Witness Statement Ref. No. 168/1

NAME OF CHILD: Claire Roberts

Name: Peter Crean

Title: Dr

Present position and institution:

Consultant Paediatric Anaesthetist
Royal Belfast Hospital for Sick Children

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

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

In N Ireland:

Member of N Ireland Working Group on Hyponatraemia in Children
2001 – 2002

Member of the Human Organs Enquire Implementation Sub-group on the guidance to the HPSS and consent 2002-2004.

Member of the Human Organs Enquiry Implementation Sub-group on Public Information and Communication 2003.

Northern Ireland Regional Paediatric Fluid Therapy Working Group 2006.

Member of 'Paediatric Surgery Working Group Phase 1', Department of Health, N Ireland. 2008

Member of the 'Paediatric ENT Surgery Group, Department of Health, N Ireland, 2008-9

Guideline and Audit Implementation Network (GAIN). Member of Guideline Development Group on 'Hyponatraemia in Adults. 2008-9

National:

Member of the Paediatric Group
National Confidential Enquiry into Perioperative Deaths
1998 – 1999

Member of Working Group on Paediatric Anaesthesia and Emergency Care in District General Hospitals 2004-6. "Care of the acutely ill or injured child: a team response" published 2006

Member of External Reference Group, Children's Hospital Service Pilot Improvement Review, Healthcare

Commission. 2004-2005

Member of the Children's Surgical Forum, Royal College of Surgeons, England 2005-07

President of the Association of Paediatric Anaesthetists of Great Britain and Ireland 2005-7

'Joint statement on the provision of general paediatric surgery provision in the District General Hospital', 2006. Member of the working group and co-signatory as President of the APA.

Member of working group revising 'Children's Surgery: a first class service'. 2006-07. 'Surgery for children – delivering a first class service' published July 2007

NICE Guideline Development Group on Sedation in Children 2008 - 2010

NCEPOD Advisor 2009 – 2011 on deaths following surgery in children. 'Are We There Yet?' Published October 2011.

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 Consultant Paediatric Anaesthetist by the Royal Group of Hospitals (Royal) and describe your experience as a Consultant Paediatric Anaesthetist in the Royal Belfast Hospital for Sick Children (RBHSC) and any other hospital in which you worked prior to 21st October 1996.**

I was appointed to the above post in October 1984. I provided anaesthesia for children and intensive care for children. For the first years following my appointment I had one clinical session in the Royal Maternity Hospital and provided emergency care for both the Children's Hospital and the Maternity Hospital.

(2) **Describe your work commitments to the Royal from the date of your appointment as a Consultant Paediatric Anaesthetist including the department/s and locations in which you worked and the periods of time in each department/location, and particularly over the period 21st October 1996 to 23rd October 1996.**

At that time I provided an anaesthetic and intensive care service to children in RBHSC.

(3) **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**

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

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

I do not believe I was involved in Claire's care

(4) **Describe what you considered to be your role in relation to and responsibilities towards Claire and her family over the period of 21st October 1996 to 23rd October 1996.**

I do not believe I was involved in Claire's care

(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**

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

I did not make any entries in Claire's notes.

(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**

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

I do not believe I was involved in Claire's care

(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 explain the reasons for your answer.**

I do not believe I was involved in Claire's care

(8) **State whether you were on duty in PICU when Claire was transferred from Allen Ward to PICU on 23rd October 1996.**

(a) **Identify all nurses and other clinicians by name and position who were involved in this transfer.**

(b) **Describe the nature of your involvement and the involvement of the other clinicians and nurses in that transfer to PICU.**

(c) **Identify the consultant/s and any other clinicians who accompanied Claire when she was transferred from Allen Ward to PICU.**

(d) **Identify any nurses who accompanied Claire when she was transferred from Allen Ward to PICU.**

(e) **Identify the consultant or other clinician in PICU to whom Claire's care was transferred on admission to PICU on 23rd October 1996.**

(f) **Identify the designated PICU nurse and any other PICU nurse/runner to whom Claire's care was transferred on admission to PICU on 23rd October 1996.**

(g) **State at what time Claire's handover to PICU clinicians took place on 23rd October 1996 and identify who was present during that handover.**

(h) **Identify who carried out the handover to the PICU clinicians on Claire's arrival in PICU on 23rd October 1996, and state what information was given to them regarding:**

(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

If you do not recall specifically what information was given, state what information was likely / normally given during that handover.

(i) State at what time Claire's handover to PICU nurses took place on 23rd October 1996 and identify who was present during that handover.

(j) Identify who carried out the handover to the PICU nurses on Claire's arrival in PICU on 23rd October 1996, and state what information was given to them regarding:

(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

If you do not recall specifically what information was given, state what information was likely / normally given during that handover.

I do not believe I was involved in Claire's care and am unable to provide information in regard to what others might have done.

(9) Identify the clinician who 'handed over' Claire's management, treatment and care to you, and the time at which this care was handed over.

(a) **State what information you were given by that clinician about Claire's condition, care and treatment and plan of care.**

I do not believe I was involved in Claire's care

(10) **In relation to the Case Note Discharge Summary (Ref: 090-009-011):**

(a) **Explain any role or responsibility you had in the completion of the Case Note Discharge Summary.**

(b) **Explain the circumstances in which Dr Mannam came to complete the said Summary.**

(c) **State if Dr Mannam discussed Claire's case with you prior to completing the Case Note Discharge Summary, and if so, state what you discussed and when you discussed it.**

(d) **Explain why the Case Note Discharge Summary was not completed until 29th October 1996.**

I do not believe I was involved in Claire's care. My name was on all PICU discharge summaries in 1996 to identify that a PICU episode of care had taken place. At that time there was no other way of documenting this on the Patient Administration System in the hospital other than using the same clinician's name for all admissions.

(11) **State whether a typed account of Claire's hospital stay was forwarded to Claire's GP shortly after her death, and if so, please furnish a copy thereof. If not, explain why not.**

I do not believe I was involved in Claire's care

(12) **In relation to the ICU discharge summary dated 1st November 1996 (Ref: 090-006-008):**

(a) **Explain any role or responsibility you had in the completion of the ICU discharge summary.**

(b) **Explain the circumstances in which Dr Mannam came to complete this Summary.**

(c) **State if Dr Mannam discussed Claire's case with you prior to completing the ICU Discharge Summary, and if so, state what you discussed and when you discussed it.**

I do not believe I was involved in Claire's care

(13) **Identify the consultant whom you believed to be responsible for Claire and her management, care and treatment immediately prior to her transfer to PICU on 23rd October 1996.**

(a) **Explain the basis for this belief.**

(b) **Describe all communication you had with this consultant, including:**

(i) **The time of each communication**

(ii) The means by which communication was made

(iii) The nature of each communication

(iv) Whether any advice or direction was given by that consultant in relation to Claire's treatment and care, and if so the nature of that advice or direction.

I do not believe I was involved in Claire's care

(14) 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.

(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.

I do not believe I was involved in Claire's care

(15) 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.

(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.**

I do not believe I was involved in Claire's care

(16) **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.**

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

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

I do not believe I was involved in Claire's care

(17) **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 have no recollection of this.

(18) **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.**

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

I have no recollection of this.

(19) **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**

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

(c) **The outcome thereof**

(d) **Any document relevant thereto**

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

I do not believe I was involved in Claire's care

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

Regular monthly meetings were held reviewing cases and topics, and discussing morbidity and mortality.

(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.**

(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.**

I do not believe I was involved in Claire's care

(21) **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.**

(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.**

I do not believe I was involved in Claire's care

(22) **Prior to 21st October 1996:**

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

I was aware of the Adam Strain case and that he had died.

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

As this event occurred in the department in which I worked I was aware of the event at the time it occurred.

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

I do not believe I was involved in Claire's care

(23) Since 21st October 1996:

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

I was aware of the Adam Strain case and that he had died.

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

As this event occurred in the department in which I worked I was aware of the event at the time it occurred.

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

I do not believe I was involved in Claire's care

(24) 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**

I was in medical school from 1970 to 1976 and have no recollection of this.

(b) **Postgraduate level**

Fluid management was taught to all anaesthetists during training. However I am unable to remember anything that was taught about hyponatraemia specifically.

(c) **Hospital induction programmes**

I have no recollection of this

(d) **Continuous professional development**

There has been a much greater awareness of issues regarding fluid management in children, and specifically the development of acute symptomatic hyponatraemic encephalopathy and death in the last 15 years in the literature. This topic is regularly taught in anaesthetic meetings.

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

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

Hyponatraemia is a sodium content of less than 135 mmol/l and is not an uncommon event. It would therefore be impossible for me to answer (b), (c) and (d).

(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**

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

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

Hyponatraemia is a sodium content of less than 135 mmol/l and is not an uncommon event. It would therefore be impossible for me to answer (b), (c) and (d).

(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**

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

I do not believe I was involved in Claire's care

(28) **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**

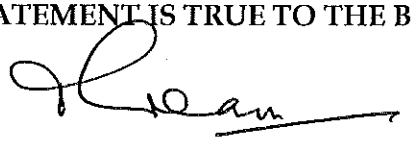
(c) **Communications with Claire's family about her condition, diagnosis, and care and treatment**

(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: 16.12.11