Witness Statement Ref. No. 143/4

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]

As before

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 – September 2012]

As before

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

As before

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

Ref:	Date:	
WS-143/1	06-03-2012	Inquiry Witness Statement
WS-143/2	10-07-2012	Second Inquiry Witness Statement

MPORTANT 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.

I. QUERIES ARISING OUT OF YOUR STATEMENT TO THE INQUEST

With reference to your statement to the Inquest dated 16th March 2005 and your previous witness statements to the Inquiry, please provide clarification and/or further information in respect of the following:

(1) Your expectations of the doctors, junior to you, who attended Claire at the times when the following entries were made in her notes; please include in your responses a description of what you would have expected them to do, record and communicate together with the basis for that expectation:

(i) General comments:

In 1996 there were 4 main grades of junior doctors in RBHSC. These were 1st term – junior doctors with less than 1 year paediatric experience (SHO); 2nd term junior doctors with usually 1-3 years paediatric experience (SHO); Registrars – junior doctors with more than 3-4 years experience (who would usually have completed specialist examinations (Membership)) and senior registrars who would have had 5 years paediatric experience. Allen Ward had a 1st term SHO, 2nd term SHO and a Registrar.

During the working day the registrar or if this doctor was not available, the 2nd term SHO would have overseen the ward. Nursing staff and the 1st Term SHO would initially refer to them but if they believed it necessary, would have contacted me by telephone or by bleep.

Out of hours, there were two 1st term doctors, one for surgery and one for medical. After 10pm one would cover both specialties. There was a 2nd Term SHO to cover PICU as well as the wards. A registrar would have been on call for the inpatients and also supported consultations in A&E. The reporting system was the same as during the day.

It would have been the normal process for any junior doctors, or at times the senior nurse to contact the named consultant, or the consultant on call when out of hours if there were concerns about a patient. After such discussions it would be usual when needed to seek further opinions. Practice in RBHSC was that telephone contact could be made with the named paediatrician from 0900 on Mondays to 1700 on Fridays if it was believed that that

consultant could deal with any issue more appropriately. The named consultant was not, however, required to respond when he/she was not on call but would do so if called upon. Please see the rota referred to in my previous statement, WS -143/2.

If the child was an inpatient and required a speciality opinion as soon as possible, referrals were usually verbally from either Registrar or Consultant to the other Registrar or Consultant and a note was written in the medical notes.

(a) ***"Dr. O'Hare reassessed her at midnight and felt she was slightly more responsive with no signs of meningism and so advised to continue with observations. It is noted that at the blood results from the sample taken earlier were U&E - sodium 132mmol/L..."*** **(Ref: 090-050-155)**

Dr O Hare was the on call paediatric registrar. I would have expected her to contact me if Claire's condition had deteriorated. I would not have expected her to contact me with a serum sodium of 132mmol/L as Claire was stable at that time and the sodium level was just below the lower limit of normal.

(b) ***"21/10/96 10pm... Bloods taken. IV fluids. 5/N saline commenced at 64mls/hr... S/B Dr and Registrar. To be reviewed following blood results and erection of IV fluids..."*** **(Ref: 090-040-140)**

This is a nursing entry. I would have expected that the junior doctors to be informed of the results. The results would have been reviewed and I would have expected a reassessment to be carried out once the results were available and the IV fluids had been erected. A summary of the reassessment should have been made in the medical records.

(c) ***"22/10/96 7am... IV fluids continued as listed..."*** **(Ref: 090-040-140)**

This is a nursing record summarising Claire's overnight condition. There is nothing in the note to indicate that there had been any deterioration or any concerns raised by the nursing staff for which a doctor needed to be informed.

(d) "8am-2pm. ... Late morning Claire became lethargic and "vacant". Parents concerned as Claire is usually very active. Seen by Dr. Sands..." (Ref: 090-040-140)

I would have expected Dr Sands to see Claire. I would have expected him to take a full clinical history from the carers and nurses present, carry out a full clinical assessment, commence any urgent investigations, liaise with the neurology service and ensured that any urgent medication was given. He should have kept me informed of Claire's progress. A summary should have been made in the medical records.

(e) ***"She was seen in and around 11 o'clock by Dr. Sands, Paediatric Registrar attached to Allen Ward at that time. Although no seizures had been noted, he was concerned at her continuing unresponsiveness and her overall general condition"*** **(Ref: 090-050-155)**

Please see reply at (d).

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

Please see reply at (d).

(g) *"She was seen around lunchtime by Dr. David Webb...He noted that "The picture is encephalopathy most probably postictal in nature. I note (N, biochemistry profile)""* **(Ref: 090-050-155)**

This was part of the Consultant Neurologist's assessment and I would have expected junior staff to carry out any requests Dr Webb would have made to facilitate Claire's care and ongoing management.

(h) *"In view of her non fitting status he advised that she be loaded with intravenous phenytoin 18mg/kg stat followed by 2.5mg twelve hourly... At 14.45 hours intravenous phenytoin was administered and she was reviewed again by Dr. Webb at approximately 15.10 hours."* **(Ref: 090-050-155)**

Please see (g) above. This was part of the Consultant Neurologist's management plan and I would have expected the junior doctors to assist as requested.

(i) *"...He requested that hourly CNS observations be carried out..."* **(Ref: 090-050-155)**

The nursing staff would have carried out the hourly observations or as per Dr Webb's instructions. It there had been any concerns I would have expected the nurses to inform the junior doctors so that they could carry out a clinical reassessment and contact Dr Webb for further advice. If, for any reason they had been unable to contact Dr Webb, I would have expected them to contact me.

(j) *"He requested that ... a CT scan be arranged for the following day if her condition did not improve."* **(Ref: 090-050-155)**

I expected junior doctors to follow Dr Webb's instructions and to inform him if there was any clinical deterioration. If they could not make contact with Dr Webb, I would have expected them to contact me. In particular, if Claire's condition was such that she had not woken up the next morning, I would have expected that Dr Webb would have been informed at the start of the working day. The CT scan could only have been organised through a Consultant Neurologist at that time in the hospital.

(k) *"...she was reviewed again by Dr. Webb at approximately 15.10 hours. He felt that she continued to be in status epilepticus and advised commencement of Midazolam with a stat dose of 12mg intravenously infusion of 2mg/kg a minute"* **(Ref: 090-050-155)**

I would defer to Dr Webb on this but would have expected that the junior doctors would have followed Dr Webb's instructions and contacted him with regards to any concerns with Claire's condition, treatment or any deterioration in her condition. If they could not contact him then they should have contacted me.

(l) *"Dr. Webb reviewed Claire again at 17.00 hours and her mother was in attendance this time....he advised...further stool, blood and urine sent for viral cultures and that in view of her continuing non fitting status that intravenous Sodium Valproate be commenced with a loading dose of 20mg/kilo IV and then an infusion of 10mg/kilo over 12 hours. ..."* **(Ref: 090-050-155).**

Again, I would have expected the clinicians present to carry out Dr Webb's instructions and if concerned reassess Claire with a review of her observations and conduct a clinical assessment. If they had any concerns they should then have contacted him immediately if it was a neurological matter, or myself.

(m) *"CNS observations continued to be carried out over this period of time and it was noted that Claire's Glasgow coma scale varied between 6 and 7."* **(Ref: 090-050-155)**

I would have expected the doctors to have been notified and to have followed Dr Webb's instructions as to what to do in these circumstances. If they had any concerns whatsoever they should have contacted Dr Webb or me as the named consultant.

(n) **"At 1915 hours Claire clenched her teeth and groaned for approximately one minute. It was noted at 2100 that she passed urine but also had an episode of screaming and drawing up of her arms. Her pulse increased at that time to 165b/min and her pupils were large but reacting to light. This episode last approximately 30 seconds and the doctor was informed of this." (Ref: 090-050-155).**

I would have expected the doctor to have attended Claire, reviewed her observations, carried out a clinical assessment and if there were concerns, that Claire's condition was changing, discuss these with a more senior colleague. A note should have been made in the medical records.

(o) **"At approximately 21.00 hours bloods were taken for phenytoin levels along a repeat urea and electrolytes. Intravenous antibiotics were given and her drug card was rewritten by Dr. Hughes. It is noted at that time she had a low grade pyrexia with a Glasgow coma scale of 6." (Ref: 090-050-155).**

I would have expected the doctor when administering the intravenous medication to have reviewed her observations, carried out a clinical assessment and if there were concerns, that Claire's condition was changing, discuss these with a more senior colleague. A note should have been recorded in the medical records.

(p) *"At 2330 hours blood results were received from the sample takes at approx 2100 hours, showing a sodium of 121 mmol/L.... Dr Neil Stewart, Paediatric SHO, was informed of these results and discussed them with Dr. Brigitte Bartholome, the Paediatric Registrar, on call for the hospital. She advised that the N/5 saline be reduced to 2/3 of its present value i.e. 41mls per hour and that urine be sent for osmolality"* **(Ref: 090-050-156).**

I would have expected the junior staff to reassess Claire, review her observation chart and her input and output chart. I would have expected them to request a repeat serum U and E osmolality and a urinary U and E osmolality to be carried out urgently. If there was any difficulty in obtaining a urinary specimen they should have considered urinary catheterization. I would have expected the IV fluids to be reduced to 2/3 and a consultant to be contacted urgently. A note should have been made in the medical records.

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

Signed: Heather J Stern **Dated:** 2014/12