Witness Statement Ref. No. 143/3

NAME OF CHILD: Claire Roberts

Name: Heather Steen

Title: Dr.

Present position and institution:

As before

Previous position and institution:
[As at the time of the child's death]
Consultant Paediatrician, North & West Belfast Health & Social Services Trust.

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

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

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

Ref:	Date:	
090-050-154	16th March 2005	Statement to the Coroner
091-011-067	25th April 2006	Deposition to the Coroner
WS-143/1	6th March 2012	Witness Statement to the Inquiry
WS-143/2	16th July 2012	Witness Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) Why did you not attend your patient, Claire Roberts, on Allen Ward?

I have addressed this issue in evidence.

(2) If you had attended on the morning and afternoon of 22nd October 1996, would you have done anything differently to what was done?

I am not prepared to speculate.

(3) If you had attended, do you think you could have made any difference to the outcome?

As per (2) above.

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

I am not aware of guidelines for admission to PICU in 1996. All admissions would depend upon a discussion between the clinicians including the PICU Consultant.

(5) After her admission to PICU please identify the clinician who was in charge of Claire's case.

Dr Steen remained in charge.

(6) What responsibility did the PICU consultants have in respect of communication with the parents of an admitted child, and what was his/her role in relation to the same?

The PICU Consultant would have been present throughout the working day and as such had the opportunity to discuss Claire's management with her Parents.

(7) In October at the time of Claire's admission were you aware of the Arieff et al paper BMJ 1992, (Ref: 011-011-074).

I no longer have a clear recollection.

(8) Was the Arieff et al paper circulated in the RBHSC in 1996 amongst:

(a) Paediatric Clinicians;

(b) Nurses;

(c) Neurologists?

(a) to (c) I have no specific recollection.

(9) Was there a heightened awareness amongst clinicians in the RBHSC in 1996 as to

hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?

I have no specific recollection.

(10) **Do you think that there was an iatrogenic contribution to the death of Claire Roberts?**

I did not believe in 1996 that there was an iatrogenic contribution to the death of Claire Roberts. However I now believe there was or may have been an iatrogenic contribution given that fluid mismanagement has been being recognised as an issue.

(11) **With respect to the biochemistry reports (Ref: 090-031-099 *et seq*) sought and received in the course of Claire's treatment, please state:**

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

I have no specific recollection if changes were made.

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

I have no specific recollection.

(12) **"Once the serum sodium result of 121 was known, I would have considered it to be a further contributory factor" [to the cerebral oedema] (Ref: WS-143/1 p.79). In respect of this statement please state the following:**

(a) **Why did you not inform Mr. and Mrs. Roberts that this was your opinion on 23rd of October 1996?**

I have no specific recollection but I believe that I did mention the topic of a low sodium reading.

(b) **Why did you not include it on the initial death certificate?**

I have no specific recollection.

(c) **Why did you not refer to hyponatraemia as a clinical problem or a significant condition in the Autopsy Request Form?**

Please see 12 (b).

(d) **Why did you not refer to hyponatraemia when writing to Dr. McMillin on 6th March 1997 (Ref: 090-002-002)?**

Please see 12 (b).

(e) **Why did you not refer to hyponatraemia at the meeting with Mr. and Mrs. Roberts in March 1997?**

Please see 12 (a).

(f) Did you make any record of this meeting with Mr. and Mrs. Roberts? If not, why not?

I did not make a note. I wrote to Claire's GP ref 090-002-002.

(13) Did you forward the PICU Discharge Summary and PICU Discharge Advice Note to the Pathologist after they were issued?

I have no specific recollection of doing so. I do not know whether these documents were forwarded by PICU staff to the Pathologist.

(14) Please specify all investigations made in relation to the treatment and death of Claire Roberts.

I cannot assist as to the totality of any investigations into the treatment and death of Claire Roberts.

(15) Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose?

I believe the first time that I was asked to make a statement in relation to the case of Claire Roberts was when Dr Walby requested a statement from me for HM Coroner. However I had completed a short "patient journey" for the meeting with Mr and Mrs Roberts in December 2004.

(16) Was Claire's case ever discussed at a Neuroscience Grand Round?

I have no specific recollection.

(17) Please state whether in 1996 you considered that hyponatraemia in a child in hospital was a condition that was:

(a) Preventable?

Hyponatraemia may be the consequence of many disease processes and so may not be wholly preventable. What is important is the need to recognize this complication and thereafter to manage the same.

(b) Treatable?

Please see 17 (a).

(18) Please specify to whom the death of Claire Roberts was reported in 1996, and in particular please state whether any of the following were informed of her death:

(a) Dr. Peter Crean;

I am unable to answer this question.

(b) Dr. Elaine Hicks;

I am unable to answer this question.

(c) Dr. Ian Carson;

I am unable to answer this question.

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

I am unable to answer this question.

(e) **Dr. Joseph Gaston;**

I am unable to answer this question.

(f) **Mr. William McKee;**

I am unable to answer this question.

(g) **Nurse Manager in Paediatric Directorate;**

I am unable to answer this question.

(h) **Miss Elizabeth Duffin;**

I am unable to answer this question.

(i) **Mr. George Brangam.**

I am unable to answer this question.

(19) **Please specify the date, nature and content of any such reports.**

Please see 18 above.

(20) **To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?**

I have no specific recollection.

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

Claire Roberts's death was unexpected.

(22) **Please state whether Claire Robert's cause of death was known to you in 1996?**

I have addressed this issue in evidence.

(23) **Was there any guidance available regarding the reporting of an unexplained death in 1996?**

There was guidance for reporting cases to HM Coroner which involved an unexplained death in 1996.

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

I have no specific recollection of such meetings, discussions, reviews and audits taking place before 2004.

(25) **Please provide information detailing those meetings which took place:**

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

Please see 24.

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

Please see 24.

(26) **Did the Pathologist attend the meeting(s), and if so please identify Pathologist?**

Please see 24.

(27) **Was any learning gained from any such meetings? If so what?**

Please see 24.

(28) **Please set out all memories you have regarding any mortality meetings/discussions at which Claire's case was discussed.**

Please see 24.

(29) **Please state whether Dr. Taylor played any role in mortality meetings/discussions? If so what was that role?**

Please see 24.

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

I cannot answer for the Nursing Directorate.

(31) **Was there an audit of the following aspects of the case of Claire Roberts:**

(a) **Record keeping;**

I have no specific recollection.

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

I have no specific recollection.

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

I would have expected such an investigation.

(33) **Was there any appraisal of staff performance in the aftermath of Claire's death?**

I have no specific recollection. I am not aware of any appraisal of staff performance.

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

I have no specific recollection.

(35) When do you believe the following individuals become aware of the death of Claire Roberts:

Please see 18 above in relation to (a) to (g).

(a) Dr. George Murnaghan;

(b) Dr. Peter Crean;

(c) Dr. Joseph Gaston;

(d) Dr. Ian Carson;

(e) Mr. A.P. Walby;

(f) Mr. George Brangam;

(g) Miss Elizabeth Duffin.

(36) Was any consideration given to inviting external specialists to review the case of Claire Roberts?

I cannot answer this question.

(37) What, in 1996, did you understand the purpose of an Autopsy Report to be?

To inform and confirm the processes leading to and/or causing death.

(38) Was there any system or process in 1996 for the audit of:

(a) Referrals to post-mortem;

I have no specific recollection.

(b) Referrals to Coroner?

I have no specific recollection.

(39) Was this system or process subject to any external scrutiny or review?

I have no specific recollection.

(40) Please state whether any guidelines or conventions existed in 1996 governing post-mortem examinations with specific reference to:

(a) When consent was required for a post-mortem examination;

I have no specific recollection. I have not been able to find any guidelines or conventions.

(b) When a limited post-mortem could be requested;

Please see (a)

(c) Authorisation for the same;

Please see (a).

(d) **The information and options given to the parents of the deceased child in respect of this decision;**

Please see (a).

(e) **Whether parents of the deceased child should be asked for their views on whether or not the Coroner be notified;**

Please see (a).

(f) **Whether parents of the deceased child should be asked for their views on whether a full or restricted post-mortem should be carried out;**

Please see (a).

(g) **Whether the Autopsy Report should have been shared with the parents and GP of the deceased child?**

Please see (a).

(h) **Did you consider the potential benefits of a conventional post-mortem examination? If so what were these considerations?**

I have no specific recollection.

(41) **What was the origin of the pro-forma consent form used for the limited post-mortem presented to Mr. Roberts for signature (Ref: 090-054-185)?**

I do not know the origin of the proforma.

(42) **Was there Trust printed advice in respect of seeking consent for post-mortem?**

I have no specific recollection of any printed advice.

(43) **Did you speak to the Pathologist before you submitted the Autopsy Request Form?**

I have no specific recollection of speaking to the Pathologist.

(44) **Did you have any subsequent discussions with the Pathologist?**

I have no specific recollection of any discussions with the Pathologist.

(45) **Did you have any input into the choice of Pathologist used for Autopsy?**

I did not have any input into the choice of the Pathologist used for the Autopsy.

(46) **On what basis did you conclude for the purposes of the death certificate that the cerebral oedema was secondary to status epilepticus?**

I have addressed this issue in evidence.

(47) **In respect of the Autopsy Request Form, please state the following:**

(a) Was the Pathologist supplied with the medical/case notes?

Yes.

(b) Was any other information provided to the Pathologist, either verbally or in writing?

I have no specific recollection.

(c) Specifically did you provide the Pathologist with a written clinical summary at time of first request for Autopsy?

No, merely the Autopsy Request Form.

(d) Why the date of admission is given as 22nd October 1996;

This was an error.

(e) Why Dr. Webb is seemingly named as lead consultant;

I do not know why I wrote Dr Webb as the first name.

(f) Why an incorrect history is given of being *"well until 72 hours before admission"*;

I have addressed this issue in evidence.

(g) Why an incorrect history of vomiting *"for 24 hours prior to admission"*?

I have addressed this issue in evidence.

(h) Why no reference is made to Midazolam?

I have addressed this issue in evidence.

(i) Why the antecedent cause to cerebral oedema is stated as *"status epilepticus"* when Claire Roberts was merely *"felt to have sub-clinical seizures"[emphasis added]*;

I have addressed this issue in evidence.

(j) Why no other significant conditions are noted as making any contribution to the death;

I have addressed this issue in evidence.

(k) Why hyponatraemia is not listed as a clinical problem or additional condition?

I have addressed this issue in evidence.

(l) Why you chose not to attend a review session on the day of Autopsy?

I have addressed this issue in evidence.

(m) Why you chose not to use the word 'hyponatraemia'?

I have addressed this issue in evidence.

(n) Why was this request not dated?

I do not know why the request is not dated.

(o) What date was the same completed?

I believe it was completed on the evening of 23rd October 1996.

(p) Were the chest x-rays brought to the attention of the Pathologist?

I do not know if the chest x-rays were brought to the attention of the Pathologist.

(48) Did you have any diagnostic doubt as to the cause of Claire Roberts' death in October 1996?

I cannot answer this as I have no specific recollection.

(49) In respect of the Autopsy Report please state:

(a) When you received this?

I have no specific recollection when I received the Autopsy Report.

(b) From whom you received it?

I do not know how or when I received the Autopsy Report.

(c) Who was the Pathologist?

Dr Herron.

(d) Why did you not share the report with Mr. and Mrs. Roberts;

I wrote to Dr McMillin ref 090-002-002 . Dr Webb's wrote to Mr and Mrs Roberts and provided them with a short summary of the Autopsy Report as requested ref 090-001-001.

(e) Why did you not share the report with Dr. McMillin;

It was not my usual practice to copy Autopsy Reports to Dr McMillin.

(f) With whom did you share the report?

I have no specific recollection.

(g) Did you speak to Dr. Heron or Dr. Mirakhur to discuss the Report and findings at this time?

I have no specific recollection.

(h) Did you take any steps to correct the mistakes and inaccuracies in the report, i.e. date of admission, time of death, epileptic history, type and duration of symptoms prior to admission?

No as I was not aware of any particular mistakes and/or inaccuracies in the Autopsy Report.

(i) **Was the Autopsy Report presented at the mortality meeting?**

I have no specific recollection.

(j) **What did you learn from the Autopsy Report that you did not already know? Did it assist you in identifying a cause of death?**

The Autopsy Report provided me with confirmation of the cause of death.

(k) **Did you file the Autopsy Report in with the case notes? If not, why not?**

I have no specific recollection.

(l) **Did you consider bringing the case of Claire Roberts before the Northern Ireland Working Group on Hyponatraemia in Children?**

No.

(50) **Did you ever receive a signed copy of the Autopsy Report? If so, please provide copy of the same.**

I have no specific recollection.

(51) **Please state if any advice was sought from the Coroner's office in respect of referral of the death of Claire Roberts to him.**

I have no specific recollection of seeking advice from HM Coroner's Office.

(52) **Why did you not report the death to the Coroner?**

I have addressed this issue in evidence.

(53) **Please state whether the advice of the Director of Medical Administration, Dr. George Murnaghan, was sought in relation to referral of Claire Robert's death to the Coroner in 1996.**

I have no specific recollection of Dr Murnaghan being contacted.

(54) **Do you accept the Coroner's findings in the case of Claire Roberts (Ref: 091-002-002)?**

Yes.

(55) **Why did you not meet with Mr. and Mrs. Roberts on 11th November 1996?**

I was not in the hospital at the particular time of the visit by Mr and Mrs Roberts.

(56) **How many patients died annually in PICU in 1995 and 1996?**

I do not have this information.

(57) **In October 1996 were you aware of:**

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

I have no specific recollection when I became aware of some or all of these publications and their contents.

(b) Good Medical Practice (GMC- 1995)

I have no specific recollection when I became aware of some or all of these publications and their contents.

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

I have no specific recollection when I became aware of some or all of these publications and their contents.

(d) Directive PEL (93)36?

I have no specific recollection when I became aware of some or all of these publications and their contents.

(e) Welfare of Children and Young People in Hospital (HMSO 1991);

I have no specific recollection when I became aware of some or all of these publications and their contents.

(f) The Paediatric Intensive Care Society (UK) Standards document, 1992.

I have no specific recollection when I became aware of some or all of these publications and their contents.

(58) With reference to document (Ref: 090-006-008), please state:

(a) Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to the initials of Dr. McKaigue? If so why was this note made?

I do not know the answers to these two questions.

(b) Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?

I do not know where these papers were filed.

(c) Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/role role in relation to this matter?

I do not know a Dr Allen.

(59) How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?

I do not know how the death of Claire Roberts was categorised.

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

I have no specific recollection of this audit.

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

(b) Investigation of patient's death;

(c) Review of medical records;

(d) Systematic programme of audit;

(e) Implementation and compliance with published guidance?

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

I do not recollect in 1996 being made aware of any details relating to the death of Adam Strain or any related changes in patient care relevant to hyponatraemia.

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

(b) How such changes were formulated and disseminated;

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

(62) Please state whether you received any training or guidance (including details of the same) in respect of:

(a) to (c) I cannot remember and now state what specific training and/or guidance I had or received either as an undergraduate or as a young postgraduate.

(a) The compilation and completion of death certificates;

(b) Referral of deaths to the Coroner;

(c) The principles governing post-mortem requests.

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

I have no specific recollection of learning any lessons from the death of Claire Roberts **at the time.** However since November 2004 it has become obvious to me that there was/is a need for a comprehensive review of **all** aspects of care relating to Claire's management.

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

Please see 63.

(65) **With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts?**

Please see 63.

(66) **Please describe how the 'culture' within the RBHSC has changed since 1996?**

Please see 63.

(67) **What was the appropriate procedure in 1996 in response to serious incidents of error in drug administration?**

I have no specific recollection.

(68) **Was there guidance in respect of reporting a drug administration error as an adverse incident? Should it not have been so reported?**

I have no specific recollection.

(69) **In 1996, whose responsibility was it to determine the type and frequency of observations of:**

(a) to (d) The overall responsibility for determining the type and frequency of observations rested with the medical staff.

(a) **Vital signs (Temp, HR, RR & BP)?**

(b) **Neurological observations including GCS?**

(c) **Fit charts?**

(d) **Accurate recording of fluid output, including decisions regarding weighing of nappies and use of naso-gastric tubes and urinary catheters?**

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

I have no further comments to make here.

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

Signed: Heather J Shum **Dated:** 6-11-12