Witness Statement Ref. No. 157/1

NAME OF CHILD: Claire Roberts

Name: Robert Taylor

Title: Dr

Present position and institution:

Consultant Anaesthetist, Belfast HSC Trust

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

Consultant Anaesthetist, Belfast HSC Trust

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

1997-8 Provision of Paediatric Surgical Services Working Party
30th September 1997. Regional Working Group on the care of Acutely Ill Children; Sub-Group on Paediatric Intensive Care.
1998-2005, Local Advisory Paramedic Steering Committee
1997-98, EH&SSB Working Party on Meningococcal Disease,
1999-2005, Sick Child Liaison Group,
Sept 2001-Jan2002, Hyponatraemia Working Party,
2002, Paediatric Long-Term Ventilation Working Party,
Jun 2003-Feb 2004, Neonatal/Paediatric Interhospital Transport Working Party,
2003-2005, Chairman Clinical Audit Committee, RGH Trust
2002-2005, Member Clinical Ethics Committee, RGH Trust
End-of life Working Party. General Medical Council, London 2008-2010
Clinical Ethics Committee, Belfast HSC Trust 2008-11
Clinical Ethics Committee, NI Hospice 2007-11

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

No previous statements regarding Claire Roberts.

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) **Describe your work commitments to the Royal over the period 21st October 1996 to 23rd October 1996.**

I cannot recall my work commitments over this period and have no records of them. However, from the medical notes I was present in PICU on the 23rd October from 09.00 to approximately 17.00.

(2) **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**

I was present in PICU on the 23rd October from approximately 08.30 to 17.00.

(b) **Whether you were on call during that period**

I do not have any records of the on call rota during that period and cannot recall if I was on call for emergencies. It is clear that Dr McKaigue was on call on the night of the 22nd and early morning of the 23rd.

(c) **What contact you had with Claire and her family during that period including where and when that contact occurred.**

From the medical notes I recorded a note about Claire during the PICU ward round on the 23rd October. I have no other record of contact with Claire or her family. As the PICU consultant it was my practice to see Claire on the ward round, and at other times if requested, and other PICU

patients, learn of her past and recent medical history from the medical records, examine her, request any relevant investigations and produce a management plan.

(3) **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 had no role in her care at this time.

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

I had no role in her care at this time.

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

My role and responsibilities as the PICU consultant were from approximately 08.30 to 17.00 on the 23rd October 1996. These were as outlined in 2(c), to see Claire, and other PICU patients, on the ward round and at other times if requested, learn of her past and recent medical history from the medical records, examine her, request any relevant investigations and produce a clinical management plan.

(4) **Describe in detail your actions in the care, management and treatment of Claire between her attendance at A&E at RBHSC on 21st October 1996 and 23rd October 1996 when ventilatory support was withdrawn, and in particular:**

(a) **State the reasons for those actions.**

My actions in the care, management and treatment of Claire as the PICU consultant were from approximately 08.30 to 17.00 on the 23rd October 1996. From my note (Ref: 090-022-061) at around 10.00 am on the 23rd October 1996 I had knowledge of her recent medical history, examined her and produced a management plan to prepare to meet the requirements for Brain Stem testing with a stable blood pressure and electrolyte status.

(b) **Specify which actions were carried out on the express instruction of other clinicians, identifying each clinician and describing the respective instructions given and identify where they are recorded in her notes.**

There is no record of another clinician being consulted during the period when I was the PICU consultant approximately 08.30 to 17.00 on the 23rd October 1996.

(c) **State whether you sought advice or consulted with any other clinician(s) prior to taking any of those actions, and if so:**

(i) **Identify the clinician(s) from whom you sought advice or with whom you consulted and state when you sought advice or consulted them**

There is no record of another clinician being consulted during the period when I was the PICU consultant approximately 08.30 to 17.00 on the 23rd October 1996. According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during this time period.

(ii) Explain the nature of the advice you sought/the issues on which you consulted

According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during this time period.

(iii) Explain the advice that was given by the clinician(s)

No advice was given by other clinicians.

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

As above answer (ii). According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during my time on duty in PICU.

(5) 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.**

I wrote the note (Ref: 090-022-061) at around 10.00 am on the 23rd October 1996.

(b) **the source of the information recorded in the entry.**

The information was sourced from the medical records (090-022-050 to 090-022-060).

(6) State whether a PICU fluid balance and IV prescription sheet was completed in respect of Claire Roberts on 23rd October 1996.

(a) **If so, identify and furnish a copy of it. If you are unable to do so, explain why.**

I knew it was completed but I do not know its location.

(b) **If this PICU document was not completed on 23rd October 1996, explain why.**

I believe it was completed and that I would have seen it on the 23rd October 1996.

(7) 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.

(a) **In particular, identify the consultant who was responsible for the care and management of Claire immediately prior to her admission to PICU and state the reasons for your answer.**

Dr Steen was the named Consultant Paediatrician responsible for Claire at this time. Dr McKaigue was the Consultant Anaesthetist responsible for her Paediatric Intensive Care management at this time.

(8) **Identify who carried out the handover to you in relation to Claire on 23rd October 1996, and state what information was given to you, or if you do not recall specifically, what information was likely/normally given during that handover, about:**

(a) **Claire**

I cannot recall what information was given to me verbally or who performed the handover. Normally the handover would include the probable/definitive diagnosis, current management and an indication of which investigations or therapies would be required.

(b) **The reason for Claire' s transfer to PICU**

I cannot recall what verbal information was given to me or by whom regarding the reason for her transfer to PICU. According to her medical records (090-022-050 to 090-022-060) the reason she was transferred to PICU was because she was intubated on the ward following her respiratory arrest and needed to be ventilated, stabilised and monitored in PICU.

(c) **Claire's diagnoses since her admission to RBHSC and on transfer to PICU**

I cannot recall what verbal information was given to me or by whom regarding her diagnosis. According to her medical records (090-022-050 to 090-022-060) the diagnoses were; viral illness, seizures, encephalopathy, SIADH, hyponatraemia and respiratory arrest.

(d) **The cause of Claire's respiratory arrest and fixed and dilated pupils**

I cannot recall what verbal information was given to me or by whom regarding the cause of her respiratory arrest and fixed and dilated pupils. According to her medical records (090-022-059) the causes of her respiratory arrest and fixed and dilated pupils were; seizures, encephalopathy, SIADH and hyponatraemia.

(e) **Claire's serum sodium concentration since her admission and in particular, the serum sodium concentration of 121mmol/L recorded at 23.30 in Claire's medical notes on 22nd October 1996 (Ref: 090-022-056), and the cause of these sodium concentration levels**

I cannot recall what verbal information was given to me or by whom regarding her serum sodium levels. According to her medical records (090-022-059) the cause of these serum sodium levels was SIADH.

(f) **The cause of Claire's cerebral oedema**

I cannot recall what verbal information was given to me or by whom regarding the cause of her cerebral oedema. I cannot identify a note of the cause of Claire's cerebral oedema in her medical records

(g) **The likelihood that Claire had SIADH and the possible causes**

I cannot recall what verbal information was given to me or by whom regarding SIADH and the possible causes. According to her medical records (090-022-056, 057, 059) SIADH is listed as a diagnosis. I cannot find a note as to the possible causes of SIADH.

(h) **Claire's fluid input and output since her admission**

I cannot recall what verbal information was given to me or by whom regarding her fluid balance. I would have seen her fluid input and output on the fluid balance sheet. I cannot identify the fluid balance sheet and I do not know its location.

(i) **Claire's presentation, attacks and central nervous observations since her admission**

I cannot recall what information was given to me or by whom regarding her presentation, attacks and CNS observations since her admission. I would have had access to her medical records (090-022-050 to 090-022-060) regarding her presentation, attacks and CNS observations.

State where this information at handover is recorded in Claire's notes. Identify any protocol, guidance and/or practice dealing with such a 'handover'.

I cannot find any record of the handover. I cannot identify any protocol dealing with this. Standard practice would have been to provide the in-coming doctor with the patient's history and probable diagnosis(es), relevant physical findings, results of investigations and those needed and the current clinical management plan.

(9) *"23/10/96 Hypotensive BP 70/3 c ¯ D.I. given HPPF 500ml. Needs DDAVP to limit polyuria. Appears B.S. Dead informally. But only 7 hrs post arrest. Na+ 129 (from 121). Plan - Maintain BP > 100 - DDAVP."* **(Ref: 090-022-061)**

(a) **Confirm if you made this note in Claire's medical notes and state the time at which you made it.**

Yes this is my note. It is an oversight that it is not timed but fortunately I have stated that it was 7 hrs since her arrest (at 3am). Therefore it was written at 10am.

(b) **State at what time on 23rd October 1996 you examined Claire.**

I cannot recall the time. It would have been prior to writing the note.

(c) **Explain** *"c ¯ D.I."*

I believe this infers that the hypotension was related to Diabetes Insipidus hence the abbreviation "with DI"

(d) **Explain** *"Needs DDAVP to limit polyuria"*.

It appeared that the large volume of dilute urine (polyuria) was causing hypotension and DDAVP was used to reduce this large volume of urine in order to maintain the blood pressure so that formal brain stem testing could be undertaken later that day.

(e) **State whether you believed that Claire had polyuria or may become polyuric on 23rd October 1996 and explain the reasons why.**

I believed that she was polyuric on the basis of neurogenic Diabetes Insipidus (DI) because of brain stem death.

(f) **Explain why you believed that polyuria needed to be limited.**

This was recommended treatment.

(g) **Explain your assessment of Claire's fluid management up to her admission to PICU.**

I cannot recall my assessment of Claire's fluid management up to her admission to PICU. At that time my care and management was to support her blood pressure and prepare for formal Brain Stem testing later that day.

(h) **Explain your decision to prescribe 500ml of HPPF at the time of your note.**

I did not prescribe this fluid. I have written "given HPPF 500 ml". This means that it had already been given prior to my care of Claire.

(i) **Explain your decision to prescribe DDAVP at the time of your note, and what volume and rate of administration of DDAVP was prescribed.**

As in 9(f), This was recommended treatment. This was prescribed as "Desmopressin 4 mcg in 39 ml N Saline 1ml/hr."(090-029-089) I cannot identify who signed this prescription.

(j) **Identify the medical notes where the administration of the HPPF and the DDAVP are noted.**

I cannot identify the PICU fluid chart where the HPPF was noted. The Desmopressin is noted as given at 11.00 hrs on the Drug Prescription chart as "A" (090-029-089)

(k) **Identify the printed laboratory biochemistry report recording the serum sodium result of 129mmol/L and/or furnish a copy of it. If this laboratory report is missing, explain why.**

I cannot identify the lab report or explain why it is missing.

(10) **Describe how your knowledge of the Adam Strain case affected your care and treatment of Claire Roberts, and, if so, how it did so.**

I believed that in Claire's case the cerebral oedema was due to SIADH and/or encephalopathy and had occurred prior to my involvement. My care for her was to maintain her Blood Pressure and electrolytes prior to brain stem testing. My knowledge of Adam's case was regarding the anaesthetic management of a child undergoing renal transplantation. I do not think that the knowledge of Adam's case was of clear relevance to my care of Claire.

(11) **State if you had any role in formulating the cause of death. If so, describe the role you had.**

I did not have any role in formulating the cause of death.

(12) State whether Claire's fluid management contributed to or caused her hyponatraemia, and explain the reasons why/not.

I believe that Claire had an SIADH response that caused hyponatraemia and agree with Dr McKaigues note in her records (090-022-059). Therefore I cannot state whether the fluid management contributed to or caused her hyponatraemia.

(13) State if you thought Claire had SIADH and explain the basis for your answer including the likely cause thereof.

As in answer 12. I believe that Claire had an SIADH response that caused hyponatraemia and agree with Dr McKaigue's note in her records (090-022-059).

(14) Describe the communications that you had with the Consultant responsible for Claire on her admission to PICU, including:

(a) **Time of each communication**

Dr McKaigue admitted Claire to PICU after her respiratory arrest at 3am. I was not on duty in PICU until around 08.30. Therefore I would not have had any communication at the time of her admission to PICU. I have previously described what happened at the time of commencement of my duty in PICU in answer 3(c) *"My role and responsibilities as the PICU consultant were from approximately 08.30 to 17.00 on the 23rd October 1996. These were as outlined in 2(c), to see Claire, and other PICU patients, on the ward round and at other times if requested, learn of her past and recent medical history from the medical records, examine her, request any relevant investigations and produce a clinical management plan"*

(b) **Means by which the communication was made**

I cannot recall or find the means of communication.

(c) **Nature of each communication**

I cannot recall or find the 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**

I cannot recall any advice or direction given.

(15) State what communication you had with Dr. Heather Steen in relation to Claire between 21st October 1996 and her death 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.**

I cannot recall if I had any communication with Dr Steen during this time. My clinical duties to Claire was as the PICU consultant from 08.30-17.00 on the 23rd October 1996. As in answer 4(ii) *According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during this time period.*

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

I cannot recall any communication.

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

I do not recall any communication with Dr Steen.

(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.**

I do not recall any communication with Dr Steen nor any advice or instructions given.

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

I cannot identify any such document.

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

As in answer 4(ii) *According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during this time period.*

(16) **State what communication you had with Dr. David Webb in relation to Claire between 21st October 1996 and her death 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.**

I do not recall any communication with Dr Webb.

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

I cannot identify who initiated any communication nor the reason.

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

I do not recall any communication with Dr Webb.

(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 do not recall any communication with Dr Webb.

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

I cannot identify any such document.

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

As in answer 4(ii) *According to my note (Ref: 090-022-061) there did not appear to be a need to consult another clinician during this time period.*

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

From my note I perceived her to be very seriously ill. I would have read the notes and seen that she had suffered a respiratory arrest at 3am and had met the criteria for brain stem death with evidence of serious cerebral oedema on the CT scan at 05.30 on the 23rd October 1996. (090-022-058).

(18) **State whether, in your opinion, consideration should have been given to admitting Claire to PICU at an earlier stage. and explain the reasons for your answer. If so, state when should this have been considered and by whom.**

I believe this is a question better answered by those involved in her care prior to transfer to PICU.

(19) **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.**

I do not recall communicating with Claire's parents and do not have any record of this.

(b) **Identify to whom you gave this information.**

I do not recall giving any information.

(c) **State when and where you told them this information.**

As in 19 (b)

(d) **Identify where the information you communicated/received was recorded or noted.**

As in 19 (b)

(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.**

As in 19 (b)

(f) **State if you discussed Claire's condition at any time with her parents. If so, state when, who was present, what was discussed and where this is noted. If it was not noted, explain why it was not noted.**

As in 19 (b)

(g) **State whether you informed Claire's parents/family of the diagnosis, its implications and the treatment needed. 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.**

As in 19 (b)

(h) **State exactly what, if anything, you informed Mr. and Mrs. Roberts after Claire's death in relation to:**

(i) Hyponatraemia and

As in 19 (b)

(ii) Claire's serum sodium level

As in 19 (b)

(iii) Whether (i) and/or (ii) caused or contributed to the cerebral oedema and/or Claire's death

As in 19 (b)

In addition, state the time when and location where you informed them of these matters, and identify the persons present on each occasion. If you did not inform Mr. and Mrs. Roberts of any of the matters above, explain the reasons for not doing so.

As in 19 (b). I cannot explain the reasons as I do not recall speaking to them. There is no record of any discussion. It may be that Dr Steen as the lead clinician would have spoken to them.

(20) **Describe any learning from Adam Strain's case which you used in your care of Claire.**

I cannot recall any learning from Adam's case which was used in my care of Claire Roberts. They appeared to differ from each other in that Adam was a child with chronic renal failure having a kidney transplant operation and Claire was being treated for encephalopathy and seizures.

(21) **Identify who should have made the decision:**

(a) **whether or not to refer Claire's case to the Coroner**

It should be the doctor who declared the patient dead.

(b) **whether or not to hold a full or limited to brain only post-mortem**

This is usually a decision made between the Doctor and the Coroner.

and explain your reasons why.

This is usual practice. The doctor declaring death has most knowledge of the clinical details.

(22) **State whether you had any involvement or role in those decisions, and if so, describe your involvement/role. If not, explain why not.**

I did not have any role in these decisions.

(23) **State whether you consider that Claire's case should have been referred to the Coroner, and explain the reasons why.**

It would be usual to refer or discuss a case with the Coroner if the cause of death was un-natural or un-explained or as a result of an accident.

(24) **State whether you consider that there should have been a full post-mortem, and explain the reasons why.**

I cannot recall if I felt that there should have been a full post-mortem. At that time the parent's wishes would have been taken into account.

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

I cannot identify and protocols or guidelines from this time.

(26) **State whether you were aware of any discussions involving the Trust, clinical or managerial staff relating to Claire's death and her inquest and the lessons that could be learned and/or action that should be taken as a result of her death.**

(a) **If so, state when those discussions took place, who participated in them and what the outcome was.**

I do not recall being involved in any discussions in this regard. I do not have any record of any discussions or who participated in them nor what the outcome was.

(b) **State, in particular, the extent to which you were involved in any such discussions and/or action.**

As in answer 26(a)

(c) **If you were not involved in either discussions or action, explain why not.**

As in answer 26(a).

(27) **State whether there is any record of learning from Claire's death through events (e.g. case conferences, grand rounds, post-graduate clinical meetings, audits, nurse education meetings, etc.) from 23rd October 1996 onwards. If so, please furnish copies of relevant documents. If not, explain why not.**

I am not aware of any such record. Please also see 28(a)

(28) **State whether Claire's death was considered / discussed in any continuing medical education meetings (e.g. Neuroscience Grand Rounds,Neuropathology (Autopsy and Biopsy Review) Department meetings, seminars, Journal Club, topic and casenote reviews, Paediatric Grand Rounds, etc.).**

(a) **If so, provide details thereof, including when, where and why this was considered / discussed, by whom, the nature of the consideration / discussion, and what was done as a result thereof, and furnish copies of all documents including notes, minutes, correspondence or memoranda relating thereto.**

It was usual practice at that time to present all child deaths at the Paediatric Directorate Clinical Audit mortality meeting held each month. I would usually attend these meetings. I do not recall the meeting where Claire's death was discussed nor have I any record of it.

(b) **If Claire's death was not considered / discussed, explain why not.**

As in answer 28(a).

(29) **State whether you were required to (i) formally report Claire's death and the circumstances thereof and/or (ii) explain what happened to Claire to a senior manager or clinician within the Trust. If so, state:**

(a) **To whom and when you reported / explained this**

I was not required to report Claire's death within the Trust. It would be usual for the Consultant in charge of a child's case to report this death as they would be in the best position to understand the presenting features, diagnoses and clinical outcomes.

(b) **The nature of the report / explanation**

As in answer 29(a)

(c) **The outcome thereof**

As in answer 29 (a)

(d) **Any document relevant thereto.**

I cannot provide any document.

If you did not report / explain this, explain why not.

I was not required to report this.

(30) **Describe the procedure for medical and clinical audit at RBHSC in October 1996 and identify any relevant documents.**

(a) **Describe what you did in terms of a 'medical and /or clinical audit' of Claire's case, and provide any relevant documents. If there was no medical or clinical audit, explain why not.**

As in 28(a). It was usual practice at that time to present all child deaths at the Paediatric Directorate Clinical Audit mortality meeting held each month. I would usually attend these meetings. I do not recall the meeting where Claire's death was discussed nor have I any record of it.

(b) **State whether your actions relating to a medical and/or clinical audit of Claire's case would differ in 2011 and if so, state how. If not, explain why not.**

It would be usual for the Consultant in charge of a child's case to present it for audit. As the PICU Consultant my role was to stabilise her and prepare her for Brain Stem tests later that day. My practice in such a case would be the same in 2011 as in 1996.

(31) **Describe the procedure for discussions of deaths amongst medical personnel (e.g. 'death meetings' / 'morbidity and mortality meetings') at RBHSC in October 1996 and identify any relevant documents.**

(a) **Describe whether you participated in any such meetings in Claire's case, and if so, state when and provide any relevant documents.**

I cannot recall if I participated in such a meeting regarding Claire's case. I would usually the monthly Paediatric Directorate Clinical Audit meeting where all child deaths are discussed. I cannot provide any relevant documents.

(b) **In particular, state whether you attended the mortality/morbidity meetings on or about 8th November 1996 in relation to Claire, and if so, state what was discussed and furnish minutes thereof.**

As in 31 (a)

(32) **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**

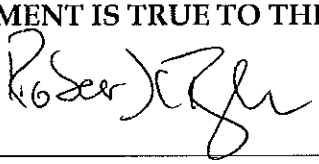
(c) **Communications with Claire's family about her condition, diagnosis, and care and treatment**

(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:  **Dated:** 20/12/11