Witness Statement Ref. No. 141/2

NAME OF CHILD: **Claire Roberts**

Name: Neil Stewart

Title: Dr

Present position and institution:

Senior Pastor, Kirk O' The Isles Presbyterian Church (PCA), Savannah, GA, USA

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

Senior House Officer, Allen Ward, Royal Belfast Hospital for Sick Children

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement dated 17th February 2012]

Not Applicable

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement dated 17th February 2012]

None

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

Ref:	Date:	
WS-141-1	17.02.2012	Inquiry Witness Statement

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.

QUERIES ARISING OUT OF YOUR INITIAL WITNESS STATEMENT

With reference to your Witness Statement dated 17th February 2012, please provide clarification and/ or further information in respect of the following:

(1) Answer to Question 3 on p.2:

"I would have arrived back at the hospital around 21:30hrs to receive a handover from the other Senior House Officers in preparation to begin my shift at 22:00 hrs on the 22nd October 1996...Although I remember accompanying Dr. Andrew Sands on his ward rounds, I do not recall having any direct contact with either Claire Roberts or her family during the daytime hours of the 21st or the 22nd."

(a) Describe the normal procedure for the handover of patients between clinicians in October 1996, including who would normally do the handover and what information would normally be conveyed.
Normally the retiring Senior House Officer gave a verbal report to their colleague coming on duty. This report covered all relevant information we would need to continue the patients' care through the night. For example, such a report might include:

(i) *The details of patients on their way for admission, or who still needed to be "clerked in" by medical staff.*

(ii) *Information regarding current ward patients whose condition was causing particular concern.*

(iii) *Important test results to check before the morning ward round.*

(iv) *A list of outstanding tests (E.G., Blood tests, x-rays, etc.) medical staff had yet to complete.*

(v) *A list of outstanding urgent test results that I would need to personally call the lab about through the night.*

(b) Please state whether you specifically attended Dr. Andrew Sands' ward round on the morning of 22nd October 1996. If you are unable to recall, explain how likely it is that you attended Claire Roberts' ward round visit, and any reasons why you may not have been present at that particular time
I may well have been present during Dr. Sands' ward round. I normally was. I would only have been absent if Dr. Sands required my presence elsewhere. I do not recall for certain whether I was there that day or not.

(c) State at what time the ward round was conducted and identify the other clinicians and nurses who attended on that ward round.
I do not recall precisely on this occasion. The round normally began first thing in the morning, I believe around 0800hrs. The ward Sister (or a senior nurse), Dr. Sands, and the Senior House Officers would have routinely attended these rounds.

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

(i) *I do recall her being out of the hospital that morning (perhaps at the Cupar Street Clinic?). I seem to remember Dr. Sands trying to contact her. I do not recall, however, whether or not his attempts were successful.*

(e) State to the best of your recollection whether or not there was any discussion or consideration of Claire's fluid management on the ward round. If so, describe that discussion to the best of your recollection.

(i) I do not recall.

(f) State to the best of your recollection whether or not there was any ward round discussion relating to carrying out a further blood test for electrolytes and/or full blood count on Claire on 22nd October 1996. If so, describe that discussion to the best of your recollection.

(i) I do not recall.

(g) State whether any request was made for a repeat electrolytes test for Claire either during the ward round or later on 22nd October 1996. If so, state who made this request, when it was made and when the sample was to be taken from Claire for that test. If no request was made, explain why not.

(i) I do not recall.

(h) State whether a repeat electrolytes test for Claire was planned either during the ward round or later on 22nd October 1996. If so, state when it was planned to carry out this test and where this was recorded. If it was not planned, explain why not.

(i) I do not recall.

(i) State where a request for blood tests for electrolytes and/or full blood count would usually have been noted/recorded in October 1996, and by whom this request would usually have been recorded. In particular state whether this request would usually have been recorded in:

(i) the clinical notes:
It would be normal to record such requests in the clinical notes, but this would not always happen. Sometimes, the only record for the test request would have been the Senior House Officer's "To-do" list. Such an omission, however, would have been unusual with Dr. Sands.

(ii) the nursing notes: *I am not privy to the kinds of details the nurses document in their notes. They would, however, include major decisions, salient concerns, and any announced plan of action.*

(iii) on a separate piece of paper. *The Senior House Officer's ward-work note book "To-do" list.*

(iv) in the ward round diary: *Yes.*

(v) in a book as 'work to do'. *Yes*

If so, explain when and by whom this would be done and whether it was done in Claire's case. *Sometimes the Registrar would make his own notes in the chart during the round. Sometimes he would delegate this task to one of the more Senior SHOs. I do not recall what happened on that particular morning.*

(2) Answer to Question 4(b) at p.2 & 3:

"...I contacted Dr. Bartholome immediately requesting her assessment of Claire's condition..Although [Dr Bartholome] was tied up treating at least one other sick child, she told me she would see Claire as soon as possible."

(a) State whether you requested Dr. Bartholome to attend and examine Claire and state the reasons why you did so/not.
I did request Dr. Bartholome to see Claire. The Serum Sodium concentration was clearly extremely low. She needed to be seen urgently by a Senior Doctor.

(b) State at what time Dr Bartholome saw Claire for the first time, and whether you were present.
I do not know whether Dr. Bartholome saw Claire before 0300hrs. I was not present during any subsequent examination of Claire by Dr. Bartholome.

(c) State whether you saw Claire again at any time following your attendance at 23.30, and if so, when and in what circumstances. If not, explain why not.
I was not present again with Claire after 23:30hrs. I received no further calls from the nursing staff to attend Claire that night, and I was not "fast-bleeped" to her respiratory arrest. I learned of her collapse early the next morning. I was tied up with patients on the other medical wards for much of the night. I do recall getting a little sleep later on and distinctly remember hearing of the unfortunate events after waking. In conclusion: I did not see Claire again for the reasons outlined under question 47 in my previous report (WS-141-1):

> "Up until 23:30hrs on 22/10/96, I believed Claire to be in a serious but stable condition. After this time and with the arrival of U+E report, I was certainly aware that her condition was much more grave. Having said that, however, Dr. Bartholome stressed the importance of gradually returning the serum sodium level to a more normal range. So I knew this was not something we wanted to correct quickly with a more rapid IV bolus of NaCl. I thought, therefore, that we had time on our hands and that Dr. Bartholome's own assessment in the near future would have shed more light on how best to proceed. I had neither the experience nor any reason to doubt that Dr' Bartholome's plan to restrict Claire's fluids would prove effective in normalizing Claire's serum Na concentration. "
>
> "Having informed Dr. Bartholome of Claire's condition, she did not request me to carry out a preliminary neurological examination. Given Dr. Webb's previous consultation at 1700hrs, the registrar would have been much better placed to carry out and interpret such a nuanced assessment. Believing the registrar would be assessing Claire in the near future, and believing all of the necessary immediate treatment modalities were in place to arrest Claire's deteriorating condition, I left Allen Ward to deal with other pressing medical matters elsewhere in the hospital. The nurses record no further need to contact either Dr. Bartholome or me until around 0300 AM with Claire's unexpected and precipitous collapse."

(3) Answer to Question 17(d) at p. 8:

"...on a child with only a marginally low serum sodium concentration, it would not have been unusual to check the U&E twice daily, and for the second test to occur later in the evening."

(a) If Claire's first blood test results derived from a sample taken at approximately 22:00 on her admission on 21st October 1996 (Ref: 090-040-140), state when you would have expected a repeat electrolytes test to have been performed in October 1996 and the reasons why.
I ceased the practice of medicine in the summer of 1999. As a result, I am no longer qualified to answer that question with precision. But, clearly, I would have to say blood for Serum Urea and Electrolytes (U &E) probably should have been drawn the next morning following her admission.

(4) Answer to Question 20 at p.9 (c):

"[T]he duty registrar, Dr. Andrew Sands ordered [Diazepam] on his ward round (090-022-053). I do not recall the precise reason for this. Given the working diagnosis at that time of non fitting status epilepticus, as I recall, this would have been an entirely normal first step measure in seeking to bring any existing seizure activity under control."

(a) State if you saw Claire's response to the administration of the Diazepam. If so, state to whom you reported her response e.g. Dr Sands or the nursing staff, when you did this, and what was discussed. If not, state, in so far as you can, who witnessed it and who informed Dr Webb of the response.
I do not recall the answers to any of these questions.

(b) In particular, state if you had any input into Dr Webb's note at 16.00 that Claire "*appeared to improve following rectal diazepam 5mg at 12.30pm*"
I do not believe I did.

(c) State whether you were aware of any change or addition to "*the working diagnosis at that time of non fitting status epilepticus*" on 22nd October 1996, and if so state when and how you became aware of this, and the nature of the change/addition to the working diagnosis. If you were not aware of any change or addition, explain why not.
I was not aware of any change or addition to the "Working diagnosis at that time of non fitting status epilepticus." I am unable to recal my precise level of awareness regarding any evolution of Claire's diagnosis.

(5) Answer to Question 21(g) at p.10:

"I would have been responsible for drawing this KCl up from a glass vial and adding it to the drip bag."

(a) Explain why you added KCl (Potassium Chloride) to Claire's IV fluids (Ref: 090-038-136). *In 1996, at least, This was standard operating in Pediatric fluid management to prevent incipient hypokalaemia which can have many deleterious effects upon a child's health. I note her Serum Potassium concentration was 3.3mmol/l at that stage (09-022-056). This is boarderline low test result that would normally require IV supplementation in patient, like Claire, who was neither eating nor drinking.*

(b) State on whose direction you did so.
I do not recall. Dr. Bartholome might have told me or I might have added it on my own initiative.

(6) Answer to Question 24(a) at p.12:

"...The doctors would liaise verbally with the doctor on call informing him of any outstanding work to be done on the ward, or of patients causing particular concern."

(a) State whether you were informed during the handover on the evening of 22nd October 1996:

(i) "*of any outstanding work to be done*" in relation to Claire during the handover or
I do not recall.

(ii) that Claire was a patient "*causing particular concern*"
As an Allen Ward Senior House Officer, I would have been aware of Claire's condition that evening before my departure from the hospital. Later, when I returned for my on call duty, I feel sure the hand over included an update on her condition. I do not recall precise details of this. It is likely that the hand over included a memo to check Claire's U&E result that had been sent to the lab earlier.

(7) Answer to Question 27(c) at p. 15:

"...*I did not inform the consultant on call that evening. This would have been beyond the purview of my position....*"

(a) Explain what you mean by "*beyond the purview of my position....*"
I simply meant beyond the remit of a Senior House Officer's position, espeically one in their first term in paediatrics. Senior House Officers liaise with the Registrar on call. They in turn make the decision to inform the on Call Consultant.

(b) Explain why contacting/informing "*the consultant on call that evening*"... would have been "*beyond the purview of [your] position....*"
My lack of Pediatric experience rendered the Registrar the appropriate member of Staff to liaise with the Consultant on call.

(8) Answer to Question 27(f) at p. 15:

"*There is no record of an urgent repeat blood sample being taken. I do not recall why this was not ordered.*"

(a) Explain whether in October 1996 you would have expected "*an urgent repeat blood sample [to have been] taken*" on receipt of the serum sodium concentration result recorded at 23:30 (Ref: 090-022-056).
I am no longer qualifed to comment what should have been done differenly that night. There is no record of Dr. Bartholome requesting such a test, and I have no recollection of taking one.

(9) Answer to Question 27(g) at p. 15:

"... *the nursing notes do record a fluctuating GCS through the day and into the evening [6-8-6]. I remember Dr. Bartholome commenting that she believed this was as a result of the hypoval infusion*"

(a) State when Dr. Bartholome commented to you that "*she believed this [the fluctuating GCS} was as a result of the hypoval infusion*".
As I recall, I we had this discussion around the time I came on duty, before the alarming Sodium result received at 23:30 hrs. We were discussing Claire's previous seizure like activity.

(b) State to what did you and Dr. Bartholome attribute Claire's low GCS after 10.40pm when the IV hypnoval is recorded as ceasing. (Ref: 090-040-138).
I do not recall.

(10) Answer to Question 28 (a) at p.16:

"*I do not recall seeing a result [of the urine osmolality sample].*"

(a) State whether you personally took and sent the urine sample for osmolality, or whether you requested or expected another member of personnel (e.g. nursing staff) to perform this task. If the latter, please identify the person who requested or expected to perform this task.
I do not recall.

(11) Answer to Question 30(d) at p.17:

"*I believe I was aware of these CNS observations and discussed them with Dr. Bartholome. As I recall she noted that the GCS level fluctuated throughout the day and may well have been related to the hyponoval infusion. Whatever the case, her seizures seemed well controlled... and at that stage we had no reason to suspect a plummeting serum sodium concentration as a cause of her coma...*"

(a) State when and where you discussed "*these CNS observations... with Dr. Bartholome*".
I have difficulty remembering this with precision. I believe we had this discussion around the time I came on duty, before the alarming Sodium result received at 23:30 hrs.

(b) Explain the basis for your view that "*her seizures seemed well controlled...*", in particular with reference to the Record of Attacks Observed (Ref: 090-042-144).
These attacks were brief and appeared self-limiting.

(c) State on what date and at what time or period of time you refer when you state "*and at that stage we had no reason to suspect...*"
When I came on duty at 21:30 hrs and I became aware of Claire's seizure like activity.

(d) Explain the basis for your statement "*...at that stage we had no reason to suspect a plummeting serum sodium concentration as a cause of her coma...*"
Dr. Webb, the Consultant Paediatric Neurologist had assessed Claire earlier that evening. His last note in the chart reads: "CT Tomorrow if she does not wake up" (090-022-54). His note did not in anyway highlight hyponatraemia as a potential cause for Claire's ongoing coma. In my mind, that evening, our goal was to nurse her through the night, ensure her serum Phenytoin levels were within normal limits, and check her serum Urea and Electrolytes which had been taken earlier. I do not remember any doctor involved with Claire's care that day expressing any fear that her Sodium level would be so severely affected by the Syndrome of Inappropriate Anti-Diuretic Honormone Production(SIADH). None of us expected it.

(12) Answer to Question 31 at p. 18

"*...The decision to contact Dr. Steen and Dr. Webb would have rested with Dr. Bartholome.*"

(a) Explain why you state "*..[t]he decision to contact Dr. Steen and Dr. Webb would have rested with Dr. Bartholome.*"
As a fledgling first term SHO, I kept to the chain of the established chain of command: I relay my concerns to the Registar, they decide if and when the Consultants are to be notified. Indeed at this stage of my training, it would not have been at all unusual for the nurses to bypass the first term SHOs and call the Registrar on call directly.

(13) Answer to Question 33 at p.19

"*At 23:30hours, with the parents at home in bed, I would have wanted to wait for Dr Bartholome's assessment before contacting the parents precipitously.*"

(a) State whether you discussed with Dr Bartholome the possibility of informing Claire's parents of her deteriorating condition, and if so, state what was discussed and what was done as a result. If not, explain why.
I do not recall discussing this with Dr. Bartholome. My only concern was that she see Claire as soon as possible.

(14) Question 51(c) at p. 24

"*As I recall, there was no formal induction program during my initial posting at RBHSC in 1996. This made the transition from an adult Junior House Officer Year to a Paediatric Senior House Officer year more than a little stressful.*"

(a) Explain why "*there was no formal induction program during [your] initial posting at RBHSC in 1996*".
I cannot.

(b) State whether there was any informal induction program during your initial posting at RBHSC in 1996, and if so, please describe any training you received in fluid management, hyponatraemia and record keeping. If not, explain why not.
There was no informal induction program at RBHSC that I recall. Consultants and Registrars would have given us ad hoc on the job training. These were not planned and came very much as and when the subjects arose. As I remember, each week, there were hospital wide case discussions of difficult cases. These times included presentations by the registrars of research papers and the like. But these were not aimed specifically at junior doctors and could not really

be described as an organized induction program.

I do remember feeling much more prepared to begin my Junior House Officer year in 1995 than I did my Paediatric Placement in 1996. This is a common feeling among junior doctors in Paediatrics. Most of the 5 year medical program at Queens University, Belfast gears the student to care for the adult patient. By comparison, as I recall, Paediatrics is a 6 week block of study in the 5th year of study. This together with the unique drug dosing and fluid management for children (both of which are tied to the child's changing weight), their nuanced response to disease, not to mention their maturing biophysiology all conspire to make the transition from adult medicine to paediatrics a uniquely stressful experience.. I do not believe my experience was unusual in this regard. I studied hard during my five years at medical school obtaining distinctions in my 2nd and 3rd Medical Examination, and winning the Ulster Hospital Gold Medal (an examination held during final year in the subjects of Medicine, Surgery, Paediatrics, and Obstetrics). Yet despite this academic preparation, during my first months in the Royal Belfast Hospital for Sick Children, I remember feeling very much "at sea", and, like the other first term SHOs, I depended heavily on the counsel and oversight of the registrars.

(15) State if Dr. Webb had a registrar and SHO allocated to the Neurology department as part of the neurology service.

(a) On 22nd October 1996, identify Dr. Webb's neurology

(i) Registrar - *I do not recall*

(ii) SHO. *I do not recall*

(b) State if Dr Webb's neurology

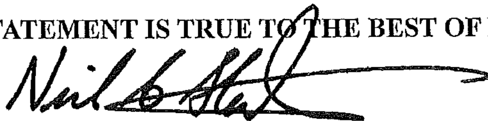
(i) registrar

(ii) SHO.

liaised with you at any time during your treatment of Claire and if so, state when this happened, what was discussed and what happened as a result.

(16) Provide any further points and comments that you wish o make, together with any documents
I have nothing to add to my testimony.

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

Signed:  **Dated:** 17th June, 2012