Witness Statement Ref. No. 160/1

NAME OF CHILD: Claire Roberts

Name: Deirdre Savage

Title: Dr

Present position and institution:
GP Partner
Castlereagh Medical Centre
210 Knock Road
Belfast

Previous position and institution:
[As at the time of the child's death]
GP Partner
Castlereagh Medical Centre
21 Ballygowan Road
Belfast

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

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

None

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 G.P.**

Appointed on April 1992

(2) **State the date when you were first employed at Castlereagh Medical Centre, and whether on 21st October 1996 you were a permanent member of Castlereagh Medical Centre, or were acting as a locum G.P.**

I was a Partner of the Practice on 21 October 1996.

(3) **State the date on which you first become involved in the medical care of Claire Roberts.**

Claire had been a patient of the Practice from 15 April 1987 and I was appointed to the Practice on 1 August 1990 as a GP Registrar.

(4) **Describe your role in the care and treatment of Claire from when you first became involved in the medical care of Claire up to your home visit on 21st October 1996.**

I first saw Claire on 16 September 1991 as GP Locum at the Practice with tonsillitis. No further consultations noted at the Practice from that time until 21 October 1996.

(5) **State the times at which you were working on 21st October 1996 and in particular:**

(a) **The times at which you were present at Castlereagh Medical Centre**

On Monday 21 October 1996, I worked from 8.30 am - 6.00 pm at the Practice.

(b) **The times at which you were on call during that period.**

I was on-call in the afternoon but I am not sure if I was on call in the morning as this was alternated between myself and Dr G McCrea.

(6) **Describe the policy of practitioners at Castlereagh Medical Centre in relation to home visits of patients in October 1996.**

All home visit requests were triaged by the Doctor and Claire's Mum stated she was too unwell to attend the Practice.

(7) **Explain how you came to visit Claire at her home on 21st October 1996, including:**

(a) **How you were initially contacted to come out**

I recall a phone call put through to my Surgery by the Receptionists

(b) **Who initially contacted you and**

Claire's Mum requesting a house call stating that Claire was unwell.

(c) **When you were initially contacted**

It was definitely after 3.30 pm as Claire had been to School that day and I recall her Mum saying she had been swimming

(d) **What you were told about her condition and symptoms prior to your home visit.**

I was told she was unwell and lying on the couch.

(8) **State the time at which you visited Claire at her home on 21st October 1996.**

I visited Claire after 6.00 pm when my surgery finished.

(9) **Describe your examination of Claire at her home on 21st October 1996, including:**

(a) **Her symptoms**

(b) **Your assessment of her condition**

(c) **Your preliminary diagnosis/diagnoses**

(d) **Your basis for this diagnosis/diagnoses**

(e) **Any discussions you had with her parents regarding her symptoms and condition.**

See referral letter dated 21 October 1996.

(10) *"9 year old girl with severe learning disability and past history of epilepsy. Fit free for 3yr – weaned off Epilim 18 months ago."* **(Ref: 090-011-013)**

(a) **On 21st October 1996, describe your knowledge of Claire's medical history, and explain the basis for your knowledge.**

I had Claire's medical records in front of me when I visited the house. I was aware of Claire's history of learning disability and previous history of epilepsy. (See letter Dr J Major dated 16 February 1995).

(b) **State what medication Claire was on at the time of her referral to hospital. In particular, state if she was on Ritalin and/or any other anticonvulsant medication at this time.**

None.

(11) *"No speech since coming home. Very lethargic at school today. Vomited x3. speech slurred earlier."* **(Ref: 090-011-013)**

(a) **State the source(s) of this information.**

History given by Claire's mother.

(b) **State if you were informed that Claire had diarrhoea in addition to her vomiting.**

If not documented, I cannot recall it being mentioned.

(12) *"On examination – pale. Pupils reacting, does not like light.*

No neck stiffness.

Tone ++ [increased]. R side plantar [reflex] ↑↑ up-going

L plantar [reflex] ↓↓

ENT – NAD [nothing abnormal detected].

Chest clear.

?Further fit

?underlying infection

I would appreciate your opn" **(Ref: 090-011-013)**

(a) **Explain why you believed Claire needed to be admitted to a hospital for diagnosis / treatment.**

My role as a GP is to identify a sick child and make appropriate timely referral. Claire was obviously unwell with neurological findings. I was unable to find a source of infection (ENT NAD, Chest clear) and I was unable to diagnose if Claire's findings were a further fit or infection and I felt she needed further investigations and assessment at RBHSC.

(b) **State if Claire was taken to the hospital by her parents or by ambulance.**

I do not recall organising an ambulance and as both parents were present and I assume they took Claire to Hospital.

(13) **In regard to the attached 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**

The referral letter was handwritten by me in Claire's home after assessment on the 21 October 2011 sometime after 6.00 pm.

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

I had Claire's medical notes with me at the House Visit and was able to refer to Outpatient letters from Dr J Major her Paediatrician.

(14) **State whether you received any letters from the Royal Belfast Hospital for Sick Children (RBHSC) in relation to Claire's death.**

I received a phone call from one of the receptionists at the Practice to home on Wednesday 23 October 1996 to let me know that Claire had died in ICU in the RBHSC. She had been on a life support machine and this had been switched off. Discharge summary was received by the Practice after her death. Letter dated 26
October 1996 received from BCH to state patients date of death but no formal discharge letter was received. A letter date 06/03/1997 was received from Dr Heather Steen, Consultant Paediatrician at RBHSC following post-mortem.

(15) **In relation to the letter sent on 6th March 1997 by Dr Heather Steen to you regarding Claire's death (Ref: 090-002-002), explain why this letter was sent to Dr McMillin and not to you.**

Historically, letters from the Hospital were addressed to the patient's registered Doctor and Claire was registered with Dr McMillan. This is regardless of whether another Doctor in the Practice would be the usual attending Doctor.

(16) **Describe all communication you had with medical personnel at the RBHSC in relation to Claire following her admission, including the identity of the medical personnel, the time of each communication, the means by which communication was made and the nature of each communication.**

I phoned the Hospital A/E RBHSC the night she was admitted and I cannot recall who I spoke to and I was informed she was admitted. I do not recall any other communications with the Hospital.

(17) **State what information you communicated to Claire's parents and family and when and where you told them this information, and where the information you communicated was recorded or noted.**

I visited the family after Claire's death but I am unaware of the date. This was a bereavement visit and therefore was not recorded in the notes.

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

I was very concerned about Claire, I felt she required Hospital admission and was keen that she was referred the RBHSC as a matter of urgency. Accident and Emergency in the RBHSC has paediatricians available which would be unique to Casualties in Belfast area.

(19) **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**

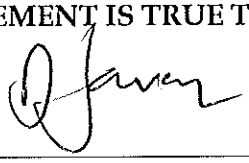
(d) **Lessons learned from Claire's death and how that has affected your practice**

(e) **Current Protocols and procedures**

(f) **Any other relevant matter**

No further information of note.

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

Signed: 

Dated: 12-1-12