Witness Statement Ref. No. 137/3

NAME OF CHILD: **Claire Roberts**

Name: Andrew Sands

Title: Dr.

Present position and institution:

Consultant Paediatric Cardiologist, Royal Belfast Hospital for Sick Children ("RBHSC")

Previous position and institution:
[As at the time of the child's death]
Registrar in Paediatrics, RBHSC

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between October 1996-August 2012]

Chair of Northern Ireland Paediatricians in Training 2000-2002
Chair of appointments committee for regional 2nd Term Paediatric Senior House Officers 2004 -2006
Regional Medical Cardiology Committee Co-Chair 2008-currentMember of Belfast Trust Drugs & Therapeutics Committee since June 2010.
Clinical lead for paediatric medicine. Women and Child Health division. BHSCT (since 1st December 2011)

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

As listed below

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

Ref:	Date:	

090-051-157	6th July 2005	Statement to the Inquest
091-009-055	4th May 2006	Deposition to the Coroner
WS-137/1	23rd December 2011	Witness Statement to the Inquiry
WS-137/2	18th June 2012	Witness Statement to the Inquiry

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 such a number then please provide a copy of the document.

1. **Please provide the following information:**

As per my CV previously provided for the inquiry

(a) **State your medical qualifications as of 1996;**

MB, BCh, BAO, MRCP

(b) **State the date you qualified as a medical doctor;**

Qualification from QUB 29th June 1992

(c) **Describe your career history before you were appointed Registrar in Paediatrics, RBHSC;**

The posts held are listed in reverse chronological order.

Locum Registrar - Paediatric Cardiology - Royal Belfast Hospital for Sick Children 1st April 1996-6th August 1996
Senior House Officer - Paediatric A+E - Royal Belfast Hospital for Sick Children 7th February 1996-31st March 1996
Senior House Officer - Neonatology - Royal Maternity Hospital
1st November 1995-6th February 1996
Senior House Officer - Paediatric Cardiology - Royal Belfast Hospital for Sick Children
2nd August 1995-31st October 1995
Senior House Officer - Paediatrics and Neonatology - Craigavon Area Hospital
3rd August 1994-1st August 1995
Senior House Officer - Paediatrics - Royal Belfast Hospital for Sick Children
2nd February 1994-2nd August 1994
Senior House Officer - General Medicine - Mater Infirmorum Hospital
3rd August 1993-1st February 1994
Pre-Registration House Officer - Royal Victoria Hospital
5th August 1992-2nd August 1993

(d) **Describe your work commitments at the RBHSC from the date of your appointment to October 1996;**

I was appointed as a registrar in Paediatrics from 7th August 1996. I worked as part of the Allen Ward clinical team under consultant supervision. I cannot recall specific daily commitments. However the post entailed inpatient clinical work, including ward rounds, patient's admissions and discharges. There were also outpatient commitments plus on-call rota. In addition there would have been regular teaching commitments plus administration duties (letters etc) in relation to clinical duties.

(e) **Was there a written job description for your post in 1996? If so, please provide copy of the same. If not, what were the functions and responsibilities of the post?**

I do not recall if there was a written job description for my post in 1996. There may have been a generic job description for the post of paediatric registrar. I do not have a copy of such a document.

(f) **Describe the accountability of the Registrar in Paediatrics RBHSC at that time.**

To the best of my recollection, a registrar in paediatrics at that time would have been assigned to a particular ward in the hospital. This may have been a general paediatric or speciality ward. A one year rotation for example may have incorporated both a general paediatric attachment and also attachment to one or more speciality wards. Depending on the attachment, a registrar would have carried out inpatient and outpatient duties under consultant supervision. The registrar would be responsible to all consultants attached to that particular ward and also would have acted under instruction from other hospital consultant specialists. Each attachment would have included working out of hours on an "on-call" rota (resident in the hospital). I do not recall the frequency of "on-call" at this time. Registrars worked within clinical teams, comprising other junior medical staff (registrars, senior house officers and nursing staff).

2. **Please specify all investigations in relation to the treatment and death of Claire Roberts.**

I do not recall any investigations in relation to Claire's death (aside from the Coroner's inquest). I am aware of the subsequent PSNI investigation.

3. **Please state when you were first informed about the death of Claire Roberts.**

I recall Dr. Bartholome advising me of Claire's collapse in Allen ward. This may have been on 23rd October 1996 or shortly afterwards. I do not recall if I was actually told of Claire's death at that time.

4. **Did you ever revisit the medical notes of Claire Roberts in either 1996 or 2004?**

Having met Claire's parents on the morning of 11th November 1996, I made an entry in Claire's notes later that day. I also had sight of Claire's notes again when asked about Claire by Dr. Steen in 2004 (prior to the meeting with Dr. Nichola Rooney). I do not believe I viewed the notes in the interim.

5. **Why did you not report the death of Claire Roberts to the Coroner?**

In my opinion, this would have been a decision for senior medical staff present at Claire's death.

6. **Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose.**

I was asked to make a written statement by HM Coroner in relation to the inquest into Claire's death. I believe this request was made via Mr. Peter Walby in or around March 2005.

7. **To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?**

Beyond my response to (3) I do not recall discussion regarding Claire's death.

8. **Please state whether you regarded the death of Claire Roberts as 'expected' or 'unexpected'.**

Whilst I felt Claire to be neurologically unwell, I still did not expect to hear of her death.

9. **Was there a heightened awareness amongst clinicians in the RBHSC in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?**

I do not know if there was a heightened awareness.

10. **Please specify all meetings, discussions, reviews and audits which took place touching on the death of Claire Roberts; identifying those who attended the meetings, where such meetings took place and whether a note was taken of the same.**

I am not aware of any such meetings in relation to Claire, until 2004. The meeting with Dr. Rooney, Professor Young, Dr. Steen, Claire's parents and myself has been recorded. (ref 089-002). Prior to Claire's inquest, I recall meeting with members of the Trust's legal team. I believe this meeting took place in Bostock House, on the Royal Victoria Hospital Site.

11. **Please provide information detailing those meetings which took place:**

   (a) **Before the Autopsy report became available;**

   In the clinical notes, I have recorded a meeting I had with Claire's parents on 11th November 1996. This was not a planned meeting. I believe the Autopsy Report was not available at this time. This meeting took place in Allen Ward (RBHSC).

   (b) **After the Autopsy report became available.**

   I am not aware of what other meetings took place (either before or after the autopsy report was available), aside from that recorded on 07th December 2004. (089-002). I also recall meeting with members of the Trust's legal team prior to Claire's inquest.

12. **Did the Pathologist attend the meeting(s), and if so please identify who the Pathologist was?**

The pathologist did not attend the meetings to which I have referred in answer to (10).

13. **Was any learning gained from any such meetings? If so, what?**

I do not know if particular learning was gained from the meetings mentioned. I do not recall if there were other meetings held following Claire's death.

14. **Please state whether you played any role in mortality meetings/discussions? If so, what was that role?**

I do not recall playing a role in mortality meetings/ discussions.

15. **Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for admittance of children to PICU; and if there was doubt as to admission, whether a PICU consultant would have been asked for advice in relation to the same.**

I am unaware of any guidelines at that time. I believe admission to PICU would usually be arranged between consultant staff. However, in an emergency such as cardiac/respiratory arrest,

I do not believe that such a convention held.

16. **Was there any appraisal of staff performance in the aftermath of Claire's death?**

I am not aware of any such appraisals.

17. **Did any change in the training/teaching provided by the RBHSC / Trust to clinicians result from Claire's death?**

I do not know if a change in teaching/training resulted from Claire's death. However, significant changes were made to teaching on fluid management, over a period of time, since Claire's death.

18. **With respect to the biochemistry reports (Ref: 090-030-094 *et seq*) sought and received in the course of Claire's treatment, please state:**

(a) **Whether the pro-forma notification report form was subsequently amended to communicate the timing of sample, analysis and report? If so when and upon whose instruction;**

I do not know if the report was amended.

(b) **Whether any complaints or requests were made in relation to report forms before or after the treatment and death of Claire Roberts?**

I do not know if any such complaints or requests were made.

19. **Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts and whether you would have expected statements to have been obtained from the nurses in respect of same?**

As a junior doctor at the time, I am unable to answer this question.

20. **Was there an audit of the following aspects of the case of Claire Roberts:**

(a) **Record keeping;**

(b) **Drug prescription and administration?**

I am unable to recall an audit of either of these aspects of Claire's care.

21. **Do you think that there was an iatrogenic contribution to the death of Claire Roberts?**

I feel that this is a question best addressed by relevant expert witnesses.

22. **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that care and treatment to have been investigated?**

I do not know what consideration was given to Claire's care, following her death. However, if medical or nursing care was felt to be inadequate or inappropriate, I would have thought further investigation would have been carried out. Claire's death may have been discussed at the RBHSC clinical audit meeting. However, I have no recollection of this.

23. **In October 1996 were you aware of:**

(a) **Circular ET 5/90 (as amended) January 1991?**

(b) **A Charter for Patients and Clients (Northern Ireland Health and Personal Social Services) March 1982:**

(c) **Welfare of Children and Young People in Hospital (HMSO 1991).**

In relation to (a,b,c) – I do not recall if I was aware of these documents.

24. **Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996? If so how did it affect the advices given to you or others in respect of:**

(a) **Communication with patient's parents and record of the same;**

(b) **Investigation of patient's death;**

(c) **Review of medical records;**

(d) **Systematic programme of audit;**

(e) **Implementation and compliance with published guidance?**

I do not recall being aware of this audit.

25. **When do you believe the following individuals become aware of the death of Claire Roberts:**

(a) **Dr. George Murnaghan;**

(b) **Dr. Elaine Hicks;**

(c) **Dr. Ian Carson;**

(d) **Mr. A.P. Walby;**

(e) **Miss Elizabeth Duffin.**

I do not know when these individuals became aware of Claire's death.

26. **Please provide details of any changes in patient care relevant to hyponatraemia between the death of Adam Strain in 1995 and the admission of Claire Roberts, including:**

(a) **Any changes that you made in respect of your own practice;**

(b) **How such changes were formulated and disseminated;**

(c) **To what extent any such changes affected or informed your approach to the treatment of Claire Roberts, or her treatment in general.**

In respect of (a,b,c) – I do not recall any changes in patient care. I was not aware of Adam's case, prior to Claire's admission.

27. **Did you learn any lessons from the death of Claire Roberts and with hindsight were lessons to be learned from it? If so, what were those lessons?**

I do not recall if I personally learnt any lessons from Claire's death (at the time). However, I

believe that fluid management of children in hospital and awareness of hyponatraemia has changed significantly since 1996. On reviewing Claire's notes in relation to her inquest and the Inquiry, I believe that some learning points are reinforced. These relate to medication prescription, documentation, clear establishment of consultant to patient responsibility, fluid management and request and follow-up of tests/investigations.

28. Please identify whether any lessons deriving from the case of Claire Roberts were disseminated either before or after the Inquest. If so please state how, where, when and to whom.

I am not aware of the dissemination of such information, before or after Claire's Inquest.

29. With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts?

I do not know if Claire's death could/should have resulted in heightened awareness of hyponatraemia at that time. However, there is clearly a heightened awareness now. This was probably a gradual process initially. I believe guidance may have been issued by the Department of Health in 2004. There was a NPSA alert in 2007 and subsequent RQIA assessment and advice.

30. Please describe how the 'culture' within the RBHSC has changed since 1996?

I believe there is a much greater awareness of hyponatraemia and indeed the potential hazards of intravenous therapy since 1996. It seems likely that individual patients, and their course have influenced doctors and nurses alike. I believe that the Inquiry itself has raised awareness further still. The cumulative result is "ward posters" and a modified fluid balance prescription, which describes how fluids are to be prescribed and monitored. I do not have these in electronic form though they should be available from the BHSCT governance department. Fifth normal saline is now used only in exceptional circumstances and I believe that junior doctors beginning attachments in RBHSC are given instruction on these matters during hospital induction. Senior doctors are required to undertake a learning module on hyponatraemia as part of annual appraisal.

31. Was any consideration given to inviting external specialists to review the case of Claire Roberts?

I do not know whether consideration was given to this.

32. Please state whether you received any training or guidance prior to October 1996 in relation to:

(a) Communication with parents of child patients;

Although, I do not recall specific training, undergraduate training would have included some communication skills assessment and training. Additional postgraduate instruction in this would have been ward based as part of daily work (from senior doctors).

(b) Recording of such communication;

See answer to (a)

(c) Timing and procedure for admission to PICU;

I do not recall specific training or guidance in this matter.

(d) **Obtaining access to CT/EEG facilities;**

I do not recall specific training or guidance in this.

(e) **Formulation of differential diagnoses;**

Although, I do not recall specific training, undergraduate training would have included some instruction in this. Additional postgraduate instruction would have been ward based as part of daily work (from senior doctors) and through taking professional examinations such as MRCP.

(f) **The process of U&E tests and checking and recording of results;**

Although, I do not recall specific training, undergraduate training would have included some instruction in this. Additional postgraduate instruction would have been ward based as part of daily work (from senior doctors) and through taking professional examinations such as MRCP.

(g) **The procedures for junior medical staff to inform consultants of changes or concerns especially after hours or when the consultant was unavailable;**

I do not recall specific instruction in this matter.

(h) **Procedure when significant errors are made in drug administration;**

I do not recall specific instruction in this matter. However, if a drug error was recognised, I would expect it to brought to the attention of a consultant and senior nurse.

(i) **The administration of the initial dose of an IV infusion of drugs;**

I do not recall specific instruction in this matter.

(j) **On the provision of care for children with known learning disabilities;**

I do not recall specific instruction in this matter.

(k) **On the filing of all relevant records including post-mortem outcomes with the case notes.**

I do not recall specific instruction in this matter.

33. **In respect of the Forfar and Arneil *"Textbook of Paediatrics"* please state:**

(a) **Whether this was known to you in October 1996;**

It was known to me in October 1996.

(b) **Whether this was in use in the RBHSC in October 1996;**

I do not recall specifically, but believe one or more copies would have been available in the RBHSC in October 1996.

(c) **Whether this was available to staff in the RBHSC in October 1996;**

See (b)

(d) **If this text was not available or commonly in use in the RBHSC in October 1996 please state what text was.**

I believe Nelson's Textbook of Paediatrics may also have been used and perhaps more frequently.

34. **Were you aware of the Arieff et al (BMJ 1992) paper *"Hyponatraemia and death or permanent brain damage in healthy children"* in 1996?**

I do not recall if I was aware of this paper.

35. **In respect of your meeting with Mr. and Mrs. Roberts on 11th November 1996 (Ref: 091-009-059) please state:**

(a) **Did you attempt to locate Drs. Steen and Webb?**

As I recall Claire's parents arrived on the Ward and Dr. Steen was unable to attend. I was advised of this by the Nurse in Charge and was asked by that Nurse to speak to Claire's parents. I do not recall if this request came from Dr. Steen by telephone, although this may have been the case. I am unaware of Dr. Webb's availability or whether I attempted to locate him.

(b) **Did you attempt to set up a meeting with Drs. Steen and Webb?**

My note states that I would speak to Dr. Steen and ask that she meet with Claire's parents, which I did.

(c) **What did you tell them in respect of the cause of Claire Roberts' death;**

I do not recall. However my talk with Claire's parents would probably have entailed expressing my condolences and listening to their concerns, as well as giving whatever account I could of her illness. It seems I did not have immediate access to Claire's chart, as indicated by the timing of my note in relation to a meeting that morning. I would have expected detailed information in respect of the cause of Claire's death to be given by a consultant.

(d) **Why you did not record the details of these communications;**

My communication would have been at the level of a junior doctor and therefore general in nature. I have recorded a summary in the clinical notes. I would have deferred to Dr. Steen and Dr. Webb for detailed counselling. My recollection of that meeting was that Claire's parents needed to talk to a senior doctor about outstanding questions they had. I recorded that I would pass this on to Dr. Steen and did so.

(e) **Whether you had access to the clinical notes at that time;**

See answer to (c)

(f) **Why you did not inform the Roberts of a diagnosis of hyponatraemia.**

I do not recall if a low sodium level was mentioned to Claire's parents at that time.

36. *"Meningo-encephalitis is a known cause of cerebral oedema... Status epilepticus may be associated with cerebral oedema"* **(Ref: WS-137/1 p.43). In relation to these statements please confirm:**

(a) That you were of the view on 22nd October 1996 that Claire was at risk of developing cerebral oedema;

This statement was made at Claire's inquest on 4th May 2006. I do not recall my precise level of knowledge in 1996.

(b) What steps you took to obviate that risk.

I do not recall

37. **Please state, to your knowledge, whether Claire's condition and treatment was appraised by the Nursing Sister in Allen Ward?**

I do not recall.

38. **Please state why the serum sodium test was not repeated on the morning of the 22nd October 1996.**

As stated previously (WS-137-2 (Question 7). I believe it very likely that a plan to repeat electrolytes was made on the Allen Ward round of 22nd October 1996 (or shortly after). However, I believe the ward round did not reach Claire until between 11am and 12 MD. The exact timing at which this test should be repeated is unlikely to have been specified. However, I would have expected this to have been carried out within routine laboratory hours if possible. On learning of Claire's collapse from Dr. Bartholome, I recall being surprised that an electrolyte result had not been available before approx. 23.30 on 22nd October 1996. This suggests to me that I expected that the test had been repeated earlier.

39. *"I believed that [hyponatraemia] was a component of the cerebral oedema in Claire"* **(Ref: WS-137/1 p.43). In relation to this statement please confirm why you did not share this belief with Mr. and Mrs. Roberts on:**

(a) 11th November 1996 (Ref:090-022-061)

(b) 7th December 2004 (Ref: 089-002-002).

This statement was made in response to a question arising from my deposition to Claire's inquest on 4th May 2006. I do not recall whether I personally discussed the role of hyponatraemia (or a low sodium level) with Claire's parents on these occasions.

40. **Please provide any further comments you think may be relevant, together with any documents or materials.**

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

Signed: [signature] Dated: 14th September 2012.