Witness Statement Ref. No. 134/1

NAME OF CHILD: Claire Roberts

Name: Janil Puthucheary

Title: Dr

Present position and institution:

Medical Director of Faculty Development, and Assistant Professor, Duke-NUS Graduate Medical School, Singapore

Head, Department of Paediatric Subspecialties, and Senior Consultant – Children's Intensive Care Unit, KK Women's and Children's Hospital, Singapore

Previous position and institution:
[As at the time of the child's death]

Senior House Officer, Royal Belfast Hospital for Sick Children

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-November 2011]

nil

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

nil

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
		nil

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

(1) State the date when you were first appointed as a Senior House Officer by the Royal Group of Hospitals (Royal) and describe your experience as a Senior House Officer in the Royal Belfast Hospital for Sick Children (RBHSC) and any other hospital in which you worked prior to 21st October 1996.

I was first appointed as a Senior House Officer by the Royal Group of Hospitals in August 1996. My first posting was to the Accident and Emergency Department of the Royal Belfast Hospital for Sick Children, where I continued to work at the time of the incident described. Prior to this I had been employed as a Junior House Officer from August 1995 to July 1996, working in the Royal Victoria and Lagan Valley hospitals

(2) Describe your work commitments to the RBHSC from the date of your appointment as a SHO, including the department/s and locations in which you worked and the periods of time in each department/location, and particularly over the period 21st October 1996 to 23rd October 1996.

My work commitments at the time in the A/E Department of RBHSC were such that I was either on duty and present within the department, or off duty, there was no on-call from home, and no on-call room to sleep in. I would have been responsible for assessing patients referred to the department by general practitioners, or brought there by ambulance, providing immediate treatment and investigation, and then arranging for further care either within the hospital or on an outpatient basis. If a child needed admission I would have been required to contact the relevant inpatient medical team who would assess the child within the A/E dept. If I needed help with a case or was unsure if a patient needed admission I would have called the inpatient medical registrar.

(3) State the times at which you were on duty between 21st October 1996 to 23rd October 1996 and in particular:-

(a) Whether you were present in the hospital or

(b) Whether you were on call during that period

(c) What contact you had with Claire and her family during that period including where and when that contact occurred

My work commitments at the time in the A/E Department of RBHSC were such that I was either on duty and present within the department, or off duty, there was no on-call from home, and no on-call room to sleep in. I would have been responsible for assessing patients referred to the department by general practitioners, or brought there by ambulance, providing immediate treatment and investigation, and then arranging for further care either within the hospital or on an outpatient basis. If a child needed admission I would have been required to contact the relevant inpatient medical team who would assess the child within the A/E dept. If I needed help with a case or was unsure if a patient

needed admission I would have called the inpatient medical registrar. I do not recall what the working times/shift patterns were during my posting to the RBHSC A/E. I had contact with Claire and her parents within a consultation room in the A/E department when I assessed her, obtained the history from the caregivers/parents, performed a physical examination and formulated a plan. I do not recall how long I was in the consultation room. I had no further contact with Claire or her parents after this occasion.

(4) Describe what you considered to be your role in relation to and responsibilities towards Claire and her family over the period from her attending A&E in RBHSC on 21st October 1996 until 23rd October 1996 when ventilatory support was withdrawn, and in particular:

(a) From Claire's attendance at A&E at RBHSC until her arrival in Allen Ward

My role would have been to attend to Claire's need for immediate treatment and resuscitation (if any), to obtain a clinical history, perform a physical examination, arrive at a presumptive diagnosis, and arrange for either admission, transfer, outpatient follow up or discharge with advice. My responsibility to the family would have been to involve them in the process and decision making and to communicate with them my assessment and decisions.

(b) While Claire was in Allen Ward until her admission to PICU

(c) From her admission to PICU until her death

After attending to Claire in the A/E Department, and arranging for her admission I would have had no further contact with her or her family.

(5) Describe your role, responsibilities and actions in relation to:

(a) Claire's fluid administration, monitoring and management

(b) The making and recording of observations of Claire including determining and reviewing the frequency of those observations

I had no involvement with her fluid administration, monitoring or management. I would have made clinical observations as part of my assessment, and would have made none further after she left my care and the A/E.

(6) In relation to the actions which you have described above in respect of Claire's fluid management etc. and the making of observations etc.:

(a) Explain the reasons for your actions.

(b) State which of them you carried out on the express instructions of a clinician, identifying in each case:

(i) The clinician concerned

(ii) The instructions they gave you

(iii) When they gave them to you

(c) Whether you sought advice from whom or consulted with any other clinicians prior to taking any of those actions, and if so:

(i) Identify the clinicians from you sought advice/consulted and state when you did so

(ii) State the nature of the advice you sought/the issues on which you consulted and explain your reasons for doing so

(iii) State and explain the advice that you received and identify the clinician who gave it to you

If you did not seek any such advice or consultation, explain why not.

I had no involvement with her fluid administration, monitoring or management. I would have made clinical observations as part of my assessment, and would have made none further after she left my care and the A/E.

(7) In regard to Claire's medical notes and records, identify precisely the entries that you made or which were made on your direction and state below:

(a) When each of the identified entries was made

(b) The source of the information recorded in the entry

(c) In particular, state whether you made the A&E Doctor's admission note at Ref: 090-012-014.

With reference to the clinical notes, the document number 090-012 is the only occasion where I made an entry. I saw Claire at 7.15pm, and noted that she was a 9 year old girl with a history of learning difficulties and epilepsy. Further she had been fit-free for three years and was off her anti-epileptic medication. She presented with non-bilious vomiting, starting that evening. There was no diarrhoea, no cough, no pyrexia. She was hardly speaking and her speech was very slurred. On clinical examination I found that she was apyrexic, drowsy and tired, with pupils that were equal and reactive to light and accommodation. There was no neck stiffness and no lymphadenopathy. Examination of her ears was normal, she had normal heart sounds, with no murmurs, her abdomen was soft and non-tender with no masses and no organomegaly, her bowel sounds were present and normal, the percussion note of her chest was normal, the auscultatory findings were normal, with good air entry and no added sounds. I was not able to examine her pharynx. There was no apparent limb weakness. Her plantar reflexes were down-going bilaterally, but I noted at the time that this was different from the GP's referral letter which noted some asymmetry. Her tone was generally increased. Her tendon reflexes were increased on the left as compared to the right. I entered a presumptive diagnosis of encephalitis.

(8) Describe and explain any discussions you had with any

(a) medical personnel and/or

(b) nursing staff

in relation to Claire whilst you were on duty between her attendance at A&E on 21st October 1996 and 23rd October 1996, the nature and location of these discussions and with whom you had those discussions.

I note that Dr Bernie O'Hare reviewed the patient and recorded a decision to admit Claire. I do not recall if I spoke to Dr O'Hare directly or had asked one of the nurses to contact her on my behalf. The usual practice would have been for me to call the medical registrar myself. She would have been called as a matter of routine given the seriousness of the presentation and the need for admission. I do not recall if I was present when Dr O'Hare assessed the patient. The usual practice would have been for me to be present, unless there was another urgent case to attend to. I do not recall discussing or reporting Claire's condition or symptoms to any other clinician.

(9) Identify who called Dr Bernie O'Hare, the Medical Registrar, and state at what time and why she was called.

(a) State whether you were present while Dr. O'Hare took the history and examined Claire which is recorded at *"8pm"* (Ref: 090-022-050).

(b) State the location where the Medical Registrar attended and examined Claire.

I do not recall if I spoke to Dr O'Hare directly or had asked one of the nurses to contact her on my behalf. The usual practice would have been for me to call the medical registrar myself. She would have been called as a matter of routine given the seriousness of the presentation and the need for admission. I do not recall if I was present when Dr O'Hare assessed the patient. The usual practice would have been for me to be present, unless there was another urgent case to attend to.

(10) State whether you reported Claire's condition or symptoms to any clinician, other than Dr. O'Hare, on 21st October 1996 at any time, and if so:

(a) Identify the clinician/s to whom you reported and state the time at which you reported.

(b) The means by which you conveyed that report e.g. orally, in person, by telephone, in writing etc.

(c) State precisely the information conveyed to that clinician.

(d) State whether Claire was reviewed or reassessed as a result of that report or whether her care/treatment was changed and provide details thereof. If not, explain why not.

I do not recall discussing or reporting Claire's condition or symptoms to any other clinician.

(11) In relation to the specimen of urine collected in the A&E Department by uri-bag and taken for analysis (Ref: 090-010-012), state:

(a) Whether the urine specimen was tested, and if so state where was it tested.

(b) The results of the urinalysis of the sample taken in A&E by uri-bag and identify the note or record of the results of that urinalysis.

I did not order or carry out urine investigations in the A/E. This would have been the usual practice if the patient was going to be admitted to the ward, where further extensive investigations would be carried out.

(12) State whether any blood samples were taken from Claire in A&E for testing at that time, and if so, state the nature and the purpose and results of those blood tests and identify the note or record of those results. If not, explain why additional blood tests involving more extensive biochemical and toxicology tests were not carried out.

I did not order or carry out any blood investigations in the A/E. This would have been the usual practice if the patient was going to be admitted to the ward, where further extensive investigations would be carried out.

(13) *"Today vomiting (non-bilious) since this evening °diarrhoea, °cough/pyrexia. Speech very slurred, hardly speaking."* **(Ref: 090-012-014)**

(a) Identify who gave you this history and state what you were told about it.

(b) State whether Claire had diarrhoea on attendance at A&E Department on 21st October 1996 and explain the reasons for your answer.

With reference to the clinical notes, the document number 090-012 is the only occasion where I made an entry. I do not recall, nor have I documented, who gave me the history, I presume that it was from Claire's parents, but it may have been from whichever caregiver had accompanied her to the A/E dept. I saw Claire at 7.15pm, and noted that she was a 9 year old girl with a history of learning difficulties and epilepsy. Further she had been fit-free for three years and was off her anti-epileptic medication. She presented with non-bilious vomiting, starting that evening. In the history reported to me there was no diarrhoea, no cough, no pyrexia. She was hardly speaking and her speech was very slurred. On clinical examination I found that she was apyrexic, drowsy and tired, with pupils that were equal and reactive to light and accommodation. There was no neck stiffness and no lymphadenopathy. Examination of her ears was normal, she had normal heart sounds, with no murmurs, her abdomen was soft and non-tender with no masses and no organomegaly, her bowel sounds were present and normal, the percussion note of her chest was normal, the auscultatory findings were normal, with good air entry and no added sounds. I was not able to examine her pharynx. There was no apparent limb weakness. Her plantar reflexes were down-going bilaterally, but I noted at the time that this was different from the GP's referral letter which noted some asymmetry. Her tone was generally increased. Her tendon reflexes were increased on the left as compared to the right. I entered a presumptive diagnosis of encephalitis.

(14) *"... o/e Drowsy tired. Apyrexic °Lymphadenopathy.... ° Neck stiffness"* **(Ref: 090-012-014)**

(a) Explain the significance of "°*Lymphadenopathy*" on examination of Claire.

Lymphadenopathy - the examination for lymphadenopathy is a routine part of the general assessment of a sick child. It's presence can indicate an increased likelihood of an infection, as well as a number of other conditions, it's absence is generally non-predictive.

(b) Explain the significance of "° *Neck stiffness*" on examination of Claire.

Neck stiffness - the presence of neck stiffness is suggestive of meningism and in the presence of a fever, or headache, or photophobia or signs of altered consciousness would raise the possibility of meningitis.

(15) *"Primary diagnosis Encephalitis ?"* (Ref: 090-012-014)

(a) Identify who made the *"Primary diagnosis"* of *"Encephalitis ?"* and state when this diagnosis was made and the basis thereof.

Encephalitis - I wrote the diagnosis of "encephalitis". The usual practice would have been for me to write down a presumptive diagnosis prior to asking the medical registrar to review the patient. I made the diagnosis on the basis of her acute presentation of altered mental state, a concern of raised intracranial pressure (vomiting, as well as asymmetric and changing neurological signs). I would have likely taken into account the GPs concern about a possible fit or underlying infection as well as his finding of photophobia, although I have not documented these.

(b) Explain if there were any alternative diagnoses and, if so, identify each of them and explain why they were not noted on the A&E notes at Ref: 090-012-014

I made the diagnosis on the basis of her acute presentation of altered mental state, a concern of raised intracranial pressure (vomiting, as well as asymmetric and changing neurological signs). I would have likely taken into account the GPs concern about a possible fit or underlying infection as well as his finding of photophobia, although I have not documented these.

(c) In particular, state whether you considered hyponatraemia and/or cerebral oedema as a diagnosis, and explain why/not, and if so, explain why this was not recorded in Claire's medical notes.

Hyponatraemia and Cerebral Oedema are descriptive terms and not primary diagnoses in themselves. They may occur as part of any number of conditions. In the setting of encephalitis one is concerned about the complication of cerebral oedema.

(d) Explain any discussions you had with the triage nurse T. Blue, admission nurse E A Jackson and with Dr Bernie O'Hare regarding Claire's condition and diagnosis and what observations, tests, scans or investigations were required.

I do not recall any discussions I had with Nurse T Blue, or Dr O'Hare.

(16) Explain whose decision it was to admit Claire at 20.45.

(a) Explain why the admission did not occur earlier than 20.45.

It appears to have been Dr O'Hare's decision to admit Claire, and that would be consistent with practice in the A/E at the time.

(17) Describe the equipment, service and facilities available to RBHSC patients in RBHSC and on the RVH site in October 1996:

(a) During working hours (09.00-17.00) Monday - Friday

(b) Out of hours (17.00-09.00) Monday - Friday

(c) At weekends

for carrying out a paediatric

(i) CT scan

(ii) MRI scan and

(iii) EEG.

I do not recall the equipment, service and facilities of the RBHSC at that time. If I felt that a child in the A/E needed a CT scan urgently, then that child would have required admission, and so my course of action would have been the same, to contact the medical registrar.

(18) Identify the other medical or clinical staff who would be required to carry out and report a paediatric:

(a) CT scan

(b) MRI scan and

(c) EEG

and describe their availability:

(i) During working hours (09.00-17.00) Monday - Friday

(ii) Out of hours (17.00-09.00) Monday - Friday

(iii) At weekends.

in October 1996.

I do not recall the staffing details of the RBHSC at that time. If I felt that a child in the A/E needed a CT scan urgently, then that child would have required admission, and so my course of action would have been the same, to contact the medical registrar.

(19) State whether you considered requesting:

(a) a CT scan and/or

(b) an MRI scan and/or

(c) an EEG

on examining Claire on 21st October 1996. If so, explain why and if not, explain why.

If I felt that a child in the A/E needed a CT scan urgently, then that child would have required admission, and so my course of action would have been the same, to contact the medical registrar.

(20) State what the threshold was for requesting a paediatric:

(a) CT scan

(b) MRI scan

(c) EEG

in RBHSC in October 1996.

If I felt that a child in the A/E needed a CT scan urgently, then that child would have required admission, and so my course of action would have been the same, to contact the medical registrar.

(21) State what authorisation was required for obtaining a paediatric:

(a) CT scan

(b) MRI scan

(c) EEG

in RBHSC in October 1996.

If I felt that a child in the A/E needed a CT scan urgently, then that child would have required admission, and so my course of action would have been the same, to contact the medical registrar.

(22) If you had requested a CT scan, MRI scan and/or an EEG of Claire on 21st October 1996 state where that would have been carried out, how long it would have taken to arrange for Claire, how Claire would have been transferred to the venue for the CT and/or MRI scan and/or EEG, whether anaesthesia or sedation was likely or necessary, and how long that journey would have taken.

I do not recall the logistics and facilities available at RBHSC at that time. I presume from subsequent experience that sedation would have been needed for an MRI but not necessarily for a CT or an EEG, however I did not document that I had assessed Claire specifically with regard to this issue.

(23) State at what time Claire left the A&E Department on 21st October 1996 to be transferred and admitted to Allen Ward.

I am unable to find a record of the time that Claire left the A/E department in the notes provided. I do not recall.

(24) Explain why no further recordings of Claire's vital signs were taken between triage admission at 19:03 and her admission to Allen Ward at 21:45 (Ref: 090-041-142).

I do not know if this was part of the normal process in RBHSC A/E at that time.

(25) Identify the paediatric consultant on call on the evening of 21st October and the morning of 22nd October 1996.

I had no further contact with Claire or her family after she was transferred out of the A/E.

(26) Identify the Consultant whom you believed to be responsible for Claire and her management, care and treatment between her admission on 21st October 1996 and her death on 23rd October 1996, and explain the basis for your belief.

I had no further contact with Claire or her family after she was transferred out of the A/E.

(27) Describe your perception of the seriousness or otherwise of Claire's condition during your care of her, and explain the reasons for your view.

I perceived Claire's condition to be serious, and that it required review by the senior doctor supervising me, admission to the hospital and further care. From the documentation it appears that my reasons are the acute presentation, the altered consciousness and the changing neurological signs.

(28) Describe your communication with Claire's parents and family and in particular:

(a) State what information you communicated to Claire's parents and family, and what information they gave to you.

(b) Identify to whom you gave this information.

(c) State when and where you told them this information.

(d) Identify where the information you communicated/received was recorded or noted.

(e) State whether you recorded Claire's parents'/family's understanding of this information and their concerns, and if so, identify the documents containing that record. If you did not record this, explain why not.

(f) State if you discussed Claire's condition at any time with her parents. If so, state when, who was present, and what was discussed, where this is noted, and if it was not noted, explain why it was not noted.

(g) State whether you informed Claire's parents/family of the diagnosis, its implications and the treatment needed, and if so, state when you provided this information, to whom and where this communication is recorded. If you did not provide this information, explain why not. If any such communication is not recorded, explain why not.

I did not document my communication with Claire's parents, but they would have been present with me as I performed my assessment. I do not recall the information conveyed.

(29) Prior to 21st October 1996:

(a) **State your knowledge and awareness of the case of Adam Strain, his Inquest and the issues arising from it**

(b) **State the source of your knowledge and awareness and when you acquired it**

(c) **Describe how that knowledge and awareness affected your care and treatment of Claire**

I had no knowledge of the case of Adam Strain, nor his Inquest.

(30) **Since 21st October 1996:**

(a) **State your knowledge and awareness of the case of Adam Strain, his Inquest and the issues arising from it**

(b) **State the source of your knowledge and awareness and when you acquired it**

(c) **Describe how that knowledge and awareness affected your work**

I had no knowledge of the case of Adam Strain, nor his Inquest.

(31) **Describe in detail the education and training you received in fluid management (in particular hyponatraemia) and record keeping through the following, providing dates and names of the institutions/bodies:**

(a) **Undergraduate level**

(b) **Postgraduate level**

(c) **Hospital induction programmes**

(d) **Continuous professional development**

I graduated from the Faculty of Medicine, Queen's University of Belfast. I was employed at the Royal Victoria Hospital and the Lagan Valley Hospital as a Junior House Officer prior to working at the RBHSC A/E as a Senior House Officer. I do not recall and do not have documentation to describe in detail the dates and specific instances of the training asked for in the question. It was part of my education at undergraduate and postgraduate levels, on several occasions, but I am unable to separate out in my memory the specific occasions.

(32) **Prior to 21st October 1996, describe in detail your experience of dealing with children with hyponatraemia, including the:**

(a) **Estimated total number of such cases, together with the dates and where they took place**

(b) **Number of the children who were aged less than 10 years old**

(c) **Nature of your involvement**

(d) **Outcome for the children**

Prior to August 1996 I had no experience in treating children. The posting to RBHSC A/E was my first paediatric posting. I do not know how many children I saw between August and October 1996, nor do I know how many of them had hyponatraemia.

(33) Since 21st October 1996, describe in detail your experience of dealing with children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place

(b) Number of the children who were aged less than 10 years old

(c) Nature of your involvement

(d) Outcome for the children

I have continued into a career in Paediatrics and specifically Paediatric Intensive Care. I have been a junior trainee, a middle grade trainee and am now a Senior Consultant and Head of Department. I would estimate the number of children I have treated with hyponatraemia to be in the several hundreds, as it is a relatively common co-morbidity associated with any number of clinical conditions. As it is not a specific diagnosis I do not have the data to describe the outcome in such a large and heterogenous group of patients.

(34) Identify any 'Protocols' and/or 'Guidelines' which governed Claire's care and treatment.

I do not recall.

(35) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The care and treatment of Claire from her attendance on 21st October 1996 to her death on 23rd October 1996

(b) Record keeping

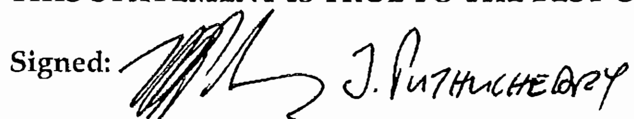
(c) Communications with Claire's family about her condition, diagnosis, and care and treatment

(d) Lessons learned from Claire's death and how that has affected your practice

(e) Current Protocols and procedures

(f) Any other relevant matter

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: 

Dated: 11/1/12