Witness Statement Ref. No. 139/1

NAME OF CHILD: Claire Roberts

Name: Roger Stevenson

Title: Dr

Present position and institution:

GP. Mountsandel Surgery, 4 Mountsandel Road, Coleraine, BT52 1JB

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

First term Paediatric SHO, as part of the 2yr RVH Medical Rotation/Training Scheme.

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

I have not been a member of any Advisory Panels and Committees.

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

I have not been asked or made any previous Statement, Depositions and Reports in relation to this child's death.

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 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 a Medical Senior House Officer (SHO) as part of a 2yr Royal Victoria Hospital (RVH) Training scheme. I was a Medical SHO in the Mater Hospital for 6months from August 1995 to February 1996 and then the Care of the Elderly unit, RVH from February 1996 to August 1996. I started as a SHO in the RBHSC on the first Tuesday in August 1996.

(2) **Describe your work commitments to the RBHSC from the date of your appointment as a Paediatric Medical 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.**

I was a first term Paediatric SHO and we were attached to the A+E Department, Medical and Surgical wards. I was initially in the A+E department for first 2 months, then Allen Ward for 2mths and finally the surgical wards, RBHSC for the final 2 months.

I recall that the medical team consisted of the Consultants attached to Allen Ward, a Paediatric Registrar and I think 2-3 SHOs. One of these SHO had more experience and was training especially in Paediatrics. We were expected to take part in daily ward rounds, write up the notes from that ward round, undertake any blood test, and write up drug kardexes/fluid charts, request x-rays, arrange referrals to others i.e. physiotherapists/dieticians/social workers, and other specialities, when required. We were expected to clerk in new patients on the ward with planned elective patients or those admitted as an emergency from A+E. I also recall that the SHOs also were called on to cover patients in Cherry Tree House, a specialist unit for patients with Cystic Fibrosis. We were generally to assist in the day to day running of the ward and liaise with the nursing staff in the care of the patient present and deal with any problems that arose. On the ward round notes were made on each patient and a working diagnosis and plan of management was decided and discussed. The various things that were needed to be done were then delegated amongst those present. We could also involved in any discussions with the families of patients and explain the treatment planned and answer any queries/concerns they had. We were to also liaise with other specialties when appropriate when further opinion was required. As this was a training placement we would also be expected to attend educational meetings as arranged over the 6 months. We also had on call duties with a rota, when you covered the Medical wards up to a certain time in the evening then you took over SHO responsibility for the general Medical and Surgical wards.

I was working on Allen Ward on the dates given above.

(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**

To the best of my knowledge and memory, I was on duty during the day of the 22nd, within normal working hours. I was neither on call the previous night or the night of the 22nd.

I was present during the ward round for initial review following her admission the previous night.

I recall that I had little contact with Claire and her family over the rest of my shift other than administrating medication as per the instruction given by Dr Webb, Consultant Neurologist, over the afternoon of the 22nd until the end of my shift.

(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**

I was not present in the RBHSC at this time.

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

I was present during the ward round on the 22nd, to document Claire's presenting history, past medical history, her symptoms and signs following her admission the previous evening. I was also to write up any management plan and medication and fluids that were deemed appropriate during and following this ward round.

I had other responsibilities in relation to the other patients who were in Allen Ward in the course of that day.

(c) **From admission to PICU until her death**

I had no role in relation to and responsibilities towards Claire and her family at that time.

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

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

My role was to ensure that the prescribed intravenous fluids were written up, over the period of time required, as per the morning ward round. The administration and monitoring was undertaken by the nursing staff.

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

I understood that the making or recording of observations of Claire was directed by the medical staff and then undertaken by the nursing staff and that any changes were to be highlighted to the medical staff.

(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 whom 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**

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

(iv) **If you did not seek any such advice or consultation, explain why not**

No changes to the fluid regime that had been commenced at the time of Claire's admission as no further instructions were given to amend this regime following on from any clinical assessment made at the time of the morning ward round on the 22nd.

(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**

I documented the ward round findings/summary/working diagnosis, 090-022-052,053. I documented the dosage of medication as advised by Dr Webb, Neurologist, 090-022-054,055. I completed a fluid chart, 090-038-136. I made entries to the drug kardex, 090-026-075.

(8) **State precisely whether and how you communicated the diagnosis of Claire's condition during and following the ward round on 22nd October 1996 to the members of the medical and nursing team, and when this was done.**

The ward round was conducted by Dr Sands on the morning of the 22nd and any notes were written up by me, during this ward round. A member of the nursing team was, as I recall, also present. Any communications were discussed within this medical and nursing team.

(9) **State whether you reported Claire's condition including her blood results to any clinician/s at any time during that period, and if so:**

(a) **Identify the clinician/s to whom you reported and state when you did so**

I documented the results of those bloods outside their normal parameters, in the notes and this was likely to have been noted at the time of the ward round, 090-022-053.

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

I am unable to recall if these results were conveyed orally during the ward round or if Dr Sands read these results for himself.

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

The results of these blood tests.

(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**

Claire was being reviewed and reassessed on this ward round following her admission the previous night. Dr Sands advised that Claire have Rectal Diazepam and that further opinion would be required from one of the Paediatric Neurologists.

(e) **Explain the reasons why not.**

N/A

(10) **Describe the equipment, services 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.

To the best of my knowledge and memory, there was access to X-ray facilities for CT and MRI scans and EEGs within the Royal Group of Hospitals in October 1996.

(11) **Identify the other medical or clinical staff who would be required to carry out and report on 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.

To my knowledge the above investigations were arranged after discussions with the duty or on-call Consultant Radiologist for CT and MRI scans and with the duty or on-call Consultant Neurologist for EEGs.

I have no knowledge of the availability for the above investigations during the periods of time given in October 1996.

(12) **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, explain why and if not, explain why.

I was not in a clinical position or level of experience to consider a request for the above investigations. It would have been my experience that these types of investigations were

arranged on the advice of a clinician with more clinical experience and seniority than me at that time.

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

(a) **CT scan**

(b) **MRI scan**

(c) **EEG**

in RBHSC in October 1996.

For the reasons referred to response to Question 12.

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

(a) **CT scan**

(b) **MRI scan**

(c) **EEG**

in RBHSC in October 1996.

It is my belief and to my knowledge and these tests were authorised usually following discussion with a more senior experienced clinician than myself at that time and the relevant consultant in Radiology and Neurology.

(15) **If you had requested a CT scan, MRI scan and/or an EEG of Claire on 21st or 22nd October 1996 state:**

(a) **where that would have been carried out**

(b) **how long it would have taken to arrange for Claire**

(c) **how Claire would have been transferred to the venue for the CT and/or MRI scan and/or EEG**

(d) **whether anaesthesia or sedation was likely or necessary, and**

(e) **how long that journey would have taken.**

I would not have been in a position during the above dates to request the above investigations due to my lack of experience and seniority. I am therefore unable to answer the above questions.

(16) **State whether you discussed with any other person carrying out an urgent electro-encephalogram (EEG) in order to make a firm and unequivocal diagnosis of non-convulsive status epilepticus, and state:**

(a) **with whom you discussed this**

(i) **the time, location and outcome of the discussion and any document recording the discussion.**

(ii) **whether you made enquiries about whether a technician and equipment was available to carry out an EEG, the outcome of those enquiries and identify any note of your enquiries and whether a technician or equipment was available to carry out that test.**

I did not discuss with any other person about carrying out an urgent EEG. I was not privy to any initial discussion that Dr Sands had with Dr Webb to request his opinion and/or need for carrying out an urgent EEG or other investigations and the availability of a technician and equipment to carry out this test.

I would not have been in a position during the above dates to request the above investigations due to my lack of experience and seniority to request any of the above tests. It would have been my previous experience that this was arranged on the advice a consultant and the relevant EEG unit.

(b) **State what EEG service was available in RBHSC on 22nd and 23rd October 1996.**

I am unable to recall what EEG service was available for these 2 dates.

(c) **State whether you considered closer observations of Claire on making this diagnosis and when the medicines (diazepam, midazolam and phenytoin) were being administered, and if so, state when and how you considered this, and the result thereof. If you did not consider this, explain why not.**

I am unable to recall if I did consider and advise that closer observations were undertaken following from the administration of these medicines.

(17) **State whether you considered carrying out more extensive biochemical tests including liver function tests, calcium, glucose, ammonia and toxicology on 22nd October 1996 and if so, explain why these tests were not conducted at this stage given Claire's condition. If not, explain why they were not considered.**

(a) **Describe the consideration, if any, you gave to carrying out a blood test for electrolytes on 22nd October 1996 to check Claire's serum sodium level.**

(b) **State whether you discussed with a more senior clinician on 22nd October 1996 carrying out a blood test for electrolytes , and if so, identify that clinician and state when this discussion took place.**

(i) **State whether any decision was made as to whether a blood test for electrolytes was to be conducted on Claire, and if so, what that decision was**

(ii) **Explain the reasons for not carrying out such a test until the evening of 22nd October 1996**

I am unable to recall if I did consider carrying out more extensive biochemical tests as those mentioned above or a blood test for electrolytes. I am unable to recall if I did discuss with Dr Sands the need to repeat a blood test for electrolytes. Any considerations were likely to have been made at the time of the ward round that day with Dr Sands.

(18) In assessing, determining and reviewing Claire's fluid management, state:

(a) 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).

To my knowledge this was continued on the 22nd from Claire's admission as it was felt to be clinically appropriate based on that day's clinical review on the ward round.

(b) What consideration you gave on 22nd and 23rd October 1996 to fluid restriction in Claire's case, and when you considered this. If fluid restriction was not considered, explain why not.

I am unable to recall if fluid restriction was considered in Claire's care on that ward round.

I was not involved in Claire's case on the 23rd October.

State whether you were aware of the possibility of inappropriate ADH secretion in Claire's case on 22nd October 1996, and if so, state whether and how you modified Claire's management and IV fluid regime to address that possibility. If you were not aware of this, explain why not. If you made no modifications to the IV fluid regime, explain why not.

I am unable to recall if I was aware of the possibility of inappropriate ADH secretion in Claire's case on 22nd.

(c) State whether you considered prescribing a higher sodium containing fluid on 22nd October 1996, and if so, state when and the reasons for considering this. If you did not consider this, explain why not.

I am unable to recall if I did consider prescribing a higher sodium containing fluid on the 22nd October 1996.

(d) If you regarded Claire as dehydrated, or potentially dehydrated at any time during your care and treatment of her.

(e) What consideration you gave on 22nd and 23rd October 1996 to Claire's urine output, urine sodium and urine osmolality, when you considered this and what the result was of this consideration.

I am unable to recall if Claire was regarded as dehydrated or potentially dehydrated at the time of the ward round or if this was discussed and what consideration was given to Claire's urine output, urine sodium and urine osmolality based on the clinical assessment made on the ward round.

I was not involved in Claire's care on the 23rd October.

(f) **Whether there was a reassessment or review of Claire's fluid management on 22nd October 1996, and if so, state when, by whom and the outcome thereof. If there was not, explain why not.**

I am unable to recall a reassessment or review of Claire's fluid management on the 22nd.

(g) **Whether you considered measuring Claire's urine output on admission. If not, explain why you did not consider this.**

I am unable to recall if consideration was made on the ward round in measuring Claire's urine output.

(h) **State whether you considered catheterising Claire on 22nd October or 23rd October 1996 and if so, state when you considered this and the reasons why. If you did not consider this, explain why.**

I am unable to recall if I did consider catheterising Claire or if this was considered during the ward round.

I was not involved the care of Claire on the 23rd October.

(19) **Identify the consultant responsible for Claire's care on 22nd October 1996.**

I think that this was Dr Steen.

(20) *"22/10/96 W/R Dr. Sands..."* **(Ref: 090-022-052)**

(a) **State if this untimed note dated 22nd October 1996 at the bottom of the clinical notes at Ref: 090-022-052 was made by you.**

(i) **If you made that note, state at what time this note was made.**

(ii) **If not, state at what time this ward round note was made and identify the author of that note.**

Yes. I recall that this note would normally be taken during the ward round which usually started around 09.00-09.30, so the time would be after this and between 11.00-11.30 following end of the ward round.

(b) **State whether you were on the ward round when Claire was attended and examined on the morning on 22nd October 1996. If not, explain why not.**

I was present on the ward round on the morning of 22nd October.

(c) **State at which time the ward round was conducted and identify the other clinicians and nurses who attended Claire on that ward round.**

I recall Dr Sands and another SHO were present on this ward round and to my knowledge nurses were also present. I am unable to remember who the other Doctor was or nurses were.

(d) **State whether at that time Dr. Sands was a Senior Registrar Grade and whether he functioned virtually as a consultant and undertook consultant-level responsibilities.**

I understood that Dr Sands was a Registrar grade not a Senior Registrar. I also recall he had his own rota and responsibilities within the ward and for Outpatient clinics/teaching.

(e) **Explain the reasons why the ward round was not conducted by Dr. Heather Steen on the morning of 22nd October 1996.**

I am unable to give a reason why the ward round was not conducted by Dr Steen.

(21) *"Admitted? Viral illness"* **(Ref: 090-022-052)**

(a) **Explain this note.**

The "?" indicates that the initial presentation and admission via A+E was due to a possible a viral illness.

(22) *"U+E – Na+ 132 FBC – WCC ↑16.4 Gluc 6.6"* **(Ref: 090-022-053)**

(a) **State the date and time at which the noted U&E results were received.**

I do not know the date and time at which the noted U&E results were received and then transcribed by myself on the ward round of the 22nd.

(b) **Explain the significance of the Sodium, White Cell Count and Glucose results received.**

These were the results outside the normal ranges for these results.

(c) **Explain the reasons why only the Sodium, White Cell Count and Glucose results were noted and not all the other electrolyte results.**

It appears that I only documented those abnormal and not the normal results.

(d) **State whether you assessed the blood chemistry and white cell count results which were recorded and in particular:**

(i) **Explain whether you reviewed Claire's fluid regime in light of the results**

(ii) **State whether you drew those results to a more senior clinician's attention in order to reassess and review Claire's diagnosis, treatment and fluid balance and regime**

(iii) **If so, identify the more senior clinician contacted, state when and how s/he was contacted, and what action, if any, resulted from this contact**

(iv) **Explain, if you did not do so, why you did not do so**

It is likely that I have noted these bloods as they were outside the normal range for these results and this was noted at the time of the ward round with Dr Sands. I am unable to recall if Claire's fluid regime was reassessed or reviewed in light of these results during the ward round.

(e) **Describe the consideration, if any, you gave to carrying out another electrolyte test to check Claire's serum sodium level on receipt of the sodium result received.**

(i) **State whether these blood test results would have caused you any concern at all, and if so, the nature of and reasons for your concern, and what steps you took to address, monitor and manage that concern over the course of 22nd and 23rd October 1996. If the test results caused you no concern at all, explain why not.**

I am unable to recall if consideration was made about carrying out another electrolyte test, possibly due to the Sodium result falling just out of the range of the normal parameters.

(23) *"On IV fluids"*. **(Ref: 090-022-053)**

(a) **State precisely which type and quantity of IV fluids were being administered to Claire on the morning of 22nd October 1996, and at what rate of administration, and the reasons for the type, quantity and rate of administration.**

This was 500mls of No. 18 Solution which was commenced at the time of her admission the previous evening and was written up for 64mls/hour. I can give no reason why this type/quantity/rate was used at that time.

(b) **State whether the type, rate and quantity of IV fluids were reassessed and reviewed during the ward round on 22nd October 1996, and if so what was the outcome of that reassessment. If not, explain why not.**

I am unable to recall if this was reassessed or reviewed during the ward round.

(24) *"Intravenous Fluid Prescription Chart*

500mls , No. 18 Soln, 64mls/ltr" **(Ref: 090-038-136)**

(a) **Identify the person/s who determined this prescription and rate of administration.**

This was written up me

(b) **State the reasons for the type and quantity of this solution being prescribed for Claire and being administered at this rate.**

It appears that I continued with the previous fluid regime started from the time of Claire's admission.

(c) **State the time at which the type and quantity of this solution and rate of administration was prescribed.**

I did not document the time that this was prescribed and I am unable to recall at what time I was likely to have written this up on the Fluid Balance sheet. It was likely to have been during morning of the 22nd Oct.

(d) State your method of calculating Claire's fluid requirements at that time.

I followed on from the previous entry made on admission as no changes were noted at the time of the ward round.

(e) State the name and amount of additives to this solution as recorded on this intravenous fluid prescription chart.

There were no additives given to this solution.

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

I am unable to recall what exactly the level of monitoring was directed/arranged on her admission to Allen Ward and thereafter, other than routine nursing observations undertaken by nursing staff.

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

I am unable to recall if monitoring was discussed on the ward round in relation to Claire's serum sodium concentration.

(h) State whether the type, rate and quantity of IV fluids were reassessed and reviewed at any time between the end of the ward round and 23.30 on 22nd October 1996 and if so, state what was the outcome of that reassessment and identify where it is recorded in Claire's medical notes. If there was no reassessment or review, explain why not

I am unable to recall if the type, rate and quantity of IV fluids were reassessed and reviewed at any time between the end of the ward round and the time I went off duty on 22nd October.

(25) ***"Imp. Non fitting status./encephalitis/encephalopathy"*** **(Ref: 090-022-053)**

(a) Identify the author of the note *"Imp. Non-fitting status"* and state the time when this note was made.

I made the entry during the morning ward round on the 22nd October.

(b) Identify the evidence of *"Non Fitting status"* upon which that diagnosis was based.

This was likely to have been taken from the conclusions or possible alternative diagnoses made at the morning ward round by Dr Sands.

(c) **Identify the author of the note *"/encephalitis/encephalopathy"* and state:**

(i) **The time when this note was made**

I believe that this was written by Dr Sands. I do not know when this entry was made.

(ii) **The reasons for this addition to the medical notes**

I do not know the reasons for these additions.

(iii) **Whether those 2 conditions comprised part of the diagnosis on the ward round, or whether they were part of a diagnosis by another person**

I am unable to recall if these specific diagnoses were considered and/or discussed at the time of the ward round or whether were part of a diagnosis by another person.

(iv) **If so, state by whom and when that diagnosis was made.**

(d) **Explain if there were any other alternative diagnoses and, if so, identify each of them and explain why they were not noted on Claire's medical notes.**

I am unable to recall if other alternative diagnoses were identified.

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

I am unable to recall if either I or Dr Sands considered hyponatraemia and /or cerebral oedema as a diagnosis. It may have been that the history of presenting symptoms, clinical findings and past medical history of epilepsy and the Sodium levels being just out of range, led us to consider alternative diagnoses in Claire's case other than hyponatraemia/cerebral oedema.

(f) **State whether you or Dr. Andrew Sands considered that Claire's reduced level of consciousness and poorly reacting pupils were caused by cerebral oedema related to hyponatraemia, and if so, state when and the reasons why you considered this. If you did not consider this, explain why not.**

As for the reasons above, 25(e), I am unable to recall that other possible diagnoses were considered more likely in light of Claire's presenting symptoms, clinical findings and past medical history.

(g) **Explain any discussions you had with the medical, clinical or nursing staff regarding Claire's condition and diagnosis and what tests, scans or investigations were required.**

Any discussions were likely to have occurred during the ward round and further opinions were sought by Dr Sands.

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

I am unable to recall if I considered monitoring Claire's intracranial pressure at any time but would have felt that this was outside my level of experience and this would be a decision for senior paediatric staff.

(i) **On attending Claire during the ward round on 22nd October 1996, state whether you or Dr. Andrew Sands considered that Claire's condition required to be investigated and/or treated as a matter of urgency, and if so, state when and the reasons why you considered this, and what action you took as a result of that consideration. If you did not consider this, explain why not.**

I recall that that Dr Sands went to seek further opinion in light of the possible diagnoses as considered/documented on the ward round. I was left on the ward to continue with the other daily duties that arose in relation to the other patients admitted/present on the ward on that day.

(j) **State precisely whether and how you communicated the diagnosis of Claire's condition during and following the ward round on 22nd October 1996 to the members of the medical and nursing team, and when this was done.**

This was discussed and communicated verbally amongst those present on the ward round.

(k) **State whether you considered requesting a CT scan on attending Claire on 22nd October 1996. If so, explain why and if not, explain why not.**

I am unable to recall if I did consider a CT scan.

(l) **State the length of time necessary in October 1996 to arrange an urgent CT scan for a paediatric patient.**

I do not know the length of time necessary in October 1996 to arrange an urgent CT scan for a paediatric patient.

(m) **State the length of time required to arrange a non-urgent paediatric CT scan in October 1996.**

I do not know the length of time necessary in October 1996 to arrange a non -urgent paediatric CT scan.

(n) **Explain why a CT scan was not arranged for Claire on 22nd October 1996.**

I am unable to recall why a CT scan was not arranged other than this was to be arranged if Claire had not have woken up by the 23rd as per Dr Webb. Ref 090-022-054

(26) *"Plan Rectal Diazepam*

Dr. Webb..." **(Ref: 090-022-053)**

(a) **Explain the meaning of this note.**

This indicates that Rectal Diazepam was to be administrated following on from the ward round. Also "Dr Webb" entry indicates that his opinion was to be sought in relation to Claire's condition/presentation.

(b) **Identify the person who prescribed and administered the *"Rectal Diazepam"* and at what time it was administered.**

I am unable to decipher the signature of the person who prescribed or administered this drug

(c) **State what effect the Diazepam had on Claire's presentation and how long that effect lasted. In particular, state whether the Diazepam made Claire any more alert or improved her conscious level, and if so, state at what time this occurred.**

I am unable to recall what effect the Diazepam had on Claire's presentation.

(d) **If the *"Rectal Diazepam"* did not cause Claire to become any more alert or improve her conscious level, state whether Claire's condition, care and treatment was reviewed and reassessed, and if so state when, by whom and what was the outcome of that review. If there was no review/reassessment, explain why not.**

I am unable to recall if or when Claire's condition, care and treatment was reviewed and reassessed.

(27) *"22.10.96 Neurology. Thank you. 4pm..."* **(Ref: 090-022-053)**

(a) **State whether you were present when Dr. Webb attended and examined Claire for the first time on 22nd October 1996.**

I was on the ward but I am unable to recall if I was present when Dr Webb examined Claire for the first time.

(b) **State at what time Dr. Webb first attended and examined Claire on 22nd October 1996.**

I am unable to recall what time Dr Webb first attended but it was likely to be after lunch, i.e. 2pm.

(c) **Identify all persons who were present during Dr. Webb's first attendance and examination of Claire on 22nd October 1996.**

I am unable to identify all persons present during Dr Webb's first attendance or anyone else at the time of his examination.

(d) **At that time and on 22nd October 1996, explain your understanding of Dr. Webb's role in relation to Claire. In particular, did you understand that:**

(i) **Dr. Webb was taking over Claire's care from Dr. Heather Steen, or**

(ii) **Dr. Webb was providing a specialist opinion and that Dr. Steen remained as the consultant responsible for Claire**

(iii) **State the basis for your understanding**

My understanding that Dr Webb's role was to give a neurological opinion in relation to Claire whilst she was a patient in Allen Ward.

(28) *"22/10/96*

2.30pm 24kg Phenytoin 18mg/kg - loading dose = 18 x 24= 632 mg

24kg Phenytoin 2.5 kg 12 Hrly = 60mg 12 Hrly either IV or orally

Check levels at 9pm" **(Ref: 090-022-054)**

(a) **State the time at which that note was recorded in Claire's medical notes.**

I assume this to be 2.30pm as per my handwritten record.

(b) **State the basis of the calculation *"24kg Phenytoin 18mg/kg - loading dose = 18 x 24 = 632mg"* recorded in the medical notes.**

I am unable to recall the basis of this calculation. It could have been done in my head or on a piece of paper or by a calculator. I am not able to remember this detail.

(c) **State whether you were aware of any errors in relation to the prescription of phenytoin, and if so, how and when did you become aware of any error, and what action was taken as a result thereof.**

I am unable to recall whether I was aware of the error in this prescription and if I was what action I took.

I now know that this was an incorrect calculation, as it should have been 432mg.

(d) **State how the *"levels"* would be checked at 9pm.**

By a blood test

(e) **State whether you prescribed and administered the phenytoin, and if not, identify who did.**

I can only assume that I did prescribe and administered the phenytoin as indicated by my hand written entry on the second line of the Drugs - once only prescription, Ref 090-026-075.

(f) **State whether you made the handwritten entry relating to phenytoin on the second line of the *"Drugs - once only prescriptions"* Table at Ref: 090-026-075.**

I did

(g) **State the time at which the phenytoin was administered to Claire.**

If I did, then I would assume that this time was as per my handwritten entry i.e. 14.45

(h) **State the number and size of ampoules you used to administer 632mg to Claire at 14.45 on 22nd October 1996, and how you gave Claire this dose of phenytoin.**

I am unable to recall how many ampoules I may have used on that day

(i) **State what effect the administration of 632g of phenytoin to Claire had on her presentation and how long that effect lasted.**

I am unable to recall what effect this had on Claire's presentation and how long this lasted.

(j) **State whether the phenytoin improved Claire's conscious level, and if so, state at what I time this occurred.**

I am unable to recall whether phenytoin improved Claire's conscious level or at what time this occurred but the there appears to have been no change at subsequent review by Dr Webb.

(k) **If the phenytoin did not improve Claire's conscious level, state whether Claire's condition, care and treatment was reviewed and reassessed, and if so state when, by whom and what was the outcome of that review. If there was no review/reassessment, explain why not.**

I am unable to recall if any review/reassessment was undertaken other than that undertaken by the nursing staff.

(l) **State whether a heart monitor was running during the infusion of the phenytoin. If one was not running, explain why.**

I am unable to recall if a heart monitor was or was not running during the infusion.

(29) *"22/10 . Time 3.10pm Lasted frequently strong seizer at 3.25.*

Duration 5 min

State afterwards sleepy

Initial Mum" (Ref: 090-042-144)

(a) **State whether you or any other member of the medical team witnessed this seizure, and if so, identify the others who witnessed it.**

I am unable to recall if I or any other member of the medical team witnessed this seizure.

(b) **State whether you or any other member of the medical team were informed of this seizure at 15.10 or at any time thereafter, and if so, identify who was so informed, by whom and state when and where you or s/he was so informed. If not, explain why not.**

I am unable to recall if I or any other member of the medical team were informed of this seizure at 15.10.

(c) **State whether Dr. Webb was aware of this seizure at any time on 22nd October 1996, and if so, state when and how he became aware of it. If Dr. Webb was not aware of it, explain why not.**

I am unable to recall if Dr Webb was aware of this seizure.

(d) **State whether you considered that Claire's seizures on 22nd October 1996 may have been provoked by a drop in sodium level and cerebral oedema, and if so, state when and the reasons why you considered this. If you did not consider this, explain why.**

I am unable to recall if I considered Claire's seizures may have been provoked by a drop in sodium levels and cerebral oedema. I may not have considered this in light of other possible diagnoses and my level of experience in paediatric medicine.

(30) *"22/10/96 S/B Dr. Webb.*

Still in status.

1. Midazalam 0.5 mg/Kg Stat Dose = 0.5 x 24 = 12 mg IV fluids

2. Midazalam 2 mcg/Kg/min = 2 x 24 mcg/min

= 48mcg/min

= 48 x 60 mcg/Hr

= 2880 mcg/Hr

= 2.88 mg/Hr infusion

= 69mg/24 Hrs" (Ref: 090-022-055)

(a) **State the time at which Claire was *"S/B Dr. Webb"* for the second time on 22nd October 1996.**

I am unable to state the time.

(b) **Identify the author of the above handwritten note at Ref: 090-022-055.**

I am the author of the above handwritten note.

(c) **State the time at which that note was recorded in Claire's medical notes.**

I am unable to state the time at which that note was recorded.

(d) **Identify the person/s who decided upon those medicines and dose and rates of administration (as recorded) to be prescribed for Claire at that time.**

I assume this to be Dr Webb, based on my handwritten entry.

(e) **State whether you made the handwritten entry relating to midazolam on the third line of the *"Drugs – once only prescriptions"* table at Ref: 090-026-075. If you did not make this entry, identify the author of this prescription.**

I made the handwritten entry relating to midazolam

(f) **State what was the dose of midazolam prescribed and recorded on the third line of the *"Drugs – once only prescriptions"* table at Ref: 090-026-075., and state the reasons for this dose of midazolam being prescribed for Claire.**

I believe that this could indicate a typographical error on my part and the actual entry should be 12mg and not "120 mg" as it may read. Ref 090-022-055

(g) **State whether Claire received a *"Stat Dose"* of midazolam intravenously during the afternoon on 22nd October 1996, and if so,**

(i) **identify who administered that medication**

I am unable to recall if I did administer this drug but can only assume that I was likely to have done so but I had not signed to this fact.

(ii) **state the time at which it was administered to Claire**

15.25

(iii) **the actual dose administered and the reason for that dose being administered**

I am unable to recall the actual dose administrated but believe that it was likely to have been the 12mg but I am aware that I cannot say for certain.

(iv) **what effect the administration of that dose to Claire had on her presentation**

I am unable to recall what effect this had on Claire's presentation, other than no changes was noted on Dr Webb's subsequent examination that afternoon.

(v) **how long that effect lasted, and**

I am unable to recall how long, if any, that effect lasted.

(vi) **the reasons why the final column of the third line of the *"Drugs - once only prescriptions"* Table at Ref: 090-026-075 was not completed.**

It is possible that I forgot to sign that I had given it.

(h) **If Claire did not receive 12mg midazolam by IV fluids in accordance with the medical notes, explain why not.**

I would be unable to explain why this was not given in accordance with the medical notes, if Claire did not receive the 12mg Midazolam by IV Fluids.

(i) **State the number and size of ampoules used to administer the *"Stat Dose"* of midazolam by IV fluids during the afternoon on 22nd October 1996 to Claire.**

I am unable to recall the number or size of ampoules used to administer the "Stat dose" of midazolam.

(j) **State whether Claire received *"Midazalam 2mcg/kg/min... 69mg/24hrs"*, and if so identify the person who administered this dose of medication, and state the time when administration of this medication commenced and terminated, what effect this medication had on Claire's presentation and how long that effect lasted.**

I can not exactly confirm if Claire did receive the above but make an assumption that she did, based on the entry in the Fluid Balance and IV prescription chart at 16.00, Ref 090-038-135. I am unable to recall who administered this dose, the time of commencement (other than that entry) and its termination and what effect this had on Claire's presentation and how long this effect lasted.

(k) **State whether the midazolam improved Claire's conscious level, and if so, state at what time this occurred.**

I am unable to state whether midazolam improved Claire's conscious level and if so at what time.

(l) **If the midazolam did not improve Claire's conscious level, state whether Claire's condition, care and treatment was reviewed and reassessed, and if so state when, by whom and what was the outcome of that review. If there was no review/reassessment, explain why not.**

I am unable to recall if the midazolam did not improve Claire's condition other than no changes were noted at Dr Webb's subsequent review and that other medication was prescribed.

(m) **State whether you were aware of any errors in relation to the prescription of midazalam, and if so, how and when did you become aware of any error, and what action was taken as a result thereof.**

I was not aware of any errors in relation to this prescription of midazolam.

(31) *"22/10 4.30pm. teeth tightened slightly.*

Duration few secs.

State afterwards asleep." **(Ref: 090-042-144)**

(a) **State whether you or any other member of the medical team witnessed this seizure, and if so, identify the others who witnessed it.**

I am unable to state if I or any other member of the medical team witnessed this seizure.

(b) **State whether you or any other member of the medical team were informed of this seizure at 16.30 or at any time thereafter, and if so, identify who was so informed, by whom and state when and where you or s/he was so informed. If not, explain why not.**

I am unable to state if I or any other member of the medical team were informed of this seizure at 16.30.

(c) **State whether Dr. Webb was aware of this seizure at any time on 22nd October 1996, and if so, state when and how he became aware of it. If Dr. Webb was not aware of it, explain why not.**

I am not able to state if Dr Webb was aware of this seizure.

(32) *"22.10.96*

17.00 Claire has had a loading dose of Phenytoin and a bolus of midazolam. She continues to be largely unresponsive...

- Plan. 1) Cover w Cefotaxime and acyclovir 48 Hrs - I don't think meningoencephalitis v likely. **(Ref: 090-022-055)**

(a) **State the time at which Dr. Webb attended Claire for the third time on 22nd October 1996.**

I am unable to recall the exact time but assume it have been 17.00, based on the hand written entry- Ref 090-022-055

(b) **Identify all persons who were present during Dr. Webb's third attendance on Claire.**

I recall that Dr Sands and I were present on the ward at the time of Dr Webb's 3rd attendance. I do not recall if I was present at his third examination and other discussions regarding further treatment for Claire's condition.

(c) **State what was the diagnosis of Claire's condition at that time and the reasons for that diagnosis. In particular, state what you, Dr. Andrew Sands and/or Dr. David Webb attributed Claire's lack of responsiveness to at that time.**

I am unable to recall what the diagnosis of Claire's condition was at that time and the reasons for that decision or what was thought to be attributing to Claire's lack of responsiveness.

(d) **Explain why Dr. Webb did not *"think meningoencephalitis v likely."***

I am unable to explain why Dr Webb did not think the above was likely

(e) **State what Dr. Webb communicated to you in terms of the urgency and timing of when Claire's blood sample was to be taken, explain why he provided this advice on timing of the sample; and state when and where Dr. Webb communicated this to you.**

I am unable to recall what Dr Webb communicated to me in terms of the urgency and timing of when Claire's blood samples were to be taken, other than that he had noted earlier in the afternoon regarding the phenytoin. I.e. 6hrs after loading dose. See Ref 090-022-054

(f) **State whether the cefotaxime was administered to Claire, and if so, state by whom and at what time.**

I cannot confirm if this was administrated but can only assume that it was given, as indicated by the handwritten "C" under 5.30pm and someone's initials beside this entry. See Ref 090-026-077.

I am unable to state by whom and at what time other than that indicated by this entry.

(g) **Identify the conditions/illnesses which cefotaxime was to address and state the time at which this medication was administered to Claire on 22nd October 1996.**

I assume that these were the conditions/illnesses considered by Dr Webb at his review of Claire's condition.

(h) **State whether the acylovir was administered to Claire, and if so, state by whom and at what time.**

I am unable to state if Acylovir was administered.

(i) **Identify the conditions/illnesses which acyclovir was to address and state the time at which this medication was administered to Claire on 22nd October 1996.**

I assume that these were the conditions/illnesses considered by Dr Webb at his review of Claire's condition.

(j) **As Dr. Webb decided to *"cover"* Claire with these medications to treat Claire for certain conditions/illnesses, explain why you did not administer these medications promptly or**

urgently, and the reasons why these medications were not administered until approximately 21.30 on 22nd October 1996.

I was asked to write up this medication on the prescription sheet based on the notes from Dr Webb but there was no instruction given in when and what dose these were to be administered. It was likely that the doses/timings for these drugs were to be worked out for by the ward SHO for Claire's age/weight.

I believe that these drugs were administered as indicated in Ref 090-022-077 at the times prescribed. A further possible reason for these drugs not being given promptly or urgently, that they were not kept on the ward and needed to obtained from another source i.e. another ward/pharmacy and thus the delay in administration and at which time I would have left the hospital following the end of my shift.

(33) *"2) check viral cultures ? enterovirus - stool, urine, blood and T/S"* **(Ref: 090-022-055)**

(a) **Explain the reasons for the lapse of approximately 4.5 hours between Dr. Webb's request for a blood sample from Claire at 17.00 on 22nd October 1996 and the sample being taken at approximately 21.30.**

It may have been the case that I had gone off duty before these tests could have been undertaken.

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

The urine culture showed no significant growth. Ref 090-030-094,097.

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

I signed the result for the urine culture, Ref 090-030-097.

(d) **If there is no note or record of the said results, please explain why not.**

N/A

(e) **State whether you were aware of and took account of the results from the urine analysis in your care and management of Claire. If not, explain why not and state whether you took any steps to ascertain these results or to repeat the urine analysis and your reasons for not/doing so.**

It would have been likely that these results were sent to Allen ward on the 23rd.

(34) *"3) Add IV sod valproate 20mg/Kg IV bolus followed by infusion of 10mg/Kg IV over 12 Hrs"* **(Ref: 090-022-055)**

(a) **State whether the Sodium Valproate was administered to Claire, and if so, state by whom, in what dose and at what time.**

I assume Dr Sands gave the initial loading dose, at the time given, as indicated in the handwritten entry. See Ref 090-026-075

(b) **State what effect that medication had on Claire's presentation and how long that effect lasted.**

I am unable to recall what effect that medication had on Claire's presentation and how long this effect lasted.

(c) **State whether the Sodium Valproate improved Claire's conscious level, and if so, state at what time this occurred.**

I am unable to recall whether this medication improved Claire's conscious level and if so at what time.

(d) **If the Sodium Valproate did not improve Claire's conscious level, state whether Claire's condition, care and treatment was reviewed and reassessed, and if so state when, by whom and what was the outcome of that review. If there was no review/reassessment, explain why not.**

I am unable to recall if a review/reassessment was undertaken. Any review was likely to have taken place at a time after I had left the hospital that evening.

(e) **After Dr. Webb's third attendance on Claire, describe the plan of care for Claire from 17.00 onwards on 22nd October 1996 and the arrangements in place for Claire's condition, treatment and care to be monitored, reviewed and reassessed.**

The plan of care was to monitor Claire in light of the treatments suggested and started as per Dr Webb, with review and reassessment by the nursing team and on call medical team as required.

(f) **After Dr. Webb's third attendance on Claire noted at 17.00 in the medical notes (Ref: 090-022-055) state whether you considered that Claire's condition required to be further investigated and/or treated as a matter of urgency, and if so, state when and the reasons why you considered this, and what action you took as a result of that consideration. If you did not consider this, explain why not.**

I am unable to recall what level of urgency was placed in considering Claire's condition after Dr Webb's 3rd review as noted at 17.00.

(35) *"22/10 7.15pm. teeth clenched + groaned.*

Duration 1 min..

State afterwards asleep." **(Ref: 090-042-144)**

(a) **State whether you or any other member of the medical team witnessed this seizure, and if so, identify the others who witnessed it.**

I was not on duty or present in the RBHSC at this time.

(b) **State whether you or any other member of the medical team were informed of this seizure at 19.15 or at any time thereafter, and if so, identify who was so informed, by whom and state when and where you or s/he was so informed. If not, explain why not.**

I was not on duty or present at this time.

(c) **State whether Dr. Webb or the consultant paediatrician responsible for Claire was aware of this seizure at any time on 22nd October 1996, and if so, state when and how s/he became aware of it. If they were not aware of it, explain why not.**

I was not on duty or present at this time.

(d) **Identify to whom you handed over, when you went off duty on the evening of 22nd October 1996 and state the nature of the handover and explain why no note was made.**

I am unable to recall the identity of whom I handed over to, this may have been Dr Stewart as per Ref 090-022-056, who appears to have been the on-call Medical SHO for the 22nd Oct. I am not able recall the level and inform them of any patients, problems or tasks which they needed to know about. nature of the handover other than it was my usual practice to speak with the on-call SHO at my

(36) **State whether you considered increasing the frequency of Claire's central nervous system and respiratory observations and monitoring of her vital signs on 22nd October 1996, and if so, state when, the reasons why you considered this, and the reasons why no change was made to the frequency of the observations/monitoring at all. If you did not consider this, explain why not.**

I am unable to recall if I did consider increasing the frequency of Claire's CNS and Resp observations and monitoring of her vital signs on 22nd other than that indicated at Dr Webb's first assessment of Claire when hourly CNS obs were commenced.

(a) **State whether you discussed increasing the frequency of Claire's central nervous system and respiratory observations and monitoring of her vital signs with any other person, and if so, identify that person and state when and where you discussed this, and the outcome of the discussion. If not, explain why not.**

I am unable to recall if I discussed increasing the frequency of observations and monitoring with any other person.

(b) **When the hourly CNS observations were started, state whether you considered passing a naso-gastric tube, and if so, state when and how this was considered and what was the outcome thereof. If it was not considered, explain why not.**

I am unable to recall whether I considered passing a nasogastric tube.

(37) **State whether consideration was given to admitting Claire to PICU and the reason/s why Claire was not admitted to PICU on 22nd October 1996, and in particular:**

(a) **When Claire did not respond to any anti-epileptic medication**

I am unable to recall if consideration was given to admitting Claire to PICU.

(b) **At 21.00 when Claire's GCS dropped**

I am unable to comment in relation to the above as I was not on-call at that time and present in the RBHSC.

(c) **At 23.30 when Claire's serum sodium result of 121mmol/L was noted**

I am unable to comment in relation to the above as I was not on-call at that time and present in the RBHSC

(d) **State whether you were aware of the recorded CNS observations (Ref: 090-039-137) on 22nd October 1996, and if so, state what you did as a result thereof and the reasons for this. If not, explain why you were not aware of these CNS observations.**

I was aware that nursing staff were undertaking hourly CNS observations following Dr Webb's 1st assessment and request that this was started.

(e) **State the Glasgow coma score that you consider to reflect the onset of coma.**

A Glasgow Coma Score of < 8 is considered severe, 9-12 moderate and >13 mild. I would feel a score of less than 8 indicates the onset of coma.

(f) **State at what GCS you would normally have discussed admission to PICU.**

I would have had to discuss this with a more experienced Paediatrician at the stage of my seniority and experience, who would then discuss this with the staff of the PICU.

(g) **State the protocols, guidelines and procedures in RBHSC between 21st and 23rd October 1996 governing admission of children to PICU.**

I am unable to state any protocols, guidelines and procedures in the RBSHC between the above dates governing admission of children to PICU.

(h) **State whether the process to seek advice from a Paediatric Intensive Care Specialist in October 1996 in RBHSC was solely via the treating Consultant or whether junior medical staff could seek support from PICU between 17.00 and 09.00 without necessarily informing their Consultant.**

At my level of seniority and experience at this time, this would be outside my knowledge/experience. I.e. I would have to defer this decision to a registrar/consultant.

(38) **State whether you considered contacting Dr Steen, Dr. Webb or Dr. Sands on 22nd October 1996 in relation to Claire's GCS and deteriorating condition, and if not, why not, and if so, what exactly was discussed, what they did about it and what the response was.**

I do not recall if I was informed of the GCS by the nursing staff. This may have been noted and discussed with Dr Webb at the time by the nurses.

(a) **State the threshold for calling a consultant in RBHSC in October 1996.**

I am unable to state the threshold for calling a consultant in RBHSC in October 1996, as we would normally have spoken with a more experienced SHO or the registrar of the ward or the registrar on call if there were concerns. They in turn may have contacted the consultant. There would have been a hierarchical process if any concerns about a particular patient.

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

I am unable to recall or explain what were the RBHSC policies, procedures and practices on 21st Oct for keeping the consultant informed or for seeking advice when required. I assume that this was an adhoc process were you had to locate during working hours or to contact the consultant by phone when on-call

(c) **State the periods of time when Dr. Andrew Sands, Paediatric Registrar, was present on Allen Ward on 22nd October 1996 after the morning ward round.**

I am unable to recall the times but I am able to recall that he was present around the ward during the morning and then later in the afternoon after completing other possible commitments such as an Outpatient clinic and/or his teaching responsibilities.

(39) **State whether you considered advising Claire's parents of her deteriorating condition and if consideration was given to addressing the situation.**

I am unable to recall if I considered advising Claire's parents of her deteriorating condition.

(40) **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 this belief.**

I believed Claire was under Dr Steen, as her named consultant between her admission and up to the time of my leaving the ward at the end of shift. I am unable to recall if there had been a formal transfer of responsibilities to Dr Webb or that if he was providing advice in managing Claire's condition.

(a) **Identify the paediatric consultant who was responsible for Claire's care, treatment and management from 17.00 on 22nd October 1996 and thereafter.**

I am unable to identify which consultant was on-call and responsible for Claire's care, treatment and management from 17.00 onwards.

(b) **Identify the duty paediatric consultant on call on the evening of 22nd October and the morning of 23rd October 1996**

I am unable to identify the duty paediatric consultant on call for the evening of the 22nd and the morning of the 23rd.

(41) Identify the members of the paediatric medical team on duty when Claire was admitted to Allen Ward on 21st October 1996, and their respective job titles.

I am able to identify that Dr O'Hare, (Registrar), was one member of the medical team on duty as per the entry in Ref 090-022-052.

(42) Describe any changes to the members of that paediatric medical team during your care of Claire, the time when each change occurred and identify the additional/new members of the team and their respective job titles.

I only recall that I and Dr Sands and another SHO took over from the morning of the 22nd during the daytime working hours. I am unable to recall who this other SHO was.

(43) Identify the members of the nursing team on duty on 21st October 1996 when Claire was admitted to Allen Ward and their respective job titles.

I am unable to identify which members of the nursing team were on duty on the 21st as I was not present or on duty on this date.

(44) Describe any changes to the members of that nursing team during your care of Claire, the time when each change occurred and identify the additional/new members of the team and their respective job titles.

I am unable recall or to describe any changes to the members of that nursing team during my care of Claire, the times of any changes, the identity of additional/new members and their respective job titles.

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

I am unable to state whether nursing care was prescribed by doctors, nurses or both in Oct 1996

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

I am unable to identify the ward sister/nurse in charge of Allen Ward between the above dates.

(47) 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, and if so the nature of that advice or direction.

(e) **Describe any protocols, if any, in place at the RBHSC on 22nd October 1996 for referral of a patient from the admitting consultant to another consultant due to the unavailability of the admitting consultant.**

I can recall and believe that I had no communications with the Consultant responsible for Claire on her admission. I am unable to recall if there were protocols, if any, in place at the RBHSC on 22nd Oct 1996 for referral of a patient from the admitting consultant to another consultant.

(48) **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.**

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

(g) **State whether Dr. 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, and if so, state the date, time and location of that attendance and examination.**

I am unable to recall if I had any communications with Dr Steen in relation to Claire for the period of time I was on duty i.e. the 22nd Oct. I am unable to recall if Dr Steen attended and examined Claire during the above period of time.

(49) **State what communication you had with Dr. David Webb 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.**

The communication took place at times he attended on the afternoon of the 22nd, from 2pm onwards. This took the form of both verbal and written instructions as per the medical notes. See Ref 090-022-053, 055 and based on my own hand written entries, Ref 090-022-055

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

To the best of my knowledge this was initiated after Dr Webb had assessed Claire and the reason was to pass on information regarding medication to treat Claire's ongoing symptoms and clinical signs.

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

I am unable to recall the information that I may have given Dr Webb, any communication between us related and followed on from on his own clinical review of Claire throughout the afternoon.

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

I am unable recall the advice/instructions other than that I have handwritten in the notes. See Ref 090-022-054-055.

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

See Ref 090-022-054, 055.

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

(g) **Identify any protocols/guidelines from 22nd October 1996 to date governing the request for and provision of a specialist opinion by another consultant, and the transfer of care and management of a child to another consultant, and furnish copies thereof.**

I am unable to identify any protocols/guidelines from 22nd October 1996 governing the request for and provision of a specialist opinion by another consultant and the transfer of care and management of a child to another consultant.

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

I believe that it may have been Dr Stewart, as he appears to be the duty SHO and he made the next clinical entry in Claire's notes. See Ref 090-022-056. I am unable to recall if this was the case or the time which we handed over this case and what information I passed on.

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

I am unable to recall what exact information that I gave that SHO about Claire's condition, care and treatment and plan of care.

(51) **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 am unable to explain the nature and status of the documented entitled 'Discharge/Transfer Advice Note' or identify who completed this document or state when and where it was completed.

(52) **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.**

I am unable to see what relevance this question has in relation to the treatment and death of Claire, for the Inquiry.

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

My perception of Claire's condition was this was a child who had very complex medical problems, who was not very well, with no clear diagnoses and who was not responding to the treatment suggested by more experienced clinicians than myself at that time.

(54) **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 am unable to recall if I had any contact, communication with Claire's parents. I believe that this had been mostly been undertaken by Dr Sands and Dr Webb.

(55) **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 was not aware of the case of Adam Strain, his Inquest and the issues that arose from it prior to 21st October 1996.

(56) **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 was only aware of this case from reading the local news details of the Public Inquiry

This knowledge and awareness has not affected my current work as a GP, other than to highlight the dangers of electrolyte disturbances in children.

(57) **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 am unable to recall in detail and provide record keeping of the education and training I have received in fluid management (in particular hyponatraemia) during the above periods of my undergraduate and postgraduate education, hospital induction programmes and CPD courses.

(58) **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 had little or no experience in dealing with children with hyponatraemia, having only spent 2 months in the A+E department, RBHSC prior to the 21st October.

(59) **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 had little further experience in dealing with children with hyponatraemia since 21st October 1996 in the subsequent clinical posts held and in my current position as a GP.

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

I am unable to identify any Protocol and/or Guidelines which governed Claire's care and treatment.

(61) **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: T.R. Stev—— **(Dr TR Stevenson)** **Dated: 6th January 2012**