Witness Statement Ref. No. 167/1

NAME OF CHILD: Claire Roberts

Name: Peter Kennedy

Title: Dr

Present position and institution:
Consultant Radiologist, Royal Victoria Hospital, Belfast, BT12 6BA

Previous position and institution:
[As at the time of the child's death]
3rd year radiology Specialist Registrar, 6 week attachment at RBHSC, Northern Ireland Training Scheme

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 - November 2011]
Northern Ireland PACS Project Team 2005-2008
Radiology Specialist Advisory Committee 2006-2008

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:	

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 Radiology Registrar by the Royal.

01/08/1994

(2) Describe your work commitments to the Royal from the date of your appointment as a Radiology Registrar and particularly over the period 21st October 1996 to 23rd October 1996.

In the first year of training much time was spent preparing for the 1st part exam for the Fellowship of the Royal College of Radiologists, studying the disciplines of anatomy, physics and investigation technique. In the second and third years of training there was an increasing service element to enable exposure to all aspects and subspecialties of clinical radiology. I was placed on a 6 week attachment to Paediatric Radiology in RBHSC from mid September 1996 to end October 1996.

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 have no record of my work schedule for those days, however expect that I was working 0900-1700 during each day 21st -23rd October.

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

On call 1700 22nd October – 0900 23rd October.

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

None

(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 involvement with Claire during this period. My only involvement with Claire was to interpret and provisionally report a CT brain performed at 05:30 on 23/10/1996.

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

I had no involvement with Claire during this period. My only involvement with Claire was to interpret and provisionally report a CT brain performed at 05:30 on 23/10/1996.

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

To provide an emergency preliminary report on the CT brain acquired at 0530 23/10/96

(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:**

As indicated above, my only part in Claire's management was to interpret and provisionally report a CT brain performed at 0530 23/10/1996. I have no recollection of these events, and my answer represents a description of normal practice at that time. I would have been contacted by telephone at home whilst on call as the radiology registrar. I have no recollection of who that contact was made by, or at what time it was made. I expect that I was given sufficient clinical information during that phone call to justify an emergency out of hours CT scan. I would have contacted the on call radiographer for neuroradiology (I have no record of who this was) and arranged for him/her to attend the neuroradiology department in the Royal Victoria Hospital (RVH). I would have asked for the earliest time that the scan could be performed and then relayed that to Allen Ward (I do not recall who to) and advised them to arrange for transfer of the patient to the neuroradiology department, RVH, at the time indicated by the radiographer. I would then have attended the neuroradiology department in the RVH, and would normally arrive at approximately the same time as the patient. I would have confirmed the appropriate set up of the scan with the radiographer. I would have reviewed the images acquired for diagnostic adequacy.

My entry into the patient notes (Ref: 090-022-058) represents my interpretation of the scan images. That information was then used to provide further information for the clinicians to optimise her medical care. I played no further part in Claire's clinical management.

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

These actions represent the expected duties of the on call radiology registrar.

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

My actions were the result of a request for CT brain scan. That request is recorded in the form of the radiology request form. A copy of that document is attached with this return (Ref 1).

(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**

I have no recollection of seeking such advice, and there is no record of me seeking such advice.

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

Not applicable.

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

I have no recollection.

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

My obligation as on call registrar to arrange and report a CT brain for Claire was clear on the basis of the information given in the written request form.

(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**

0530, 23/10/1996. (Ref: 090-022-058)

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

My interpretation of the CT brain scan performed at 0530, 23/10/1996.

(6) 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.

I have no recollection.

(7) State at what time you were first contacted in relation to Claire on 23rd October 1996, by whom, for what reason were you contacted, what you were told about Claire at that time and what you did as a result of that contact.

I have no recollection of the specific details concerning my first contact with respect to Claire, which was a phone call to my house whilst I was on call. As a result of the contact I arranged and reported a CT brain for Claire.

(a) **Describe any advice or instructions which you gave in relation to Claire when you were first contacted**

I have no recollection.

(b) **State at what time and where you first attended Claire on 23rd October 1996**

I first attended Claire in the neuroradiology department, RVH. I have no recollection of the exact time but with reference to my entry in the clinical notes (Ref: 090-022-058), and the time recorded

on the film images, 05.29 - 05.35, expect that it would have been at approximately 05.00, 23/10/1996.

(c) **State what information you were given about:**

I have no recollection of the information I was given: the only information that I can confirm that I received with respect to parts i-ix below is contained in the written request form. That was "Mental handicap. Usually active and alert, walking and very chatty. Drowsy for last 36 hours ? cause. Respiratory arrest at 3am. Severe cerebral oedema. Pupils fixed and dilated. ? cause." The request form was signed by Dr Bartholome.

(i) **Claire**

(ii) **the reason for Claire' s transfer to PICU**

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

(iv) **the cause of Claire's respiratory arrest and fixed and dilated pupils**

(v) **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.**

(vi) **the cause of Claire's cerebral oedema**

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

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

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

State when you were given this information, and by whom.

(8) *"22.10.96 05.30 CT [computerised tomography]Brain...*

There is severe diffuse hemispheric swelling, with complete effacement of the basal cisterns. No focal abnormality is identified...." **(Ref: 090-022-058)**

"CT scan shows severe cerebral oedema." **(Ref: 090-022-059)**

"... RBHSC

DR HE STEEN

DR MI MCMILLAN

CAT [Computerised Axial Tomography] SCAN OF BRAIN 23-OCT-96 13:07

There is generalised cerebral swelling with effacement of the cortical sulci as well as the basal cisterns and the third ventricle. No focal lesion has been identified." (Ref: 090-033-114)

(a) **State at what time the first CT/CAT scan of Claire was carried out.**

05.29 – 05.35 23/10/1996.

(b) **State where that CT scan was carried out and how Claire was transferred to the venue for that CT scan.**

Neuroradiology department, RVH. I have no recollection regarding her transfer.

(c) **Identify the report arising from that CT/CAT scan. If that report is shown at Ref: 090-033-114, explain:**

Ref: 090-033-114 records the final report of the scan. It was reported by Dr Mark Love, Radiology Registrar for Neuroradiology sometime in the morning of 23/10/1996. His name has been obscured during the photocopying process and so does not appear on the digitised record available on the Inquiry website. (photocopy attached, with name visible Ref 2).

(i) **Why that report records the scan as occurring at 13.07.**

This time stamp relates to the time that the request information was first input into the radiology information system (NIRADS). A screen shot from the NIRADS database is attached (Ref 3). The paper request form would have stayed in the neuroradiology department, RVH, and that data entered into the NIRADS database by the RVH clerical staff the next day.

(ii) **Why that report differs in terminology to the note of the CT scan findings at Ref: 090-022-058.**

Different individuals usually use different terminology and phraseology to convey the same meaning.

(iii) **The significance of the differences between that report and the note of the CT scan findings at Ref: 090-022-058.**

There is no significant difference between Ref: 090-022-058 and Ref: 090-033-114.

(d) **State whether a 2nd CT/CAT scan was carried out on 23rd October 1996, and if so, explain why and at what time.**

There was no second scan.

(e) **Identify the report arising from that later scan.**

Not applicable.

(f) **Explain the reasons why *"DR HE STEEN"* was named as the paediatric consultant on the CAT Scan report (Ref: 090-033-114), and the significance thereof.**

The written request form does not identify a responsible consultant. I do not know why the clerical staff assigned the scan to Dr. HE Steen, when the data was entered into the NIRADS database at 13.07 on 23/10/1996.

(g) **State whether the description of the brain, including its weight, in the autopsy report (Ref: 090-003-003 to 090-003-005) is consistent with:**

(i) The CT scan image recorded as occurring at 05.30 on 23rd October 1996 (Ref: 090-022-058)

I have not interpreted CT brain images since my appointment as consultant in August 1999, and am therefore no longer qualified to comment.

(ii) The findings of the CT scan recorded at Ref:090-022-058

The pathological findings and preliminary CT report (Ref: 090-022-058) are consistent.

(iii) The CAT Scan report at Ref: 090-033-114

The pathological findings and final CT report (Ref: 090-033-114) are consistent.

Please state the reasons for your answer.

All three documents describe the findings of, or radiological consequences of, cerebral oedema.

(h) **In relation to the CT scan which is recorded as occurring at 05.30 on 23rd October 1996:**

(i) Describe the degree of cerebral oedema evident from that scan

I have not interpreted CT brain images since my appointment as consultant in August 1999, and am therefore no longer qualified to comment.

(ii) Describe the significance of *"No focal abnormality"* being *"identified"*

No focal (or "individual") separate lesion or abnormality, (for example, abcess, tumour or infarction) is present on the scan images to indicate a local (ie. within the brain) cause for the cerebral oedema.

In relation to the CAT scan report at Ref: 090-033-114:

(iii) Describe the degree of cerebral oedema evident from that scan

I have not interpreted CT brain images since my appointment as consultant in August 1999, and am therefore no longer qualified to comment.

(iv) Describe the significance of *"No focal lesion"* being *"identified"*

No focal (or "individual") separate lesion or abnormality, (for example, abcess, tumour or infarction) is present on the scan images to indicate a local (ie within the brain) cause for the cerebral oedema.

(9) **Describe the communications that you had with the Consultant responsible for Claire on her admission, including:**

I have no recollection of any communication with the Consultant responsible for Claire. To my knowledge there is no record of any such communication.

(a) **Time of each communication**

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

(c) **Nature of each communication**

(d) **Whether any advice or direction was given by the Consultant in relation to Claire's treatment and care. If so, describe the nature of that advice or direction.**

(10) **State what communication you had with Dr. Heather Steen in relation to Claire from 03.00 on 23rd October 1996 onwards including:**

I have no recollection of any communication with Dr Heather Steen in relation to Claire. To my knowledge there is no record of any such communication.

(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.**

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

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

(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**

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

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

The only information that I had available to convey was contained in my entry into the clinical notes, Ref: 090-022-058.

(11) **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:**

I have no recollection of any communication with Dr David Webb in relation to Claire. To my knowledge there is no record of any such communication.

(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.**

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

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

(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**

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

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

The only information that I had available to convey was contained in my entry into the clinical notes, Ref: 090-022-058

(12) Describe your communication with Claire's parents and family and in particular:

None

(a) **State what information you communicated to Claire's parents and family, and what information they gave to you**

(b) **Identify to whom you gave that information**

(c) **State when and where you gave them that information**

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

(e) **State whether you recorded the understanding of Claire's family of that information and their concerns. If so, identify the documents containing that record. If you did not record this, explain why not**

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

I have no recollection of my perceptions at that time.

(14) Prior to 23rd October 1996:

(a) **State your knowledge of and awareness of the case of Adam Strain, his inquest and the issues that arose therein.**

(b) **State the source of this knowledge/awareness and the date/time when you acquired this knowledge**

(c) **Describe how this knowledge/awareness affected your care and treatment of Claire Roberts**

I have no recollection regarding my knowledge of and awareness of the case of Adam Strain at that time

(15) **Since 23rd October 1996:**

(a) **State your knowledge of and awareness of the case of Adam Strain, his inquest and the issues that arose therein**

(b) **State the source of this knowledge/awareness and the date/time when you acquired this knowledge**

(c) **Describe how this knowledge/awareness affected your work**

I have become aware of the case of Adam Strain since my involvement in this Inquiry. This knowledge/awareness does not influence my practice of medicine. I am never involved in paediatric fluid management.

(16) **Describe in detail the education and training you received in fluid management (in particular hyponatraemia) and record keeping through the following, providing dates and names of the institutions/bodies:**

(a) **Undergraduate level**

Fluid management as a part of my undergraduate degree in Clinical Medicine, BM BCh (Oxon) 1986-1989.

(b) **Postgraduate level**

Fluid management as a component of the first part exam for the Surgical Fellowship, London (FRCS), obtained 1991.

(c) **Hospital induction programmes**

Not available in 1994

(d) **Continuous professional development**

Not relevant to my practice, therefore not a part of my continuous professional development.

(17) **Prior to 21st October 1996, describe in detail your experience of dealing with children with hyponatraemia, including:**

I have no recollection of dealing with another case of paediatric hyponatraemia.

(a) **the estimated total number of such cases, together with the dates and where they took place**

(b) **the number of the children who were aged less than 10 years old**

(c) **the nature of your involvement**

(d) **the outcome for the children**

(18) **Since 21st October 1996, describe in detail your experience of dealing with children with hyponatraemia, including:**

I have no recollection of dealing with another case of paediatric hyponatraemia.

(a) **the estimated total number of such cases, together with the dates and where they took place**

(b) **the number of the children who were aged less than 10 years old**

(c) **the nature of your involvement**

(d) **the outcome for the children**

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

I am not aware of any Protocols or Guidelines which governed Claire's care and treatment.

(20) **Provide any further points and comments that you wish to make, together with any documents, in relation to:**

None

(a) **The care and treatment of Claire from her attendance on 21st October 1996 to her death on 23rd October 1996**

(b) **Record keeping**

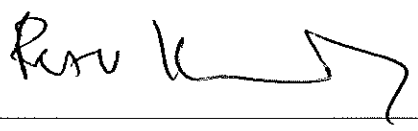
(c) **Communications with Claire's family about her condition, diagnosis, and care and treatment**

(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:** 30/12/11

WNC 771/OS 2132

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

Surname and First Names	Mr. Mrs. Miss	Age	Hospital No.
Roberts Claire ♀ 10-1-87			

Address [redacted] Ward or Dept.

Occupatio [redacted] Physician or Surgeon

Clinical Diagnosis

Relevant History, clinical findings and previous operations Mental handicap. Usually active and alert, walking and very chatty. Drowsy for last 16 hrs? cause.

Radiological information required Respiratory arrest at 3 AM ? cause. Severe cerebral oedema. Pupils fixed + dilated. CT brain

Patient	Bed	Trolley	Chair	Walking

Signature Bathole Date 23/10/96

PLEASE ENSURE THAT ALL PREVIOUS FILMS ACCOMPANY THE PATIENT

FOR DEPARTMENTAL USE

Previous X-Ray | Yes | No | Previous No's | X-Ray No.

Appointment for examination of at a.m. p.m. on

Date of Request:

X-RAY REQUEST FORM

13

Date	17 × 14	15 × 12	14 × 14	15 × 6	12 × 10	10 × 8	8 × 6	6 × 4	Occl.	Dental	Others

Number	Date	Radiographer's Remarks	Signature
		- severe hemisphere swelling & complete effacement of III / basal cisterns - no midline shift : no focal mass - no haemorrhage. Vous Int: 3 – 15 Top MCA16 12 slices.	

ADDITIONAL NOTES

MR/7/1

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

(Consent forms to be affixed to back of sheet)

11	
10	
9	
8	
7	
6	
5	
4	

from the bottom upwards

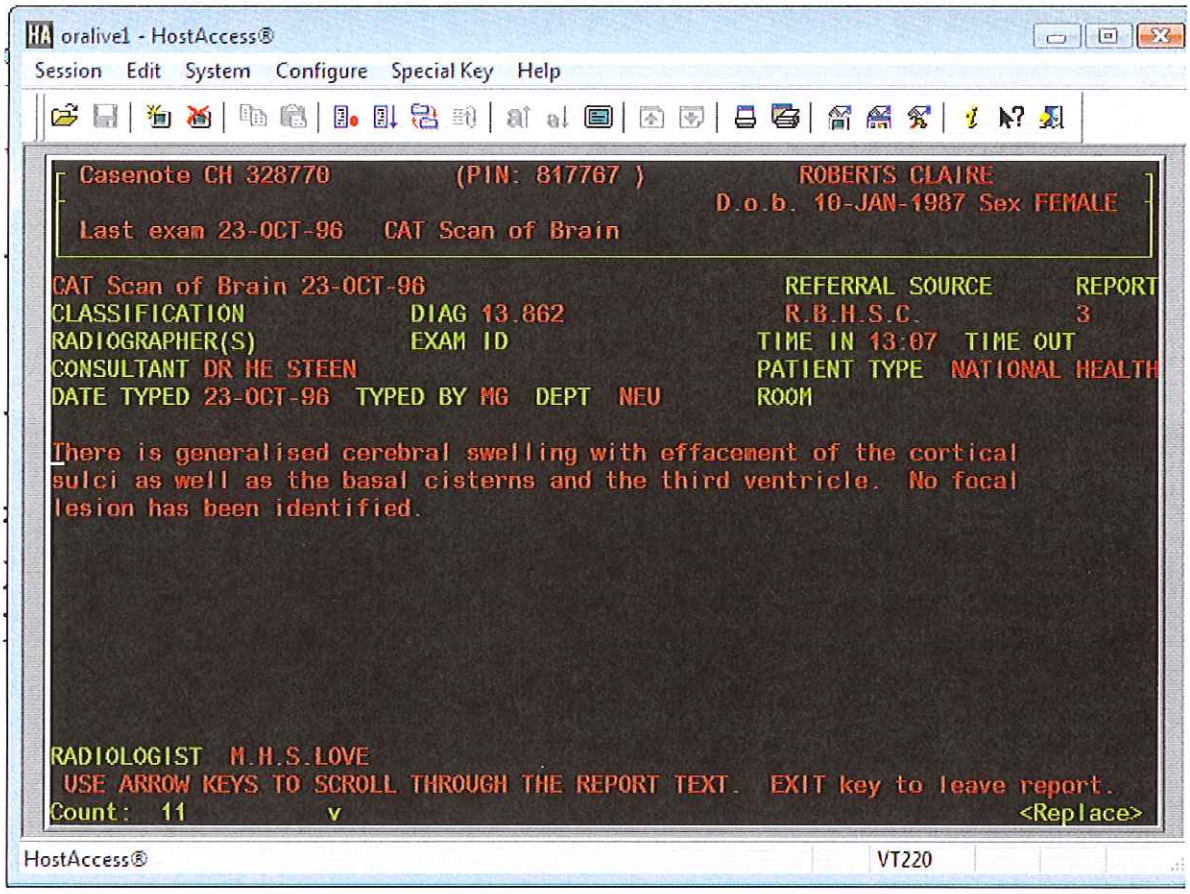
R.B.H.S.C.
DR HE STEEN
DR MI MCMILLAN

SURNAME	**ROBERTS**
FORENAME(S)	**CLAIRE**
CASENOTE	CH 328770
D.O.B./SEX	10-JAN-87 FEMALE
DATE TYPED	23-OCT-96 MG

CAT SCAN OF BRAIN 23-OCT-96 13:07
Diagnostic Code 13.862

There is generalised cerebral swelling with effacement of the cortical sulci as well as the basal cisterns and the third ventricle. No focal lesion has been identified.

M.H.S.LOVE RADIOLOGIST [redacted]
23-OCT-96 NEURO XRAY R.V.14
CAT SCAN OF [redacted]


oralive1 - HostAccess®
Session Edit System Configure Special Key Help
Casenote CH 328770 (PIN: 817767) ROBERTS CLAIRE
D.o.b. 10-JAN-1987 Sex FEMALE
Last exam 23-OCT-96 CAT Scan of Brain
CAT Scan of Brain 23-OCT-96 REFERRAL SOURCE REPORT
CLASSIFICATION DIAG 13.862 R.B.H.S.C. 3
RADIOGRAPHER(S) EXAM ID TIME IN 13:07 TIME OUT
CONSULTANT DR HE STEEN PATIENT TYPE NATIONAL HEALTH
DATE TYPED 23-OCT-96 TYPED BY MG DEPT NEU ROOM
There is generalised cerebral swelling with effacement of the cortical sulci as well as the basal cisterns and the third ventricle. No focal lesion has been identified.
RADIOLOGIST M.H.S.LOVE
USE ARROW KEYS TO SCROLL THROUGH THE REPORT TEXT. EXIT key to leave report.
Count: 11 v <Replace>
HostAccess®
VT220