Witness Statement Ref. No. 135/1

NAME OF CHILD: Claire Roberts

Name: Dr Bernadette O'Hare

Title: Senior Lecturer in Child Health, College of Medicine, University of Malawi, Malawi

Present position and institution:

Senior Lecturer in Child Health, College of Medicine, University of Malawi, Malawi

Previous position and institution:
[As at the time of the child's death]
Specialist Paediatric Registrar in Northern Ireland Paediatric Training Rotation based at Royal Belfast Hospital for Sick Children, Belfast, and N.Ireland at the time of the child's death. Registrar training commenced January 1996, ended July 2001

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

No

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

None

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

Ref:	Date:	

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 Paediatric Registrar by the Royal Group of Hospitals (Royal) and describe your experience as a Paediatric Registrar in the Royal Belfast Hospital for Sick Children (RBHSC) and any other hospital in which you worked prior to 21st October 1996.**

At the time of the child's death, I had 9 months and 3 weeks experience as a paediatric registrar. I started my training in RBHSC 1st August 1996, having worked in the Ulster Hospital Dundonald prior to this.

(2) **Describe your work commitments to the RBHSC from the date of your appointment as a Paediatric Registrar and particularly over the period 21st October 1996 to 23rd October 1996.**

I believe I was a paediatric registrar based in Musgrave ward during the day and on call my commitments would have included responsibility for all wards in the RBHSC.

(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**

I was registrar on call on the 21st October 1996 and was in the hospital

(b) **Whether you were on call during that period**

I was the registrar on call

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

I reviewed Claire in A&E and would have had contact with her family at that time, I later reviewed her in Allen ward, I do not recall if I had contact with her family during the second review.

(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**

As registrar on call I was asked to review the patient, which I did at 8pm on 21/10/96

I noted her history of severe learning difficulties and epilepsy which was controlled in the past with Sodium Valproate. I also noted that she had not had any seizures for several years and that her anticonvulsant medication had been discontinued. I also noted that she used the left side of her body more than the right side, she could talk in complete sentences and was able to walk up and down stairs but needed supervision to feed herself and could not dress herself. On examination she did not have a fever. Her central neurological examination revealed her to have normal fundi, normal response to light, normal seventh, ninth and tenth cranial nerves. Her tone and reflexes were asymmetrical and she had bilateral clonus. It would have been difficult to ascertain, without access to old notes, how much of this asymmetry was pre-existing in view of her history and how much was due to her intercurrent illness.

My working diagnosis was a viral illness. I appear to have also written encephalitis and then deleted it. I presume my reason for deleting this as a differential diagnosis was the absence of a fever as infective encephalitis is usually associated with fever.

My initial management was to give her intravenous fluid and should there be any seizure activity to treat with intravenous diazepam and to review her after her IV fluids.

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

I reviewed Claire at 12 midnight on 21st October 1996 in Allen Ward, 4 hours after my initial review in A&E. I have recorded that she was slightly more responsive. There were no clinical signs of meningitis and in view of the improvement I have written that she could be reassessed in the morning. During the day, I was the registrar in Musgrave Ward and would have done the morning round in this ward; I therefore had no further contact with Claire.

(c) From her admission to PICU until her death

I had no responsibility for Claire after 9am 22/10/1996

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

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

In view of the vomiting I ordered that Claire should receive intravenous fluids.

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

I did not order specific observations but expected she would receive routine observations

(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 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 did not prescribe the fluids but I see that she was prescribed 64 mls of fluids per hour which is correct maintenance fluids for her weight. I did not specify which type of fluid but she was prescribed 0.18% Normal Saline which was standard IV fluids in use in paediatrics in 1996.

(7) **Identify precisely on Claire's medical notes and records the entries that you made or which were made on your direction and state below:**

(a) **when each of the identified entries was made**

090-012-014 – I wrote "admit" and signed my name

090-022-050 to 052 - First entry was made 8 pm 21st October 1996.

090-022-052 - Second entry was made 12 midnight 21st October 1996.

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

Source of information – I have not recorded the source of information but from memory I believe the source of information from the entry at 8pm was Claire's parents, possibly her mother.

I have not recorded the source of information for the 12 MN entries but it appears to have been made after I examined Claire.

(8) **Describe and explain any discussions you had with any: (i) medical personnel and/or (ii) 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 and the date and time when each discussion took place.**

I have not recorded the discussions which took place between me and junior medical or nursing staff. Given that I have written that she was to receive IV diazepam should any seizures be witnessed my normal practice would be to communicate this both to nursing and junior medical staff.

(9) **State whether you reported Claire's condition including her blood results to any clinician at any time during that period, 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 the reasons why not.**

(e) **State the threshold for calling a consultant in RBHSC in October 1996 and explain where that is to be found or how you became aware of that threshold.**

(f) **Explain what you understood to be the RBHSC policies and procedure and practice on 21st October 1996 for keeping the consultant informed and for seeking advice when required.**

(a) I reported to no other clinician

(b) I reported to no other clinician

(c) I reported to no other clinician

(d) I reported to no other clinician

(e) and (f)) I do not recall there being a specific policy or procedure for calling a consultant or keeping the consultant informed in October 1996 in RBHSC. There was no evening handover when the consultant and the resident on call staff would have made contact.

(10) **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**

I did not request a urine sample in A&E and I have made no record and do not recall if Claire passed urine in A&E

(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 have made no record with regard to urine analysis

(11) *"S/B Medical Reg Admit Allen Ward... Time 20.45"* **(Ref: 090-010-012)**

"Admit B O'Hare...Admit Allen Ward...

Primary diagnosis Encephalitis ?

Decision to admit time 20.45" **(Ref: 090-012-014)**

(a) Please state whether you are the Medical Registrar referred to at Ref: 090-010-012

Ref 090-010-012, Yes, I have written "admit" and signed and I was the medical registrar on call

(b) State at what time on 21st October 1996 you were called to examine Claire, who called you and why you were called.

I have recorded the time that I began my review as 8pm 21/10/96. I have not recorded who called me but the usual procedure would have been that the SHO would have called the registrar to review patients. Ref 090-022-050 to 052' and '090-022-052

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

Encephalitis? Appears to have been written by the SHO who called me to see the patient.

I have written "admit" and signed my name on the A& E sheet. (Ref: 090-010-012)

(d) 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 appear to have written on a continuation sheet in A&E at 8pm when I reviewed the patient (090-022-050 to 052). My working diagnosis was a viral illness. I appear to have also written encephalitis and then deleted it. My reason for deleting this as a differential diagnosis was the absence of a fever. Encephalitis with an infective etiology is associated with fever. I believe I also considered a subclinical seizure as I have written to give diazepam if there were any seizures observed. However, the GP, the SHO and I, who took the initial history, appear not to have elicited the history of focal signs with right sided stiffening on the day of admission. This is first recorded the following day by Dr Webb.

(e) In particular, state whether you considered hyponatraemia and/or cerebral oedema as a diagnosis, and explain the reasons why/not.

(i) If so, state why this was not recorded in Claire's medical notes.

In a child who had just presented to hospital and who had not yet received IV fluids, hyponatraemia and/or cerebral oedema would have been unusual. Claire's pulse rate on presentation was 96 beats per minute, later recorded by myself as 80 beats per minute – this is

within the normal range for her age. A child who had cerebral oedema and raised intracranial pressure would be expected to be bradycardic i.e. have a slow pulse rate.

(f) **Explain any discussions you had with the triage nurse T. Blue, admission nurse E A Jackson, Dr. Janil Pathucheary (SHO in A&E) and with Dr Andrea Volprech (SHO, Allen Ward) regarding Claire's condition and diagnosis and what tests, scans or investigations were required.**

I have not recorded discussions and do not recall the content of any discussions that I may have had.

(g) **State whether you considered monitoring Claire's intracranial pressure at any time, and if so, state when and explain the reasons why. If not, explain why not.**

In a child who had just presented to hospital and who had not yet received IV fluids, hyponatraemia and/or cerebral oedema would have been unusual. Claire's pulse rate on presentation was 96 beats per minute, later recorded by myself as 80 beats per minute - this is within the normal range for her age. A child who had cerebral oedema would be expected to be bradycardic i.e. have a slow pulse rate. Monitoring of intracranial pressure is an invasive procedure generally done in a ventilated patient in intensive care situation. Although Claire's condition subsequently deteriorated at the time of her initial presentation this would not have been indicated.

(h) **Explain why you decided to admit Claire to Allen Ward.**

My recollection of the admission procedure at the time is that Allen and Musgrave ward admitted children on alternate days. I assume it was Allen wards day for accepting all admissions.

(i) **State at what time Claire left A&E Department to go to Allen Ward.**

I reviewed Claire at 8pm and the first nursing entry was made at 9.45 pm 21/10/96 - so Claire was moved to Allen ward between these two times.

(j) **State whether you or any other person informed the Allen Ward nursing staff of *"Primary diagnosis Encephalitis ?"* made in the A & E Department. If so, state who was informed of this primary diagnosis and when they were so informed. If not, explain the reasons why not.**

There is no record, the working diagnosis after my review was a viral illness.

(k) **Identify the person(s) who was responsible for informing the nursing staff on Allen Ward of the reasons for Claire's admission and the primary diagnosis of Claire's condition.**

The nurse transferring the patient would have informed the ward nurse of the diagnosis

(12) *"21/10/96 8pm Nine year old girl admitted via A&E. Vomiting at 3.00pm and every hour since. Slurred speech & drowsy. Off form yesterday. Loose motion 3 days ago. Severe learning difficulties. Seizures 6 mths - 1 year of age controlled by Na Valproate. Age 4 - X1 seizure. Anti-*

convulsant gradually weaned until Epilim stopped ... can speak in sentences meaningful ... Dr. Gaston ... previously Dr Montague. Recently tried Ritalin – Dry mouth then became agitated. Dry mouth ... Pres, sit-up + stares vacantly ... Tone upper limb cogwheel rigidity ... (Ref: 090-022-050)

Clonus ... not responding to parents voice / intermittently responding to deep pain ... (Ref: 090-022-051)
[Diagnosis] 1. Viral illness 2. ~~encephalitis~~" (Ref: 090-022-052)

(a) **State where you examined Claire at 20.00 on 21st October 1996 and where you made these medical notes.**

A&E

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

From memory I believe it was Claire's mother

(c) **Please clarify if you were informed that Claire had one "*[l]oose motion 3 days ago*" or more than one.**

I have recorded that Claire had loose motions 3 days ago.

(d) **State whether it was you who struck out "*~~Encephalitis~~*" in Claire's medical notes.**

Yes, in A & E

(i) **If it was you, explain why you deleted encephalitis from your diagnosis.**

It appears as though I considered encephalitis but in view of the lack of fever, decided this was unlikely. I believe I also considered a subclinical seizure as I have written to give diazepam if there were any seizures observed. However, the GP, I nor the SHO who took the initial history appear to have elicited the history of focal signs with right sided stiffening on the day of admission. This is first recorded the following day by Dr Webb.

(ii) **If not, identify the person who did by name and job title.**

N/A

(iii) **State the date and time when this word was struck out and the reasons why it was struck out.**

This was struck out on 21/10/96, sometime between 8 and 9pm. It appears as though I considered infective encephalitis but in view of the lack of fever decided this was unlikely.

(e) **Explain if you considered or had any alternative diagnoses. If so, explain what they were, the basis upon which you formed them and why they were not noted in the medical notes at Ref: 090-022-052. If you did not consider or have any alternative diagnoses, then explain why not.**

It appears as though I considered infective encephalitis but in view of the lack of fever decided this was unlikely.

(f) **Explain why hourly neurological observations or more frequent observation of vital signs were not commenced on Claire's admission or at any time prior to 13.00 on 22nd October 1996.**

I cannot explain

(g) **On the basis of your observations at 20.00, state what you would have considered Claire's Glasgow Coma Scale reading to have been and the reasons for this score.**

I did not record the Glasgow Coma Score

(h) **On the basis of your observations, state how serious you considered Claire's presentation to be at the time of admission.**

It was difficult to ascertain how unwell Claire was in view of her history of severe developmental delay; however I viewed her as sufficiently unwell to warrant a registrar review later in the evening after the initial intervention of IV fluids.

(i) **State whether you or any other person informed the Allen Ward nursing staff of your diagnosis of "*1. Viral illness 2.* ~~*encephalitis*~~" made on Claire's admission to Allen Ward. If so, state who was informed of this diagnosis and when they were so informed. If not, state the reasons why not.**

This normally would have been the responsibility of the staff transferring Claire from A &E to Allen Ward

(j) **Identify the person/s who were responsible for informing the nursing staff on Allen Ward of the reasons for Claire's admission and the ongoing diagnosis of Claire's condition.**

This normally would have been the responsibility of the staff transferring Claire from A &E to Allen Ward

(k) **Explain what information you provided to Staff Nurse Geraldine McRandal prior to 21.45 on 21st October 1996 about the reason for Claire's admission and about her Claire's diagnosis, and identify who provided that information to S/N McRandal. In so far as you can, identify any other person who did or was likely to have provided her with such information prior to that time.**

The information provided to the staff nurse on Allen ward would have been the admission note written in A&E and my assessment and the information given by the nurse transferring the child from A&E to Allen Ward.

(13) *"inv. FBC*
U&E
BCx
Viral titres ..." **(Ref: 090-022-052)**

(a) Identify the person who took a blood sample from Claire on 21st October 1996 between her admission to Allen Ward and midnight on 22nd October 1996.

It is not recorded and I do not recall

(b) State the time at which that blood sample was taken from Claire.

'The two reports are in the notes at 090-030-094 and 090-030-097

(c) State whether you considered carrying out more extensive biochemical tests including liver function tests, calcium, glucose, ammonia and toxicology on Claire's admission to Allen Ward. If not, explain why. If you did, then explain why these tests were not conducted at this stage.

There was no history of intoxication and I did not consider sending laboratory tests for toxicology at this stage. There was no history to indicate liver disease and she was not jaundiced and there was no hepatomegaly on examination so I did not consider doing liver function tests at this stage. She did not demonstrate any signs of deranged calcium. There was no history of ingestion of aspirin to indicate a possible Reyes syndrome so I did not consider checking her ammonia. However given that she was a child with developmental delay it would have been reasonable to check her ammonia should her altered state of consciousness persist. It would also have been reasonable to check her blood sugar level in view of the vomiting; however hypoglycaemia in a child of this age after fasting/vomiting would have been unusual.

(14) *"Urine direct √*

O+ S √" **(Ref: 090-040-140)**

(a) State the results of the analysis of the urine samples taken on the ward.

Urine microscopy and culture were negative.

(b) Identify where these results are noted or recorded, and by whom the record or note of the results was made.

The two reports are in the notes at 090-030-094 and 090-030-097.

(c) If there is no note or record of them, explain why not.

N/A

(d) State whether you were aware of and took account of the results from the urine analysis in making your diagnosis of Claire. If not, explain why not. State whether you took any

steps to ascertain these results or to repeat the urine analysis. If you did not, then explain your reasons.

The urine results were not available to me during the time i was responsible for Claire.

(e) **State whether you considered measuring Claire's urine output on admission. If not, explain why you did not consider it.**

I have not recorded that Claire was moderately or severely dehydrated and therefore her urinary output may not have routinely been monitored

(15) *"IV fluids... Re-assess after fluids"* **(Ref: 090-022-052)**

(a) **Identify the person who prescribed the type and quantity of IV fluid and rate of administration to Claire.**

I cannot read the signature of the person who prescribed the IV fluids; the usual practise would have been for the senior house officer on the ward to prescribe the fluids.

(b) **Explain the reasons for the choice of this type and quantity of IV fluid and the rate of administration.**

Claire was administered IV solution of 0.18 Saline/4% dextrose as this was the standard fluid in use in paediatrics at this time. The rate is maintenance IV fluids for a child of her weight, to calculate maintenance fluids for a child see 15(g) below.

(c) **Explain why Claire was administered IV solution of 0.18 Saline/4% dextrose on admission when she had been** *"Vomiting at 3pm and every hour since"* **(Ref: 090-022-050).**

This was the standard fluid in use in paediatrics at this time and the prescribing SHO would have prescribed these fluids unless there was a clear indication to do otherwise such as an abnormal urea and electrolyte result or on instructions from a senior member of staff.

(d) **Explain why you continued to administer IV solution of 0.18 Saline/4% dextrose to Claire on 22nd October 1996 when on admission she had been** *"Vomiting at 3pm and every hour since"* **(Ref: 090-022-050), and she continued to vomit frequently overnight (Ref: 090-038-133).**

This was the standard fluid in use in paediatrics at this time. At the time they were prescribed there was no urea and electrolytes result available and the blood would have just have been drawn at the time the fluids were erected.

(e) **Describe any monitoring of Claire's consciousness you directed or arranged following her admission to Allen Ward, state when you directed/arranged this and who was responsible for that monitoring of Claire and any record made thereof.**

I have not indicated monitoring but would have expected that the usual temperature, pulse rate, respiratory rate to have been recorded. It was normal procedure for all admitted children to have

these routine observations performed. This would generally happen without instructions from any doctor.

(f) Describe any monitoring of Claire's serum sodium concentration you directed or arranged following her admission to Allen Ward, state when you directed/arranged this and who was responsible for that monitoring of Claire and any record made thereof.

I requested urea and electrolytes at my initial review at 8pm.

(g) Explain the method of calculating Claire's fluid requirements at that time.

There are several ways to calculate maintenance fluid

The most commonly used one is to

Give 100mls per kg for the first 10kg of the child's weight

For the next 10kg we give 50mls per kg

For the remaining weight we give 20mls per kg

So for example if a child weighs 15kg they will get 10x100mls = 1000mls plus 5x50mls = 250mls. This totals 1250 mls per 24 hours. The child will receive 1250/24 = 52 mls per hour

For a child who weighs 24 kg as in Claire's case will get 10x100=1000 plus 10x50 = 500 plus 4 x20 =80 giving a total of 1000 + 500 + 80 = 1580 mls over 24 hours or 64 mls per hour.

This is similar to what was prescribed and what she received.

(h) State whether you considered prescribing restricted fluids. If so, explain why you did not prescribe them. If you did not consider this, explain why not.

It would not have been usual to restrict fluids in a child who was vomiting unless the electrolytes indicated that they were significantly hyponatraemic.

(i) State whether or not you regarded Claire as dehydrated or potentially dehydrated when she was admitted and explain the basis for your view.

I have not recorded that Claire was moderately or severely dehydrated and her pulse rate was normal so it is unlikely that she was severely dehydrated.

(j) State whether or not you were aware of the possibility of inappropriate ADH secretion in Claire's case on 21st and 22nd October 1996 and explain the basis for your view. If you were aware of that possibility, then state whether and how you modified Claire's management and IV fluid regime to address it. If you made no modifications to the IV fluid regime, explain why not.

On admission I had not considered this diagnosis, she was a child with severe developmental delay who had been vomiting and I considered an electrolyte imbalance which may respond to IV fluids.

(k) **State whether there was any reassessment of Claire *"after fluids"*, and if so, identify who carried out that reassessment, when it was carried out, its outcome and where it is recorded in Claire's medical notes. If there was no reassessment, explain why not.**

I reviewed Claire at 12 midnight on 21st October 1996, 4 hours after my initial review. I felt she was slightly more responsive. There were no clinical signs of meningitis and in view of the improvement I have written that she could be reassessed in the morning. The nursing note records her as being much brighter and more alert at 7am and I was not contacted about her before the day team took over her care.

(16) **In assessing, determining and reviewing Claire's fluid management, state and explain what (if any) consideration you gave on 21st, 22nd and 23rd October 1996 to:**

(a) **Fluid restriction in Claire's case**

On initial review in A& E, I did not consider fluid restriction, see 15 (h)

On my subsequent review in Allen Ward, when I had the results of the U& E, it does not appear as though I made changes to the fluid regime.

A Sodium of this level is not unusual in children who have been vomiting and would not routinely have triggered a change in the child's fluid regime, especially when she would have been on these fluids for a very short time, if at all, when the blood was drawn. The blood probably was drawn when the canula was inserted which means the U&E result is a reflection of her blood electrolytes prior to any IV fluid administration.

(b) **Use of a higher NaCL concentration containing fluid**

At this time in paediatrics it was standard to use 0.18% Normal Saline

(c) **Claire's urine output, urine sodium and urine osmolality**

Urinary sodium and osmolality would not have been available after hours and in hours a result would not have been available for 1-2 days, as I recall

Identify where any such consideration is recorded in Claire's medical notes. If you did not consider any of these factors, explain the reasons.

(17) *"12MN Slightly more responsive. No Meningism· Observe and reassess AM"* (Ref: 090-022-052)

(a) **State and explain the basis upon which you formed the view that Claire was *"Slightly more responsive"*, including describing any examination you performed or observations you made. If it was on the basis of information reported to you, then identify the person and state the information they provided.**

I believe this was on my own assessment as I have written no meningism. I presume, but I have made no record, I discussed her condition with the nursing staff and junior medical staff. I do not recall if I discussed her condition at this review with her parents.

(b) **State whether or not you were aware of the blood and urine sample results at this time. If so, explain what effect (if any) they had on your assessment of Claire's condition.**

The urea and electrolyte looks as though it was written by me, the FBC results are not in my handwriting.

(18) *"Na 132 ↓... WCC 16.5↑"* **(Ref: 090-022-052)**

(a) **State on what date and at what time you received Claire's U&E serum results and by what means you were made aware of them. State also the time at which these results were recorded in Claire's medical notes at Ref: 090-022-052.**

There is no record of the time that the results are written but I presume I wrote the U&E results after the review at 12MN.

(b) **State whether you assessed the blood electrolytes and white cell count results at any time. If so, state when and how.**

I do not believe I reviewed the FBC results, the U&E results I seem to have noted the slightly low Sodium, at 132, as indicated by the arrow, normal range 135-145.

(c) **Explain whether or not you reviewed Claire's fluid regime in light of the results and explain the reasons for either doing so or for not doing so.**

It does not appear as though I made changes to the fluid regime. A Sodium of this level is not unusual in children who have been vomiting and would not routinely have triggered a change in the child's fluid regime, especially when she would have been on these fluids for a very short time, if at all, when the blood was drawn. The blood probably was drawn when the canula was inserted which means the U&E result is a reflection of her blood electrolytes prior to any IV fluid administration.

(d) **State whether or not you drew Claire's U&E serum results to the attention of a more senior clinician. If so, explain your reasons identify the clinician and state when and how they were contacted, and what action (if any) resulted. If not, explain you reasons.**

I did not, for the reasons please see answer to 18c.

(e) **Having received Claire's serum sodium result, state whether or not you gave consideration to carrying out another blood test to check her serum sodium levels. If you did, then state when you did so, explain your reasons, what view you formed as to what to do and the basis for that view. If you did not consider it, explain why not.**

I have written for further assessment in the morning, the blood may have been drawn when the canula was inserted which means the U&E result is a reflection of her blood electrolytes prior to any IV fluid administration.

(f) **State whether you discussed with a more senior clinician carrying out a further blood test, for serum electrolytes and if so, identify that clinician and state when this discussion took place.**

I did not, for the reasons please see answer to 18c

(g) **State whether any decision was made as to whether a further such test was to be conducted on Claire, and if so, what that decision was.**

The was no decision beyond to reassess in the morning.

(h) **Explain the reasons for not carrying out a further electrolyte test until the evening of 22nd October 1996.**

I was not responsible for Claire after 9 am on 22 October 1996

(i) **State what consideration you gave to prescribing a higher concentration of salt containing fluid regime on receipt of the serum sodium results at midnight. If you did not consider this, explain why not.**

The fluid regime which Claire was receiving was standard at that time; this level of hyponatraemia is something which we commonly see in children.

(j) **State whether you considered prescribing restricted fluids on receipt of the serum sodium results at midnight. If you did not consider this, explain why not.**

I cannot recall if I considered this, I do not appear to have ordered her to be placed on restricted fluids.

(19) **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.**

CT available in hours, I do not recall how difficult it was to arrange out of hours or at the weekends

MRI - I do not believe it was available

EEG was only available within working hours

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

(a) **CT scan**

Neuroradiologist

(b) **MRI scan and**

Neuroradiologist

(c) **EEG**

EEG – Paediatric neurologist or neurophysiologist

and describe their availability:

(i) **during working hours (09.00-17.00) Monday – Friday**

Available

(ii) **out of hours (17.00-09.00) Monday – Friday**

Neuroradiology - I cannot comment for 1996

Neurophysiologist – working hours

Paediatric neurologist – I cannot comment for 1996

(iii) **at weekends.**

EEG not available out of hours or at the weekend as far as I can recall

Neuroradiologist – I cannot comment for 1996

in October 1996.

(21) **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 and 22nd October 1996. If so, state why and if not, state the reasons why.

I did not consider requesting these investigations as I felt the first step was a period of observation after IV fluids

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

(a) **CT scan**

(b) **MRI scan**

(c) **EEG**

in RBHSC in October 1996.

I believe a CT scan would have been ordered after consultant review, EEG after consultant neurologist review in 1996

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

(a) **CT scan**

(b) **MRI scan**

(c) **EEG**

in RBHSC in October 1996.

As in 22

(24) **If you had requested a CT scan, MRI scan and/or an EEG of Claire on 21st or 22nd 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 cannot comment for 1996

(25) **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 cannot explain

(26) **Identify the paediatric Consultant on call on the evening of 21st October and the morning of 22nd October 1996.**

I do not know

(27) **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 do not know who was on call on 21st October 1996. The consultant in Allen ward would have been responsible from 9am on 22 October 1996

(28) **Identify the members of the medical team on duty between Claire's admission on 21st October 1996 and her death on 23rd October 1996, and the positions each person held during that period.**

I was the registrar on call 21st October 1996; I cannot remember the other members of staff on call

(29) **Identify the members of the Allen Ward nursing team on duty between Claire's admission on 21st October 1996 and her death on 23rd October 1996, and the positions each person held during that period.**

Due to the time lapse I cannot comment

(30) **In October 1996 state whether nursing care was prescribed by doctors, nurses or both.**

From memory, I believe by both doctors and nurses

(31) **Identify the ward sister/nurse in charge of Allen Ward between 21st and 23rd October 1996.**

I cannot recall

(32) **Describe the communications that you had with the Consultant responsible for Claire on her admission, including:**

(a) **Time of each communication**

(b) **Means by which the communication was made**

(c) **Nature of each communication**

(d) **Whether any advice or direction was given by the Consultant in relation to Claire's treatment and care. If so, describe the nature of that advice or direction**

(a-d) I do not believe I communicated with the consultant on call on the night of 21st October 1996 as I have not recorded any such contact.

(33) **State what communication you had with Dr. Heather Steen in relation to Claire between 21st October 1996 and c. 04.00 on 23rd October 1996 including:**

(a) **The date and time each communication was made, and the means by which communication was made e.g. in writing, telephone, in person etc.**

(b) **Identify who initiated each communication and the reason for each communication being made.**

(c) **State what information you gave Dr. Heather Steen about Claire during each communication.**

(d) **State what advice or instructions Dr. Heather Steen gave you in relation to Claire on each occasion and what the plan of care was for Claire following each communication.**

(e) **Identify any document where each communication is recorded and produce a copy thereof.**

(a) to (e) I do not recall and have not recorded any communication with Dr Heather Steen

(f) **If no communication was made, explain why not.**

If I had decided to call the consultant on the night of 21st October it would have been the on call consultant - I do not know who this was and I have not recorded any contact which I generally would do.

(g) **State whether Dr. Heather Steen attended and examined Claire at any time between Claire's attendance at A&E on 21st October 1996 and Claire's death on 23rd October 1996. If so, state the date, time and location of that attendance and examination.**

At 9am 22nd October 1996, Claire's care was taken over by the Allen Ward team and I had no further input to her care. The registrar covering Allen ward would then have taken over her care and communicated with the consultant as they felt warranted. I do not know what contact was made with Dr Heather Steen.

(34) **Identify the Paediatric Registrar to whom you 'handed over' Claire's management, treatment and care, and the time at which you handed over this care.**

(a) **State what information you gave that Registrar about Claire's condition, care, treatment and plan of care.**

In 1996 there was no system of handing over patients between shifts as far as I recall, each of us went to our wards and started our ward rounds first thing in the morning. Critically unwell patients who required immediate review would have been identified to us by the nurses on the ward.

(35) **Explain the nature and status of the document entitled *"Discharge/Transfer Advice Note"* at Ref: 090-007-009. Identify who completed that document and state when and where it was completed.**

I do not know who completed this document

(36) **State whether you are a member of a medical defence organisation, and if so, state whether you have communicated with that organisation in relation to the treatment and death of Claire, and if so, state when you communicated with it.**

(37) **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 believe Claire was unwell but was difficult to assess in view of her past medical history. The absence of a fever made infectious encephalitis less likely. In view of her history of epilepsy the possibility of non convulsive status was a possibility but there were no visible seizures on admission and EEG out of hours was not routinely available. On her admission I felt an initial period of observation with a review was warranted. I was reassured by her review at midnight that there was some improvement in her condition.

(38) **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 that information.**

(c) **State when and where you gave them that information.**

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

(e) **State whether you recorded the understanding of Claire's family of that information and their concerns. 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 not.**

(g) **State whether you informed Mr and Mrs Roberts about the severity of Claire's condition whilst they were in attendance on 21st and 22nd October 1996.**

(h) **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 have not recorded what information I gave to the family and cannot recall. The information they gave to me is as I have recorded.

(39) **Prior to 23rd 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 do not remember what my knowledge and awareness was of the case of Adam Strain in October 1996

(40) **Since 23rd 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 have no knowledge of this case.

(41) **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**

How to calculate maintenance fluids

(b) **Postgraduate level**

How to calculate maintenance fluids

(c) **Hospital induction programmes**

Hospital induction – none that I recall

(d) **Continuous professional development**

CPD – I have attended several APLS courses

(42) **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**

I do not recall managing any children with severe hyponatraemia prior to 1996

(43) **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 managed a few cases of severe hyponatraemia since 1996. I would have prescribed IV fluids.

The outcome was good.

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

I cannot recall any protocols, however she would have received usual maintenance fluids unless she was clinically dehydrated and the usual choice of fluids at that time was 0.18% normal saline.

(45) **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:

Tughans

Ms Anne Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast BT1 4GB

Our Ref: AFA/AYW/CD/SC/3M D28022

Your Ref:

Date: 5 October 2012

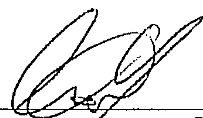
Dear Ms Dillon

OUR CLIENT: Dr B O'Hare

I refer to the above and would like to draw your attention to an error that Dr O'Hare has recognised in her statement. Her answers provided in her statement, particularly at paragraph 18, were prepared by her under the mistaken belief that she made the entry in the records at 090-022-052 which listed the Sodium result of 132. She has now realised that in fact that note was made by another Doctor. Her note on page 090-022-052 seems to end with her signature, just before the test results are recorded. This mistake may have an impact on her evidence. Should the inquiry have any questions that they wish her to answer before she gives evidence, please let us know and we will do all that we can to provide her answers in advance of her giving evidence. Alternatively these issues may need to be dealt with in the context of the oral hearings. In either event, we confirm that we have no objection to this letter being shared with the other interested parties so that they have advance notice of this issue.

We apologise for any inconvenience this causes. We hope the inquiry will recognise that errors of this nature can occur in cases where doctors have to review photocopies of records that were made many years ago.

Yours sincerely



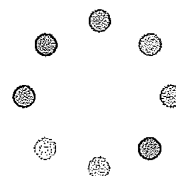
CONRAD DIXON
conrad.dixon@tughans.com

Marlborough House
30 Victoria Street
Belfast BT1 3GG

T 028 9055 3300
F 028 9055 0096
DX 433 NR Belfast 1

W www.tughans.com
E law@tughans.com

In association with
William Fry Solicitors, Dublin



A list of our partners is available for inspection at the above office.
Regulated by The Law Society of Northern Ireland.