicated to the
7 clinicians, should they have been taking that as
8 a baseline or should they have had it in their mind that
9 that might indicate that she was in a falling serum
10 sodium condition, if I can put it that way?
11 A. I think she should have been taken to be in potentially
12 a falling situation.
13 Q. And with nobody being entirely sure of when she had
14 dropped from whatever is her normal position, which
15 presumably would be something between 135 and 145, if
16 that's the normal range, nobody knowing how quickly she
17 had fallen from her normal range --
18 A. No. No, that's right.
19 Q. And if she had -- all this is speculation, I entirely
20 accept that, but in a sense much of it is speculation
21 until they start getting some hard evidence about her.
22 If she had fallen rather speedily for whatever reason,
23 could that have been part of an explanation for her
24 presentation when she was admitted?
25 A. Yes, it could have been. I have a feeling that it would

92

1 not be the only explanation.

2 Q. Yes. I think your view was that there was likely to be
3 something else going on as well?

4 A. Yes.

5 Q. But could that have contributed to her presentation?

6 A. Yes.

7 Q. Thank you.

8 The other question that I have for you relates to
9 the communication that went out after the autopsy report
10 had been received. I don't know if you have seen the
11 autopsy report.

12 A. I think I must have done, actually.

13 Q. I'm going to pull up one thing alongside it.

14 A. I'm sure I did. Was that the first autopsy report?

15 Q. Sorry?

16 A. Was that the first -- the --

17 Q. Yes. If we can pull up the final page of it, which is
18 the conclusion, 090-003-005.

19 A. Is that the one that contains somewhat misleading
20 information perhaps? I don't know. Anyway.

21 THE CHAIRMAN: Yes, there is an issue about the accuracy of
22 the autopsy request form and that feeds in, to some
23 degree, to a question about the accuracy of some of the
24 factual information in the autopsy report.

25 A. Yes.

93

1 Q. Yes.

2 A. -- and explains how that would have arisen if it had
3 arisen --

4 Q. Yes.

5 A. -- explains the encephalitis ...

6 Q. Is there any difference between saying, "The cerebral
7 tissue showed that ...", as opposed to saying, "The
8 features here are those of ..." I think certainly when
9 Dr Herron and maybe also Dr Mirakhur, the pathologists,
10 were asked about that, their view was that they were
11 less conclusive about these things because they didn't
12 feel they could be sufficiently conclusive.

13 A. I thought they were saying the same things, but ...

14 THE CHAIRMAN: I'm not sure -- we're asking a neurologist to
15 comment on a letter written by a paediatrician. I'm not
16 sure if this helps very much. I've already got evidence
17 on this.

18 A. The problem seems to be that it doesn't say very much
19 about brain swelling --

20 MS ANYADIKE-DANES: Yes.

21 A. -- Dr Steen's letter.

22 Q. If we pull up in substitution for 090-002-002,
23 090-001-001. This is the letter Dr Webb wrote to
24 Claire's parents. He had his own view as to what had
25 happened, which he has put in Claire's medical notes and

95

1 MS ANYADIKE-DANES: Yes. It's a very short brain-only, and
2 part of the inaccuracies are in the clinical summary,
3 but in any event this is the "comment" bit, which is
4 actually their conclusion or their attempt at
5 a clinicopathological correlation is here. What I had
6 wanted to put to you is, alongside that, the letter that
7 was written to the Roberts, or at least Claire's GP,
8 which is at 090-002-002. What I wanted to ask you is
9 how accurate or how much does that letter reflect what
10 the pathologist had found at autopsy?

11 A. Well, the finding of a neuronal migration defect was
12 later countermanded by Dr Harding and by another
13 neuropathologist.

14 Q. Dr Squier, yes. But Dr Steen wouldn't have known that
15 at this stage.

16 A. No, exactly. So that's what she was given in order to
17 send out the letter --

18 Q. Yes.

19 A. -- so she gave that information.

20 Q. Ultimately, its features are cerebral oedema with
21 a neuronal migrational defect and a low grade sub-acute
22 meningoencephalitis.

23 A. Yes. But Dr Steen doesn't quite say that, does she?
24 She starts, really, with the abnormal neuronal
25 migration --

94

1 records. I'm not going to pull it up to confuse matters
2 further, but just to tell you what he included, he said:
3 "SIADH, hyponatraemia, hypoosmolality, cerebral
4 oedema and coning, following prolonged epileptic
5 seizures."

6 That's what he included in his note at 4.40, but
7 of course at that stage he hadn't had the benefit of
8 a pathologist's report. So now he has the autopsy
9 report, and this is the letter that he writes to
10 Claire's parents. The question is: so far as you are
11 concerned, how accurate is that description of what had
12 happened to their daughter and why?

13 A. Well, it's uncertain about the status epilepticus, isn't
14 it?

15 Q. Mm-hm.

16 A. And a later report failed to find any evidence of that.

17 Q. Yes.

18 A. But I don't know when that will have been available. It
19 wouldn't have been available for this letter.

20 Q. That's why I'm asking you. Is that a fair enough letter
21 or should he have said a little bit more?

22 A. Well, the neuronal migration defect was one that was put
23 in, so I think it has to be accepted as part of what
24 goes in. And the low grade infection, I think is what
25 is in there as well. So I think, yes, it's probably

96

1 fair.

2 Q. And do you see any reference to the metabolic cause

3 or --

4 A. No.

5 Q. Where it says:

6 "... with the clinical history of diarrhoea and

7 vomiting, this is a possibility, although a metabolic

8 cause cannot be entirely excluded."

9 Do you see reference to that?

10 A. No, sorry, where's that?

11 Q. That's taken from the autopsy comment, that there is

12 a possibility of a metabolic cause.

13 THE CHAIRMAN: I think the point is that it's not there,

14 professor.

15 MS ANYADIKE-DANES: Yes. And how significant would it have

16 been to have included that and explained it? That,

17 incidentally, as I understand from the pathologists, is

18 the bit they couldn't really address, the whole issue of

19 SIADH, hyponatraemia and so forth. They say there's

20 nothing that they're going to find as pathologists of

21 that, but that's something that clinicians would have to

22 address.

23 A. I'm not sure that that's going to help a great deal,

24 really, because it's just a potential cause.

25 THE CHAIRMAN: It's not really going to help Mr and

97

1 THE CHAIRMAN: Okay, thank you. Mr Sephton?

2 MR SEPHTON: Sir, there are a couple of matters that I wish

3 to raise. In my closing submissions, I will be making

4 remarks about what weight ought to be given to the

5 evidence of various experts.

6 THE CHAIRMAN: Yes.

7 MR SEPHTON: And one of the things I will be pointing to

8 is that it is an expert's obligation to indicate, first

9 of all, his expertise, where he's making criticisms, and

10 secondly, where there's a range of acceptable views,

11 whether the expert has identified that and explained his

12 reasons.

13 THE CHAIRMAN: Yes.

14 MR SEPHTON: I wished counsel to the inquiry to raise those

15 issues and I've been told that she is not allowed to do

16 so. I simply put down a marker at this stage that --

17 THE CHAIRMAN: Let me deal with those two issues. The

18 second one that you have just raised is whether the

19 professor has acknowledged sufficiently that there are

20 views other than ones which he expressed.

21 MR SEPHTON: Yes.

22 THE CHAIRMAN: His reports contain a number of references to

23 him saying, "This isn't the only view, there are other

24 views"; isn't that right?

25 MR SEPHTON: No, I don't accept that.

99

1 Mrs Roberts to say that there's a possibility of

2 something which can't be excluded, is it, in this

3 letter?

4 A. It could be there, yes.

5 THE CHAIRMAN: Yes, but Mr and Mrs Roberts have a number of

6 other reasons to be concerned about the information

7 which they received at different times.

8 A. Yes.

9 THE CHAIRMAN: Including, in this letter, the fact that

10 there is a possibility of something else cannot be

11 excluded.

12 A. Yes.

13 THE CHAIRMAN: Would that be on the fringes of what they

14 might be worried about?

15 A. Yes, it could be.

16 THE CHAIRMAN: Okay.

17 A. The trouble is it's got several things that are not even

18 true.

19 THE CHAIRMAN: As it turns out, yes.

20 MS ANYADIKE-DANES: Then finally, because I know I'm going

21 to be asked, should it have included any reference to

22 low sodium, SIADH or anything of that sort?

23 A. I think, to be complete, it should contain hyponatraemia

24 as a cause.

25 MS ANYADIKE-DANES: Thank you. That's it, Mr Chairman.

98

1 THE CHAIRMAN: Let me take you to an example. Do you have

2 his statement at 232-002-004? If we could bring that

3 up. Thank you. He's asked about the appropriateness of

4 the prescription at admission for IV fluid therapy. And

5 he says in his answer:

6 "On Claire's admission, many would have administered

7 IV fluids of 0.45 or 0.9. The use of Solution No. 18 in

8 a drowsy child should have been at least with

9 a warning."

10 But then he continues at the end of that paragraph:

11 "I have commented ... on this as being potentially

12 unwise ..."

13 Then he says in the third line of the next

14 paragraph:

15 "Although not everyone would have done so."

16 Is he not acknowledging there that he's not being

17 prescriptive and saying that this is absolutely wrong,

18 but it's a view which not everyone would have taken, but

19 it's a view which many did take?

20 MR SEPHTON: I accept that in relation to that issue,

21 clearly.

22 THE CHAIRMAN: Well, are we really going to pore through his

23 reports section by section to find out what bits he

24 conceded and what bits he didn't? Because I re-read his

25 evidence last night and there are significant parts in

100

1 it where he does accept that there are other views.
2 I have to say, if any of the expert witnesses has been
3 far from being dogmatic, it's Professor Neville.
4 MR SEPHTON: Very well. I have made my point.
5 THE CHAIRMAN: I entirely accept that you're entitled to say
6 in the closing submission that although he may have made
7 some concessions of the type that I've just taken you
8 to, he should have made more.
9 MR SEPHTON: I wouldn't want it to be said that my closing
10 submissions are unfair because witnesses haven't been
11 given the chance to deal with the points.
12 THE CHAIRMAN: No, I understand.
13 MR SEPHTON: I've raised the matter and there it is.
14 THE CHAIRMAN: Thank you very much.
15 Okay, professor, thank you very much. I think
16 you're about to leave us, so if you go on ahead.
17 (The witness withdrew)
18 We're going to have the video link, ladies and
19 gentlemen, from about 2.30, but in order to get it set
20 up, could we re-group at 2.40? I understand that the
21 volume of questioning for Dr Scott-Jupp is not very
22 extensive and, in any event, we can't go beyond 4.30,
23 when the link will go down. So we'll break now until
24 2.40. Thank you.
25 (1.00 pm)

101

1 Q. The question really is what you think ought to have been
2 done about that result in terms of the way the fluids
3 ought to have been addressed. Just to help you with
4 that, do you have with you there a copy of Claire's
5 medical notes and records?
6 A. I'm afraid I don't, no. I only have my own reports.
7 Q. That's all right. I can read it out to you. It's
8 a very, very short extract of what happened at 11.30.
9 At 11.30, Dr Stewart, who was a junior SHO, made an
10 entry in Claire's notes. He had received the blood
11 results indicating Claire's phenytoin levels and he also
12 received the serum sodium level. The serum sodium level
13 that he recorded was 121 at that time. He also made
14 a note that she was obviously hyponatraemic. But he
15 made a note in relation to how he thought that had
16 arisen. The first line of which is:
17 "Query fluid overload and low-sodium fluids."
18 And the second line of which is:
19 "Query SIADH."
20 He then noted his impression -- sorry, can you still
21 hear me? Hello? I think we've lost him. (Pause).
22 He also noted:
23 "Query: need to increase the sodium content in
24 fluids."
25 Just for those who can pull it up, this is

103

1 (The Short Adjournment)
2 (2.40 pm)
3 THE CHAIRMAN: Ladies and gentlemen, we have some bits and
4 pieces to sort out after Dr Scott-Jupp's evidence, but
5 let's get the link up, if we can, and take
6 Dr Scott-Jupp.
7 DR SCOTT-JUPP (continued)
8 Questions from MS ANYADIKE-DANES (continued)
9 (The witness appeared via video link)
10 THE CHAIRMAN: Doctor, can you see us in Banbridge?
11 A. Yes, very clearly.
12 THE CHAIRMAN: Great, and we can hear and see you too.
13 Thank you very much for making yourself available
14 again today. You weren't able to finish your evidence
15 last time, but we are most of the way through it.
16 Ms Anyadike-Danes will now pick up the questioning where
17 she left off a few weeks ago. Okay?
18 A. That's fine. Yes, I'm ready.
19 MS ANYADIKE-DANES: Good afternoon, Dr Scott-Jupp.
20 A. Good afternoon.
21 Q. There are just a few issues. Unfortunately, because of
22 the pressures of time, we couldn't quite get through
23 your evidence. One of them relates to the serum sodium
24 result at 23.30.
25 A. Yes.

102

1 090-022-056. And then he noted:
2 "Discussed with the registrar."
3 His record of the outcome of that was to reduce the
4 fluids to two-thirds of their present value, which would
5 make it 41 ml an hour, and also to send the urine for
6 osmolality. Although he had thought that perhaps a way
7 of addressing that was to increase the sodium content,
8 that's not what the outcome of his discussion with the
9 registrar was.
10 So Dr Steen's response, just so that you have
11 that -- and I think one gets that in the transcript.
12 You won't be able to see that, but just for the purposes
13 of those in the chamber here, it's 17 October 2012,
14 page 106 at line 7 to line 9 in page 107. She says that
15 to reduce it to two-thirds was in line with the
16 textbooks at the time.
17 Dr Bartholome, who was the registrar that Dr Stewart
18 spoke to, in her transcript, 18 October 2012, page 52,
19 line 20 to page 53, line 4, says that she didn't want to
20 correct matters too quickly without knowing what the
21 urine osmolality result was.
22 So that's their explanation. And I'm conscious you
23 don't have all the notes, so I'm giving you the
24 information, if I can put it that way. You have your
25 own report, which I think is 234-002-008, and

104

1 Professor Neville in his report at 232-002-011, says
2 that Dr Stewart's assessment of the significance was
3 appropriate at SHO level, the significance of the serum
4 sodium level, however he would have expected
5 Dr Bartholome to take further action, including inducing
6 diuresis by mannitol and ventilating Claire to reduce
7 intracranial pressure.

8 So that's the landscape, if I can put it that way.
9 My query for you is: was the two-thirds restriction
10 appropriate in the absence of a urine osmolality result?

11 A. I think the urine osmolality result often in this
12 situation is not immediately available and my practice
13 in that situation would have been to restrict fluids
14 without necessarily waiting to acquire a specimen
15 because the likelihood of doing harm by continuing on
16 the higher infusion rate of the fluids is greater than
17 the likelihood of doing harm by reducing the rate.
18 That'd be my view in that situation.

19 Q. Would you have also increased the sodium content?

20 A. Yes. In 1996, as has been discussed many times at this
21 inquiry, it was less common to use 0.45 or 0.9 per cent
22 saline, but I think in this circumstance where there
23 clearly is a low sodium, I think both actions should
24 have been taken to increase the sodium content and to
25 reduce the quantity of fluid given.

105

1 Q. Can I ask you, apart from the fact that Claire had
2 a very low serum sodium result, would your view as to
3 what step to take be influenced by the fact that she had
4 these neurological presentations or she had obviously
5 had some sort of neurological problem? Does that affect
6 what you do about the fluids?

7 A. Yes, it would. At this point nobody had made
8 a diagnosis of raised intracranial pressure or cerebral
9 oedema. That was clearly what was developing -- it is
10 easy to say that with hindsight. It would have
11 required -- sorry?

12 Q. Yes, we can hear you.

13 A. Sorry, I thought I heard an interruption.

14 It would have required somebody with sufficient
15 insight to consider that as a possibility at that point.
16 And it's not always obvious, as is clear from this
17 case -- at least it wasn't obvious to the doctors
18 looking after Claire at that time that that was
19 developing. It's common practice to reduce fluids where
20 it is known that a child has cerebral oedema or raised
21 intracranial pressure, for example, after a head injury.

22 Q. Yes. As you probably know now from the transcripts, the
23 registrars are very stretched in the evening shift.
24 They have a number of beds they have to look after and
25 there is really only one of them. They do have access

106

1 to consultants who are on call. There has been
2 a suggestion that really what she ought to have done at
3 this stage is get hold of the consultant.

4 Dr Webb, who you may recall, was the consultant
5 paediatric neurologist, felt at this stage he would
6 quite like to have been informed that Claire had reached
7 that stage since it wasn't what he expected to happen to
8 her. And it's possible that the consultant
9 paediatrician who was on call, or Dr Steen, who was
10 Claire's consultant, should have been contacted.

11 You may not be able to speak for what a consultant
12 paediatric neurologist would consider, but if an
13 experienced consultant paediatrician is contacted and
14 given the information that was available in relation to
15 Claire, would you have expected not only for the rate to
16 be reduced, but also for the sodium concentration in the
17 fluids to be increased?

18 A. The sodium, yes. It was, at that time, a controversial
19 area. As you've already heard the discussion between
20 previous expert witnesses, I think you would have had
21 a variation, a variety of opinions of what different
22 people would do at that stage. But I think even then,
23 in 1996, there was an increasing appreciation of the
24 need to reduce fluids where there was a suspicion of
25 raised intracranial pressure and to bring the serum

107

1 sodium up slowly, not too quickly.

2 The debate in some circles, as I think has been
3 covered by other expert witnesses, is whether one should
4 have used hypertonic saline -- that is saline that is
5 more concentrated than normal saline, greater than 0.9
6 per cent. Personally, I wouldn't have used that and we
7 very rarely ever use that. I would have used, in that
8 situation, either 0.45 per cent or 0.9 per cent saline
9 in order to bring up, to slowly increase the serum
10 sodium concentration.

11 Q. So not only would you have reduced the rate of the
12 fluids being administered to her by perhaps the
13 two-thirds, but you would have also increased the sodium
14 concentration of those fluids?

15 A. Yes.

16 Q. And then the issue becomes by what degree, but you would
17 have increased it.

18 Can I also ask you: at that time, would you have
19 been thinking of the possibility of SIADH? You have
20 certainly thought that somebody might have thought that
21 raised intracranial pressure was developing. Would it
22 be reasonable to have considered the possibility of
23 SIADH at that stage?

24 A. Yes. On the receipt of that very low sodium result,
25 I think that was high on the list of possibilities, in

108

1 fact the most likely explanation of that very low sodium
2 at that time.
3 Q. Thank you. Then if I can go on to another area, which
4 is after Claire's collapse. She has a respiratory
5 arrest, she collapses and is ultimately transferred to
6 paediatric intensive care. At that stage, at some point
7 reasonably soon after that, Dr Steen arrives, Dr Webb
8 arrives, and Claire's parents do as well. And there is
9 a discussion between them to try and explain to Claire's
10 parents what has happened and what is effectively the
11 prognosis.

12 You, in your report at 234-002-010, thought that the
13 discussions with Claire's parents were appropriate given
14 the information that was available and the clinicians'
15 views at the time. Professor Neville thinks that the
16 cerebral oedema caused or aggravated by hyponatraemia
17 should have been explained to the parents. Obviously,
18 there is a range of time in which you could be talking
19 to the parents when you have increasing amounts of
20 information. One is before the results of the CT scan,
21 another is after the CT scan has been received, and you
22 see what the position is, and then of course there's the
23 position after the brainstem tests have been carried
24 out.

25 But if we go to the point when the CT scan has been

1 received. At that stage, they're concerned that
2 Claire's condition was irreversible and that would have
3 been confirmed by the results of that scan, and they
4 would have known presumably that what they're then
5 preparing the parents for is ultimately the brainstem
6 tests and what they would have believed to be her death.
7 So that's the stage that they're at.

8 Can you help with, given the information that they
9 would have had at that time, what you think, if
10 anything, the parents ought to have been told about the
11 role of Claire's fluid management in her condition?

12 A. I think this is very difficult. The situation is very
13 distressing, it's the middle of the night, they've been
14 called in because their child has deteriorated and ended
15 up on an intensive care unit. That in itself is a lot
16 of information to take in, particularly when they
17 apparently had been reassured earlier in the day. To go
18 into detail about blood results, about numbers, about
19 quantities of fluid and that sort of thing may not have
20 been appropriate at that time. And I think one has to
21 judge what, in a very distressing state for the parents,
22 is appropriate to say in that very acute situation. One
23 can always come back and go over the things in the cold
24 light of dawn, as it were, later, but I think it would
25 have been more advisable at that time to just

1 communicate the most important aspects to the parents,
2 that is that there was an acute deterioration, that
3 there was brain swelling and that it was very serious
4 and could be fatal, which was the situation that they
5 were dealing with at the time.

6 Q. Does a point come on that 23 October day when you do
7 start to explain to the parents in a little bit more
8 detail -- maybe not even on that day, after that -- what
9 you think has happened in terms of Claire's care and her
10 fatal cerebral oedema?

11 A. Yes. There does come a point, but it's very difficult
12 for me to be specific about when that should be.
13 It would depend on many things. It would depend on the
14 perceived receptiveness of the parents at the time from
15 their behaviour, how distressed they were, whether they
16 were in a position to talk. And people are extremely
17 distressed and tearful and it's sometimes difficult to
18 take things in. It would depend on, importantly,
19 whether both of them were there or whether only one of
20 them were there -- I believe both of them were there in
21 this situation. Sometimes one waits for the other
22 parent to come in or a supporting relative before going
23 into these sort of details. It would depend on the
24 likely sequence of events that were going to follow.
25 There was how quickly things were likely to proceed and

1 whether there was going to be time and how much
2 information had to be given in a very short space of
3 time or whether it could be left.

4 Q. Whatever you formed the view that it's appropriate to
5 do, which is a judgment call --

6 A. Yes.

7 Q. -- do you at any stage go into the details of what role
8 her fluid management might play?

9 A. I think in this case, at some point, I believe it should
10 have been mentioned. Now, there is a case for saying
11 that as in fact the most important issue at the time was
12 them moving towards brainstem death criteria, which is
13 obviously extremely distressing and that, I would
14 imagine, dominated the conversation between the doctors
15 and the parents at that time, and what might have been
16 seen as a less pressing detail, the fluid management,
17 might have been considered to wait. You may be coming
18 on to this anyway, but after Claire had passed away,
19 I think those aspects should have been discussed with
20 the parents at some point.

21 Q. I don't know if you had an opportunity to see some of
22 the transcripts of the evidence around this point, but
23 Dr MacPaul in particular was -- hello? He's gone.
24 (Pause).

25 A. I can see you again.

1 Q. Sorry. Dr MacFaul was asked about what the parents
2 ought to have been told at whichever point the judgment
3 is made that you can go into that kind of detail. And
4 his view is that very definitely they ought to have been
5 told about the fluid management issue because fluid
6 management is something that's within the control of the
7 clinicians and, if that has had any role to play in her
8 deterioration and the development of her cerebral
9 oedema, then that's something that, unpleasant and
10 difficult as it is to broach, that the hospital has to
11 say because that indicates that you have had a role to
12 play in what has happened.

13 A. Yes.

14 Q. Do you have a comment on that?

15 A. I agree with that. The question is when. I'm sorry,
16 I haven't been able to read Dr MacFaul's evidence in
17 great detail. Did he have a view on when that
18 conversation should have taken place?

19 Q. I didn't ask him in that way. I put to him the
20 discussion that is recorded and asked: if you were going
21 to have a discussion of that sort, should you have
22 mentioned certain other things? Then he said, "If I was
23 going to explain to the parents, this is what I would
24 have said". So in fairness to him, I don't think
25 I particularly tied him down to when you would do it;

113

1 A. Yes. I do. I think an expert pathologist would
2 probably have a much more detailed and expert view than
3 mine. But I believe that it might have been possible to
4 gain more information on the nature of Claire's illness
5 by doing a full autopsy. When I first read the notes,
6 I was slightly surprised that they only did a brain-only
7 autopsy, and I assumed, as others did, it was the
8 parents' request, but apparently not.

9 Q. There may well be a difference in the evidence between
10 Dr Steen and Dr Webb as to how that came about. But in
11 any event, at the time when it's being raised, it would
12 seem that both Dr Steen and Dr Webb are there. Is that
13 the sort of thing that you feel they should both have
14 discussed and reached a view on together, if possible?

15 A. Yes, I do.

16 Q. And that particularly if, for example, Dr Steen as
17 a paediatrician had it in mind that maybe we could just
18 proceed by way of a limited autopsy, confined to the
19 brain, that if she was thinking in that way, might that
20 be a particular thing that she could have raised with
21 Dr Webb, who is the neurologist, to get his view about
22 that?

23 A. Yes. One of the consultants, I presume, had
24 a discussion with the parents about the nature of the
25 autopsy.

115

1 I was more trying to extract from him what the content
2 would be. I'm not sure that there is a great issue as
3 to when it should happen, the question is: should the
4 family ever have known that? As you may appreciate,
5 they went some time without ever appreciating there was
6 anything of that sort involved in their child's death.

7 In fairness, I also put the same point to
8 Professor Neville, and he didn't go into details as to
9 when you would do it, but he certainly thought,
10 difficult as it was, that that was something that ought
11 to have been communicated to the parents.

12 A. Yes. I agree with that. My only reservation is that to
13 do it at the time when they had just come back in, when
14 Claire had just collapsed, might have been an
15 overwhelming amount of information for them to take in
16 at that time.

17 Q. I understand. Then I wonder if I could ask you about
18 the brain-only autopsy. Dr Webb's view is that unless,
19 for some reason, the parents didn't want to have a full
20 autopsy and although that's commonly the position, in
21 this case that wasn't the case. But absent that, then
22 he would have thought that you would have conducted
23 a full autopsy and seen what the information that
24 disclosed is to assist in determining exactly what had
25 happened. Do you have a view about that?

114

1 Q. Yes.

2 A. And I can't recall whether either of them gave reasons
3 for them requesting a brain-only autopsy in their
4 evidence. But it seems to me that if the parents are
5 prepared to give consent to an autopsy, which is a very
6 difficult thing for them to do, if they're prepared to
7 do that, distressing though it is, one might as well
8 take the opportunity to get the maximum amount of
9 information rather than just a limited amount. Because
10 there is evidence -- and a pathologist would be able to
11 tell you more about this than I -- but there's evidence
12 of a surprisingly high number of alternative diagnoses
13 that are found at autopsy, which are never even
14 suspected while the patient is still alive.

15 Q. The autopsy form, request form -- which you can't see,
16 but for reference here it's 090-054-183 -- is a standard
17 form and then it's filled in by Dr Steen. It indicates
18 the consultants as being Dr Steen and Dr Webb. Then it
19 describes very briefly the clinical presentation. Then
20 there is about a paragraph's worth in Dr Steen's writing
21 as to the history of the present illness and Claire's
22 past medical history.

23 So that you have it, her past medical history is
24 indicated as being:

25 "Mental handicap, seizures for six months to four

116

1 years."

2 In the history of the present illness, there's

3 reference to "vomiting" and "loose stools" and "speech

4 becoming slurred" and "becoming increasingly drowsy" and

5 she was felt to have subclinical seizures. And then

6 there's a reference to the medication, which lists all

7 the medication given, apart from the midazolam.

8 There is a record of the serum sodium dropping to

9 121 and when that happened. There's a query about

10 inappropriate ADH secretion, but not the other potential

11 query about fluid overload and so forth. Then it

12 records when the brainstem tests were carried out and

13 fulfilled. Under "investigations", it says that it is

14 coming accompanied by her chart. The clinical diagnosis

15 is given as "cerebral oedema, secondary to

16 status epilepticus", with a query over "underlying

17 encephalitis". And then over the page, the clinical

18 problems are to be listed in order of importance, and

19 there's space for four of them. And they are listed

20 in the order of:

21 "Cerebral oedema, status epilepticus, inappropriate

22 ADH secretion [and a query over] viral encephalitis.

23 It's not entirely clear what time that form was

24 filled in and there may be a difference here between

25 Dr Webb and Dr Steen as to whether there was discussion

117

1 presentation and so forth, when it comes down to what

2 was considered to be the clinical diagnosis or the

3 differential diagnoses, is that something that you think

4 that Dr Steen and Dr Webb should actually have

5 discussed?

6 A. I think they should have discussed it in terms of what

7 they were going to say to the parents to explain the

8 nature of Claire's illness. I think discussing

9 precisely what is written on the request form, which is

10 just a request form, it's not a terribly important piece

11 of the patient record. I think it is less important.

12 And as I said, the pathologist is at liberty to look

13 at the notes in detail and may choose to come to

14 a different conclusion to what's written on the request

15 form.

16 Q. If they have discussed what the differential diagnoses

17 were for the purposes of communicating that to the

18 parents, would you expect that to be recorded somewhere?

19 A. Yes, I would.

20 Q. And so if somebody was using the medical notes and

21 records, perhaps a more junior member of staff, to draft

22 up this form for the consultant to sign, would that be

23 available in the medical notes and records --

24 A. Yes.

25 Q. -- if they'd done it that way?

119

1 between them before that was done. But given that

2 Dr Steen had not been on the ward and had not actually

3 treated Claire, is that form something that should have

4 been discussed, so far as you consider it, between

5 Dr Steen and Dr Webb?

6 A. I don't think they needed to discuss the precise wording

7 of the form. I think the general issues of whether an

8 autopsy was required and the extent of an autopsy -- it

9 may have been that a junior member of staff could have

10 actually physically filled the form out, somebody who

11 was familiar with the case. Every trust has a different

12 system of requesting autopsies, which is very different

13 these days to what it was in 1996. So I don't think the

14 actual paperwork is that important, given that the

15 pathologist has access to the case notes anyway. So the

16 pathologist can look at any detail he or she wants to

17 find in the case notes without -- whatever is written on

18 the form is a guide to the pathologist.

19 Q. Yes. When it comes down to the clinical diagnosis,

20 Dr Webb's view is that what is written there doesn't

21 entirely conform with what he had recorded in Claire's

22 notes as to what he considered the clinical diagnosis to

23 be. Leaving that aside, if you say that a junior member

24 of staff could cull from the notes, if I can put it that

25 way, the history of the present illness and the clinical

118

1 A. Yes. You may be coming on to this, but what's written

2 on the death certificate is rather more important than

3 what's written on the autopsy request form.

4 Q. Yes, we are going to come on to that. If you give us

5 a moment so we can pull it up. Maybe I'll go on to

6 something else while we're waiting to get that up.

7 Whilst that's coming, can I ask you this: do you

8 think, given what was known or what their concerns were

9 in 1996, that this is a case that should have been

10 reported to the coroner --

11 A. Yes, I do. I think even though thresholds for reporting

12 to the coroner are lower now than in 1996, I think even

13 then a child who had died very soon after admission to

14 hospital with some uncertainty about the diagnosis --

15 they had a working diagnosis, but it wasn't certain.

16 With that rapid deterioration in a child who was

17 previously well who had not had a firm diagnosis of

18 a potentially fatal illness made before this admission,

19 that, in my view -- certainly in the English system and

20 I believe it is very similar in Northern Ireland --

21 would have been an indication for reporting to the

22 coroner.

23 Q. Thank you. And I can now give the reference here. You

24 won't be able to see it, but I'll be able to tell you

25 what's on it. The death certificate. 091-012-077.

120

1 There we are. You see the cause of death:
2 "1(a), cerebral oedema; (b), status epilepticus."
3 A. Yes.
4 Q. In fact, that's the same thing that is recorded on the
5 second page of the autopsy request form because there's
6 a particular section in this pro forma that says:
7 "Death certificate. If a death certificate has
8 already been prepared, please copy it below for our
9 records."
10 And that's exactly what that says. So the
11 pathologist knows what is the death certificate that the
12 clinicians have issued.
13 So in your view, when you said this is rather more
14 important, at that time, on the information that they
15 had, was that an accurate or an appropriate cause of
16 death?
17 A. Sorry, can you just repeat 1(a) and 1(b) again?
18 Q. 1(a) is "cerebral oedema" and 1(b) is
19 "status epilepticus".
20 A. Given the information that was available in the notes
21 at the time, I think that was an appropriate thing to
22 write on the death certificate, even though the
23 discussions that you've had at length in this inquiry
24 have suggested there were other things going on. But
25 given the information that was available to the doctors

121

1 consider, although they say that's not the sort of thing
2 that you would be able to determine from the brain-only
3 autopsy. My reason for asking you is, one, that in
4 their view that wasn't anything that was going to be
5 advanced by the autopsy, so it had not been confirmed
6 during her life because there was no EEG that would have
7 done that. And in the pathologists' view, it's not
8 something that could be confirmed during their
9 examination. In terms of what else was the differential
10 diagnoses during her life, encephalitis was the other
11 one.
12 A. Yes.
13 Q. And in fact, for some considerable time there was
14 a concern that the underlying presentation was viral in
15 some way. That's what's on the early notes.
16 A. Yes.
17 Q. Ultimately, it's something that Dr Webb thinks may be
18 a part of the problem because he administers or
19 prescribes medication and a treatment plan for it.
20 A. Yes.
21 Q. So what happens here is that there seems to be no
22 reference to that whole viral aspect, if I can put it
23 that way, of her presentation. But there is an
24 inclusion of something which has been completely
25 unconfirmed by the tests that would do so. And that's

123

1 at the time, that was not an unreasonable thing to
2 write. The question which I think you are going to move
3 on to is: should they have included hyponatraemia on the
4 death certificate? And I think --
5 Q. Well, I am going to ask you that. But before we do
6 that, I'm going to ask you whether it was appropriate to
7 include status epilepticus, given that it had not been
8 confirmed in any way throughout her admission.
9 A. The situation would have been that Claire died on an
10 intensive care unit, where she had been handed over to
11 by the clinicians looking after her on the children's
12 ward previously, who had made this working diagnosis and
13 treated her for status epilepticus. That may have been
14 an incorrect diagnosis, an incorrect treatment, but one
15 would not expect the person writing the death
16 certificate at that stage to go over that and pick over
17 that and do a reassessment with hindsight at that stage.
18 That's something that would be done later, probably with
19 the benefit of an autopsy.
20 Q. I'll be corrected, but I think it might be Dr Steen who
21 actually writes up the death certificate.
22 A. Yes. I think it was, yes.
23 Q. Of course, you are right in terms of the autopsy request
24 form. Whether there was status epilepticus is one of
25 the very things that she had wanted the pathologist to

122

1 why I'm asking you about the status epilepticus, whether
2 it wouldn't have been more appropriate simply to have
3 had the cerebral oedema, which is a fact -- and nobody
4 denies that she died from the cerebral oedema -- and the
5 autopsy report will disclose what led to the cerebral
6 oedema?
7 A. Yes. I think if you put it like that, I would agree
8 with you. The secondary diagnosis that is listed on
9 death certificates, that's the 1(b), 1(c) is often more
10 speculative than the more definite one that's listed at
11 1(a), and that's common practice in writing death
12 certificates in any situation. In this case, I would
13 imagine that Dr Steen chose not to write "encephalitis"
14 because that is something that she may have expected to
15 have been proven or disproven at autopsy. The cause of
16 death can then be altered after an autopsy has been done
17 in any situation.
18 Q. Could she have included, though, inappropriate ADH?
19 Because remember when I was reading to you the list of
20 clinical problems that she had included in the autopsy
21 request form, you are right, she did put a query over
22 the viral encephalitis, which was her fourth problem, if
23 I can put it that way, but the first three, in order,
24 were: cerebral oedema, status epilepticus and
25 inappropriate ADH secretion. The inappropriate ADH

124

1 secretion is also something that Dr Webb had identified,
2 so my question to you is: if she's going to have the
3 status epilepticus, which has not been established,
4 should she, by parity of reasoning, have included the
5 inappropriate ADH secretion?

6 A. Yes. I think that should have been included.

7 MR FORTUNE: Sir, can we bear in mind that Dr Scott-Jupp
8 does not have the advantage of seeing the certified copy
9 of the death certificate? By way of a reminder to
10 Dr Scott-Jupp, I represent Dr Steen.

11 In the medical records at 090-022-061, it's written
12 that the death certificate was issued by Dr Steen. It's
13 in her handwriting, "Cerebral oedema secondary to
14 status epilepticus", so I accept that.

15 Insofar as the date of registration of the death is
16 concerned, if we can go back to the death certificate,
17 that's 24 October 1996.

18 THE CHAIRMAN: Yes.

19 MR FORTUNE: So it is before the autopsy has been performed.

20 THE CHAIRMAN: Yes.

21 MR FORTUNE: It is before the post-mortem autopsy report is
22 prepared because that is dated 11 February 1997. So
23 there is effectively some degree of speculation as to
24 1(b), although, as Dr Scott-Jupp says, everyone would
25 agree with 1(a), cerebral oedema.

125

1 A. Yes.

2 THE CHAIRMAN: I think the doctor has acknowledged,

3 Mr Fortune, that there is a degree of speculation in the
4 secondary causes on the death certificate. But I think
5 the particular question he was being asked about was if
6 the clinical problems listed on the document that
7 Dr Steen signed -- that's the autopsy request form -- if
8 they were, one, cerebral oedema, two, status epilepticus
9 and, three, inappropriate ADH secretion, whether that
10 should not at least be reflected in the death
11 certificate.

12 MR FORTUNE: The difficulty, sir, may be -- and perhaps
13 we can ask --

14 THE CHAIRMAN: That's setting aside the encephalitis, which
15 she had a question mark beside.

16 MR FORTUNE: The difficulty, and perhaps we can hear
17 Dr Scott-Jupp on this, is whether you have, in addition
18 to 1(a), (b)(i), (b)(ii), (b)(iii), and so you include
19 status epilepticus, inappropriate ADH secretion and
20 query viral encephalitis. It may be a matter of, let's
21 say, poor form completion, but if I've heard
22 Dr Scott-Jupp correctly, it would be open to the
23 clinicians to have the certified copy of death revisited
24 and the cause of death confirmed more appropriately once
25 the autopsy had taken place.

126

1 THE CHAIRMAN: Yes.

2 MS ANYADIKE-DANES: Yes.

3 THE CHAIRMAN: That's right, doctor, is it, that the death
4 certificate can be corrected or varied after the
5 autopsy?

6 A. Yes, it can. It can. I believe it may not be present
7 on that certificate, but some forms of the death
8 certificate have a specific box that the doctor can tick
9 to say further information may be available from an
10 autopsy later. That is frequently present on some
11 versions of the death certificate. I can't remember if
12 it was in 1996 and it may vary between different parts
13 of the UK. But there's a system for doing that and the
14 pathologist could then re-register the cause of death
15 for statistical purposes. In some cases, completely
16 changing what the clinicians' view of the cause of death
17 was.

18 MS ANYADIKE-DANES: Yes, it was. Dr Steen's evidence was
19 that there was a box on the back, which could be ticked
20 if you wanted to receive the autopsy report so that you
21 could then take its findings into consideration for that
22 purpose. I was putting it to you slightly differently.

23 I had used the autopsy request form as a convenient
24 place from which to take what Dr Steen at that stage was
25 regarding as the clinical problems. Mr Fortune has

127

1 said, yes, the autopsy request form wasn't completed
2 at the time that the death certificate was being drawn
3 up by Dr Steen. But in fact, as I had put to you
4 earlier, the note that Dr Webb makes immediately after
5 Dr Steen's entry -- he makes a note at 4.40, in Claire's
6 records -- and you have a disadvantage in not having it
7 before you, but for those here it's 090-022-057.

8 He has the chain of events, if I can put it that
9 way, starting with SIADH, and that leads to the
10 hyponatraemia, the hypoosmolality and, ultimately, the
11 cerebral oedema, and that, being unchecked, leads to her
12 coning, following prolonged epileptic seizures. So the
13 SIADH is a definite line of development, if I can put it
14 that way, to lead to her cerebral oedema. And the point
15 that I was putting is: presumably Dr Steen has looked
16 at the notes and records in order to produce the death
17 certificate, and if she has seen the cerebral oedema,
18 obviously that's what Claire had. If she's putting the
19 status epilepticus as one line through to that cerebral
20 oedema, whether she shouldn't have included the SIADH,
21 which the paediatric consultant neurologist had
22 identified as another stream into the cerebral oedema.
23 That was why I was putting it in that way. And I think
24 your answer was: yes, that might have been done.

25 A. Yes. It could have been included, it would have been

128

1 entirely justified to include it. I don't think it's --
2 I think it would be a mistake to read too much into its
3 exclusion from the death certificate. That would be my
4 view. The death certificate -- I just come back to what
5 I was saying earlier -- is important in that it is seen
6 by the family because they then have to register the
7 death with the registrar. So in that respect, it's more
8 important than things like the autopsy request form.
9 Q. Yes.
10 A. And of course, it's important for statistical reasons,
11 which is its primary purpose anyway.
12 Q. You have said in the course of giving your evidence
13 a couple of times, I think, that the autopsy request
14 form itself is not so important, you get the main issues
15 down there, because you furnish the pathologists with
16 the medical notes and records and they look at that and
17 if there is anything that is inaccurate, well, they're
18 seeing the raw material, if I can put it that way.
19 A. Yes.
20 Q. The evidence that we received -- certainly from
21 Dr Herron -- was, yes, even if you did get the medical
22 notes and records, they were so pressed in their work --
23 I think he referred to, from time to time, conducting
24 six autopsies in a day -- that really they relied very
25 heavily on the details provided in the autopsy request

1 specific points in relation to some of the tests that
2 were received, for example in the cerebrospinal fluid,
3 and whether that affects matters. But you've now had
4 the opportunity to read the experts' reports --
5 A. Yes.
6 Q. -- and see the evidence in the transcripts and to see
7 most of the key people's witness statements. What is
8 your view as to how Claire died or why she died, more to
9 the point?
10 A. I feel very anxious about giving a view here because
11 I am outside my area of expertise in terms of the
12 pathology. Neuropathology is a very highly specialised
13 and difficult area anyway, paediatric neuropathology
14 even more so. And there appear to have been conflicting
15 views from different pathologists on what the actual
16 findings were in Claire's post-mortem. So I'd like the
17 inquiry to appreciate that I am speaking from the
18 perspective of a non-expert here in neuropathology or
19 any sort of pathology.
20 I was frankly surprised to read from one of the
21 pathology reports that there was no evidence of viral
22 encephalitis. I would have expected, from the clinical
23 picture given, that there would have been. How
24 significant that is, I can't comment on, and whether
25 it's possible for some form of viral encephalitis to set

1 form. And Dr Mirakhur, who thought that you might have
2 a look, if you had the opportunity, at the medical notes
3 and records, her view was similarly that they didn't
4 think that they would be looking through the medical
5 notes and records to see if the clinical history had
6 been accurately presented and they would be taking it as
7 read that the clinician had provided that information,
8 that information should have come from the medical notes
9 and records, ergo that's what should be reflected there.
10 A. Yes.
11 Q. So it may be that local practices differ, but it's not
12 so much a matter that they would be checking that. And
13 if that's the practice, then doesn't that make more
14 important, if you know that and you're the
15 paediatrician, the care that is taken with furnishing
16 that information?
17 A. It does. What you have told me does alter my view on
18 that. I had assumed, perhaps naively -- I know that
19 case notes always go with the deceased patient to the
20 mortuary, and my assumption was that pathologists always
21 looked at them. This may not always be true. It
22 depends entirely on the degree of pressure the service
23 is under, I imagine, and that would vary hugely.
24 Q. The final point I want to ask you is about the cause of
25 death. You may not be able to help with some of these

1 in place the chain of events that led to Claire's death
2 without there being the classic changes that one expects
3 to see, I don't know, and that's something that
4 I imagine you'd have asked or will be asking expert
5 pathologists on that.
6 Q. Yes.
7 A. Clinically, whatever the pathology says, I think the
8 most likely chain of events was Claire had a viral
9 infection that may or may not have originated from her
10 bowel -- but that's not that important -- but which did
11 have an effect on her brain, which caused some change in
12 her conscious level, caused an encephalitic-type
13 illness, which subsequently led to a probably relatively
14 minor degree of brain swelling, but enough to cause
15 inappropriate ADH secretion, which then set up a vicious
16 circle, so that the increasing hyponatraemia as
17 a consequence of the inappropriate ADH secretion
18 worsened the pre-existing mild cerebral oedema, and that
19 an accelerating vicious circle was set up and the
20 cerebral oedema then became irreversible. That's my
21 view of the course of events, from my reading of it.
22 Q. Thank you. I have only really two areas to ask you
23 about, subject to what anyone else might want to say.
24 One of them is the brainstem death test itself.
25 There has been quite a bit of evidence, which is not all

1 in one direction, as to whether the brainstem test form
2 or, rather, the test itself should have been performed
3 when it was performed. You don't have it, but for those
4 here I'll give the reference: 090-045-148. It is signed
5 by Dr Webb as the first doctor and by Dr Steen as the
6 second.

7 The first test is done at 6 o'clock that Wednesday
8 morning, so three hours after her respiratory arrest.
9 The second test is done at 6.25 that evening. Are you
10 familiar with the tests that are carried out and the way
11 the form is structured?

12 A. Again, I have to say that it's not -- this is an area
13 outside my expertise. I have never personally done
14 brainstem death criteria on a child.

15 Q. Then I won't --

16 A. So I'm not really in a position to comment on that.

17 THE CHAIRMAN: That's fine, doctor. Thank you.

18 MS ANYADIKE-DANES: That's a complete answer to that.

19 Then the next thing that I want to ask you about
20 is: do they have neurological grand rounds in your
21 hospital?

22 A. No.

23 Q. Do they have any neurological cases in your hospital?

24 A. I think it's not a fair comparison because I work in
25 a district general hospital rather than a children's

133

1 hospital, and of course we have -- there are adult
2 neurological grand rounds, which I don't get involved
3 in, and there are grand rounds for the entire hospital,
4 most of which are not very relevant to me as
5 a paediatrician because they deal with adult cases. But
6 within our own departments we frequently have -- we
7 don't call them grand rounds, but we have case
8 discussions and clinical meetings to discuss not just
9 neurological cases, but everything.

10 Q. Let's take that latter, which is something that you'd be
11 more familiar with. Would you have expected some
12 meeting of clinicians involved in Claire's case to
13 discuss Claire's case?

14 A. Yes, I would. In recent years, since all children's
15 deaths are investigated much more thoroughly, we're now
16 obliged to meet it and there is now a system in place --
17 at least it is in England and I think it covers
18 Northern Ireland too -- that all children's deaths need
19 to be discussed by all the relevant people. That wasn't
20 in place then. But nonetheless, even in 1996, I think
21 there were some, just from a purely educational point of
22 view, valuable learning points from the management of
23 Claire that ... And it would have been a pity not to
24 use those as an educational case, which is how junior
25 doctors and students are taught. But quite apart from

134

1 the educational aspects, I think having a discussion
2 with all the people involved and all the complicated
3 aspects of it, I would have expected it to happen,
4 really, yes.

5 Q. And if there was going to be any meeting that discussed
6 Claire's care and treatment and the reason for her
7 death, would you, if you had been her consultant
8 paediatrician, expect to be invited to that?

9 A. Yes, undoubtedly. In fact, if I was not able to attend,
10 I would ask them to defer the discussion to a time when
11 I was able to attend.

12 Q. Thank you. I just want to refer you to the
13 correspondence that was written on the one hand by
14 Dr Steen to the GP, and on the other hand by Dr Webb to
15 Claire's parents. The one from Dr Steen, which is
16 essentially your discipline, if I can put it that way --

17 A. Yes.

18 Q. She writes to the GP. It's 090-002-002. And she says
19 that the post-mortem results are now available. She
20 does not furnish the autopsy report, and that's another
21 issue as to whether you think that that would be
22 appropriate. Let me stop there. If you'd had it
23 available --

24 A. No. I mean, I frequently write letters to GPs when
25 a child has died, but I wouldn't normally send the full

135

1 post-mortem report because it is lengthy and it's far
2 more helpful to the GP to summarise the important points
3 because most of it is not very relevant --

4 Q. Thank you.

5 A. -- and that would be the purpose of the letter.

6 Q. What she actually states is:

7 "The cerebral tissue showed abnormal neuronal
8 migration, a problem which occurs usually during the
9 second trimester of pregnancy, and would explain
10 Claire's learning difficulties. Other changes were in
11 keeping with a viral encephalomyelitis meningitis.
12 Dr Webb and myself have since seen Claire's parents and
13 discussed the post-mortem findings with them. They are
14 obviously both finding this an extremely difficult and
15 traumatic time, but do not want any further professional
16 counselling at present."

17 Then it refers to their doors always being open:

18 "Mr Roberts wanted a short summary of the
19 post-mortem report, which Dr Webb will send to him
20 shortly."

21 So the bit that concerns the actual findings is
22 really:

23 "The cerebral tissue showed abnormal neuronal
24 migration."

25 And then how that relates to Claire's learning

136

1 difficulties, and that:
2 "Other changes were in keeping with a viral
3 encephalomyelitis meningitis."
4 A. Yes.
5 Q. Just to help you, because I'm very conscious of the fact
6 that you don't have it there in front of you, what the
7 summary of the autopsy report actually says is:
8 "The features here are those of cerebral oedema with
9 neuronal migrational defect and a low-grade sub-acute
10 meningoencephalitis."
11 And then it also says:
12 "... with the clinical history of diarrhoea and
13 vomiting, there is a possibility, though a metabolic
14 cause cannot be entirely excluded."
15 And that reference to the possibility is because the
16 reaction in the meninges and cortex, they thought, was
17 suggestive of a viral aetiology, although some viral
18 studies were negative and so that is when it goes on to
19 say:
20 "With the clinical history of diarrhoea and
21 vomiting, this is a possibility [and then the rider]
22 though a metabolic cause cannot be entirely excluded."
23 So it's very short, it's about a paragraph, and
24 that's what the autopsy said, and the issue is, if you
25 are the consultant paediatrician writing to the GP to

137

1 advise the GP of what happened and how it happened,
2 presumably so that he can discuss matters with the
3 parents, is the letter to the GP a fair representation
4 of what has come out of autopsy or, for that matter,
5 what the clinicians thought if those were matters that
6 couldn't be established at autopsy?
7 A. It seems that Dr Steen's letter was concentrating more
8 on the underlying brain problem that Claire was born
9 with, that long pre-existed this acute illness, to
10 explain her previous fits and her learning difficulties,
11 and that there seemed to be relatively little on the
12 acute events that led up to her death. I suppose it
13 would have been helpful for the GP to have information
14 on both those things. Dr Steen was going on the report
15 of the first post-mortem done by the pathologist in
16 Belfast, I think.
17 Q. Yes.
18 A. And I think that given what she said that there was
19 evidence of a viral aetiology and an encephalitic
20 illness. I think it is reasonable. It may be brief,
21 but I think as a GP, a GP doesn't want a lot of detail.
22 That isn't what they would really need.
23 MS ANYADIKE-DANES: Thank you very much.
24 Mr Chairman, I wonder if you'd give me a minute.
25 There is a follow-up.

138

1 THE CHAIRMAN: I'm not going to rise in case the link goes
2 down, but I will give you a moment or two. (Pause).
3 MS ANYADIKE-DANES: There is one question. For those in the
4 chamber, the reference is 090-022-060. If we can bring
5 alongside of that an extract from yesterday's
6 transcript, page 234, which is essentially a question
7 that is generated by the line starting
8 "Dr Webb/Dr Steen".
9 Dr Scott-Jupp, this might be a little difficult for
10 you to address, but I'm going to try and help you with
11 it. After Claire's collapse, at least three clinicians
12 wrote in her notes. The paediatrician in paediatric
13 intensive care wrote in her notes, as did Dr Steen and
14 Dr Webb. And I'm going to read an extract from the note
15 made by Dr McKaigue, who was the paediatrician in
16 intensive care.
17 He writes quite a full note and then he comes to
18 a place where he says:
19 "Dr Webb/Dr Steen have discussed Claire's clinical
20 condition with her parents. They initially appear to be
21 giving consent for organ donation, but Dr Webb will
22 speak again to both parents at 10 am."
23 The note is timed at 7.10 itself.
24 THE CHAIRMAN: This is on the Wednesday morning after
25 Claire's collapse at about 3 am.

139

1 MS ANYADIKE-DANES: Exactly.
2 So she has collapsed at about 3, she is transferred
3 to paediatric intensive care. Dr Steen writes a note at
4 4 am, Dr Webb writes his note at 4.40. The first
5 brainstem death test is done at 6 am. Dr McKaigue is
6 writing his note at about 7 o'clock. So that's what's
7 happened. I'll just give it to you again since that's
8 rather a lot of information to take on:
9 "Dr Webb/Dr Steen have discussed Claire's clinical
10 condition with her parents. They initially appear to be
11 giving consent for organ donation, but Dr Webb will
12 speak again to both parents at 10 am."
13 The question is: if he was able to write that at
14 about 7 o'clock, does that mean that the issue as to
15 whether that is a coroner's case or not has already been
16 ruled out?
17 A. You mean because organ donation had been raised as
18 a possibility?
19 Q. Yes.
20 A. No, it doesn't mean it's ruled out. I'm trying to
21 remember what the policy was on organ donation in 1996
22 and I can't reliably remember and you may need to take
23 advice from another expert on that. But I think there
24 was -- I think it was at the individual coroner's
25 discretion as to whether they would allow organ donation

140

1 if there was a possibility of it being a coroner's case,
2 but I may be wrong about that. There may, at that time,
3 have been a complete prohibition on any organ donation
4 that was --
5 Q. I think you might be right about that because in an
6 earlier case, Adam's, the case immediately preceding
7 Claire's, there was that very discussion where the
8 mother had wanted to do that and there's a record of the
9 coroner giving permission for that to happen.
10 A. I think, as I remember, it did -- and still does -- vary
11 from region to region, depending on the individual
12 coroner's views.
13 Q. So is the upshot the fact that the parents are
14 discussing issues to do with organ donation at that
15 stage doesn't necessarily mean that the matter is not
16 considered by the clinicians, or at least one of them,
17 to be appropriate for a coroner's case and doesn't mean
18 that decision to refer to the coroner has been ruled
19 out?
20 A. No, it doesn't, but I think it would be highly advisable
21 for a clinician to discuss with a coroner if it may be
22 going that way before raising the issue of organ
23 donation with the parents, I would have said. But at
24 7 o'clock in the morning, it may have been difficult to
25 get hold of anybody.

141

1 Professor Neville represent one school of thought and
2 perhaps there are other schools of thought.
3 THE CHAIRMAN: Right. So what we're asking Dr Scott-Jupp
4 isn't how delicately or otherwise it would have been
5 raised or the precise time at which it was raised,
6 whether it was 4 o'clock on Wednesday morning or later
7 on Wednesday morning or even on Thursday -- doctor, have
8 you followed the exchanges?
9 A. I think so. Mr Fortune is asking whether there was
10 a consensus amongst paediatricians, in the context of
11 a child being extremely ill or having died, whether they
12 would all have discussed aspects like fluid management
13 with the parents.
14 THE CHAIRMAN: Yes.
15 A. Is that what Mr Fortune is asking?
16 THE CHAIRMAN: That's the gist of it.
17 A. I think every case is so different, so unique, and
18 I think it would not be fair to say there was any kind
19 of consensus or any kind of universal policy on that.
20 Certainly we do discuss things in more detail with
21 parents now than we did in 1996. But even then, I think
22 most consultants would have, if it seemed appropriate,
23 as I said earlier, the right time, want to discuss
24 aspects of management. What's particularly difficult
25 about Claire's case, I think, is that when a child has

143

1 MS ANYADIKE-DANES: Thank you very much. Mr Chairman.
2 I don't think there's anything further.
3 THE CHAIRMAN: Mr Fortune?
4 MR FORTUNE: I have been toying with a topic which I find
5 quite difficult to articulate. And it's simply
6 this: could we find out from Dr Scott-Jupp whether, back
7 in 1996, he would expect all consultant paediatricians,
8 when faced with a situation similar to Claire's, to
9 discuss the concept of fluid management in the way that
10 Dr MacFaul has described and Professor Neville has
11 described? It's not so much the timing; it's the fact
12 of how the fluid was managed or arguably mismanaged.
13 THE CHAIRMAN: Sorry, just to clarify the question for
14 Dr Scott-Jupp. We're asking him whether he would have
15 expected all consultant paediatricians to discuss the
16 concept of fluid management in the way that has been
17 described by two of the experts, and that's to discuss
18 it about Mr and Mrs Roberts?
19 MR FORTUNE: Yes. We accept that events moved on to 2004,
20 and, of course, the situation would be markedly
21 different now in 2012.
22 THE CHAIRMAN: Yes.
23 MR FORTUNE: But I'm trying to get the feel of 1996 and
24 whether there was a universal expectation amongst
25 consultant paediatricians or whether Dr MacFaul and

142

1 died and the original, fundamental cause of death may
2 have been inevitable, however there were things about
3 the treatment that were less than ideal and yet it may
4 be that in the view of the person speaking to the
5 parents the things that were not done optimally with the
6 treatment were not actually the main contribution to the
7 child's death, it's a difficult issue as to whether it's
8 worth raising those.
9 These days, I think we would. In 1996, I am not so
10 sure because it is not going to change anything, it's
11 not going to bring the child back and one might have
12 formed the view that whatever one would have done, the
13 death was inevitable anyway. I'm not saying that was
14 the case in Claire, but that might have been the view of
15 the person talking to the parents.
16 Therefore, there might have, in 1996, been
17 a tendency to perhaps gloss over some of the aspects of
18 the care which, if one were to pick over them, might not
19 have been ideal or the sort of care that one might
20 expect as a high standard. Does that answer the
21 question, Mr Chairman?
22 THE CHAIRMAN: In order to do that, doctor, don't you have
23 to have formed some view about the extent to which the
24 fluid management contributed to her death?
25 A. Yes, you do. I'm speaking in --

144

1 THE CHAIRMAN: Because the greater the possible
2 contribution, even in 1996, the more difficult it is to
3 gloss over it.
4 A. Yes, exactly. I'm speaking from the perspective of
5 somebody who believed that the fluid management was not
6 the primary cause of the death, but rather that viral
7 encephalitis and cerebral oedema were the primary causes
8 and the fluid management was a secondary contribution.
9 I'm not saying that is my opinion; I'm saying how
10 somebody who felt that might have chosen to discuss it
11 with the parents in that context.
12 THE CHAIRMAN: Okay, thank you.
13 MR FORTUNE: Thank you, sir.
14 THE CHAIRMAN: Thank you very much. Doctor, we're going to
15 let the link go. Thank you again for your contribution.
16 We're very grateful to you.
17 A. Mr Chairman, do you mind if I just make one final
18 comment?
19 THE CHAIRMAN: Please do.
20 A. It's just, I'm sure that other people have said this,
21 but Claire's case -- and I think some of the others that
22 you are investigating in this inquiry -- are tragic, but
23 I think they are highly exceptional. I'm sure you
24 realise this, but I just wanted to give my own view that
25 the way in which her cerebral oedema and hyponatraemia

145

1 Dr Harding is now in Philadelphia. We think we have
2 a video link set up with him for tomorrow afternoon.
3 That's a little bit uncertain, but it will be in the
4 afternoon because he's five hours behind us.
5 Then on Thursday, you will all already have received
6 the inquiry opening on governance. So what will happen
7 on Thursday morning from 10 am is that Ms Anyadike-Danes
8 will highlight some particular aspects of that. I think
9 Mr Quinn, you wanted to --
10 MR QUINN: I have a short opening, which will be available
11 tomorrow morning.
12 THE CHAIRMAN: Thank you very much. Does anyone else intend
13 to say anything on Thursday morning?
14 MR FORTUNE: Sir, on a matter of housekeeping, bearing in
15 mind the transatlantic time difference, what time is the
16 video link?
17 THE CHAIRMAN: I have asked for it to be at 3 o'clock our
18 time, which is 10 am his time.
19 MR FORTUNE: And how long is it envisaged that the link will
20 be open?
21 THE CHAIRMAN: We think a maximum of two hours is all that's
22 required. Dr Harding's comments tend to be concise.
23 MR FORTUNE: I was merely thinking of the stenographer in
24 this case.
25 THE CHAIRMAN: Yes. Then on Thursday, after the two

147

1 developed was alarmingly rapid and most children, even
2 presenting in very similar situations, having received
3 exactly the same treatment, would not have deteriorated
4 so rapidly. There was something -- and I don't think
5 we have any idea what it was -- that made her much more
6 susceptible and vulnerable to all the things that
7 contributed to her death, which another child of the
8 same age and same situation may not have done that.
9 Our understanding and our level of scientific
10 knowledge of the nature of these types of problems is
11 still really quite primitive and we have a long way to
12 go to understand why different patients react
13 differently to treatments given and to illnesses that
14 they have. It still is difficult to understand and
15 comprehend quite why Claire deteriorated so rapidly in
16 this situation.
17 THE CHAIRMAN: Thank you very much.
18 A. I hope you don't mind me adding that.
19 THE CHAIRMAN: Not at all, thank you, doctor.
20 (The witness withdrew)
21 TIMETABLING DISCUSSION
22 Ladies and gentlemen, that brings an end to today's
23 evidence. Let me update you with where we're going
24 next.
25 We have Dr Squier tomorrow morning from 10 am.

146

1 openings, we've got Miss Jackson to give evidence, and
2 that will be the end of Thursday. As you know, we're
3 not sitting on Friday. That takes us into next week.
4 Just on a couple of points, I think, Mr Sephton, in
5 your absence last week, there were a couple of issues
6 raised about documents from Dr Webb, which I'm afraid we
7 rather overlooked yesterday. There were two categories
8 of documents. One is picked up from his third
9 statement, 138/3, page 2, in which he refers to
10 published concerns about sending children to an adult
11 facility for an emergency investigation such as
12 a CT scan.
13 MR SEPHTON: My instructing solicitor has drafted a letter
14 to the inquiry dealing with that point and will be
15 sending it. I have today e-mailed Dr Webb to remind him
16 about the matter that was raised right at the end of his
17 evidence yesterday evening.
18 THE CHAIRMAN: That's about whatever e-mail exchanges he had
19 with Mr Walby about his statement for the inquest?
20 Okay, thank you very much indeed.
21 Beyond that, we have a four-day week next week and
22 then a three-day week on the following week -- the week
23 before Christmas -- that's Monday, Tuesday and
24 Wednesday, and I hope that gives us the time we need.
25 I think it should give us the time we need to complete

148

1 these aspects of the investigation into Claire's death.
2 In the week commencing 14 January, you will have
3 seen Dr Rating's reports have been circulated. They
4 have gone to Professor Kirkham. We have asked her for
5 any comment that she wants to make. But both Dr Rating
6 and Dr Kirkham will be giving evidence in the week of
7 14 January. And we also intend to use that week to
8 finish off and catch up on the evidence of
9 Dr Ian Carson, Mr William McKee, both from what was then
10 the Royal Trust and which became the Belfast Trust, and
11 the evidence of the inquiry's expert governance expert
12 in Adam governance. That's Mr Aidan Mullan. So we're
13 going to do those all in that week. That will
14 inevitably be a five-day week and we don't quite have
15 the witnesses in the order we would like because, as
16 I understand it, Dr Rating is available on Monday and
17 Professor Kirkham is available on Thursday, which is
18 a bit less than ideal, but there it is. You have
19 Dr Rating's reports and we have asked Professor Kirkham
20 for her concise response.
21 Beyond the week of 14 January, we will be moving
22 into the first element of the investigation into
23 Raychel's death, which is the aftermath of
24 Lucy Crawford's death. I'm not yet in a position to
25 give you a timetable on that, but I hope to do so next

1 week. I think if we do have a five-day week in the week
2 of 14 January, I think you can take it it's highly
3 unlikely that we'll be sitting in the week of
4 21 January.

5 10 o'clock tomorrow morning. Thank you very much
6 indeed.

7 (4.00 pm)

8 (The hearing adjourned until 10.00 am the following day)

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1	I N D E X
2	
3	PROFESSOR BRIAN NEVILLE (continued)1
4	Questions from MS ANYADIKE-DANES1
	(continued)
5	DR SCOTT-JUPP (continued)102
6	Questions from MS ANYADIKE-DANES102
	(continued)
7	TIMETABLING DISCUSSION146
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	