Witness Statement Ref. No. 168/2

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]
Consultant in Paediatric Anaesthesia and Intensive Care, Royal Belfast Hospital for Sick Children.

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between October 1996-August 2012]

In N Ireland:

Chairman of the Paediatric Anaesthetic Group in N Ireland 1999-2004

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:	
WS-130/1	15th May 2012	Witness Statement to the Inquiry (Adam Strain)
WS-168/1	16th December 2011	Witness Statement to the Inquiry (Claire Roberts)

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 such a number then please provide a copy of the document.

(1) **Please specify any changes occurring in the period from November 1995 to October 1996 in respect of the following:**

(a) **Your professional and/or medical qualifications;**

(b) **Your job, role and functions;**

(c) **Your responsibilities and accountability.**

None

(2) **Please specify all investigations in relation to the treatment and death of Claire Roberts.**

I was not involved in the care of Claire Roberts and have no recollection of the above.

(3) **Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose?**

I was not involved in the care of Claire Roberts. I was asked to provide a statement by the Inquiry last year as my name was on her PICU discharge summary.

(4) **What attempts did you make to identify all hyponatraemia deaths at the RBHSC for the purposes of analysis for the Northern Ireland Working Group on Hyponatraemia in Children?**

I have no recollection of this.

(a) **How many of these deaths did you analyse for the same?**

(b) **Did you make any investigations into the Claire Roberts case in connection with the Northern Ireland Working Group on Hyponatraemia in Children?**

(c) **Did the RBHSC/Trust's statistical database permit any identification of Claire Roberts' case with hyponatraemia?**

This information is best provided by the Belfast Trust.

(d) **Did you seek information from colleagues as to hyponatraemia cases in the RBHSC within the preceding 10 years to assist in the work of the Northern Ireland Working Group on Hyponatraemia in Children?**

I have no recollection of this.

(5) **Please state whether in 1996 you considered that hyponatraemia was a condition that was:**

(a) **Preventable?**

Yes

(b) **Treatable?**

Yes

(6) **Please specify to whom the death of Claire Roberts was reported in 1996, and in particular please state whether any of the following were informed of her death:**

I am unaware of to whom, if anyone, Claire Roberts' death was reported in 1996. As I was not involved in Claire Roberts' care it is unlikely that I would have been aware of this information at the time.

(a) **Dr. Elaine Hicks;**

(b) **Dr. Ian Carson;**

(c) **Dr. George Murnaghan;**

(d) **Dr. Joseph Gaston;**

(e) **Mr. William McKee;**

(f) **Nurse Manager in Paediatric Directorate;**

(g) **Miss Elizabeth Duffin;**

(h) **Mr. George Brangam.**

(7) **Please specify the date, nature and content of any such reports. Please see my response at (6) above**

(8) **To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?**

I have no recollection of this.

(9) **Please state whether you regarded the death of Claire Roberts as 'expected' or 'unexpected'.**

I was not involved in the care of Claire Roberts, nor am I acquainted with the details of her care. I do not feel in a position to give an opinion.

(10) **Did you forward the PICU Discharge Summary and PICU Discharge Advice Note to the Pathologist after they were issued?**

I have no recollection of doing so.

(11) **Please state whether you were asked for your opinion as to whether or not Claire Roberts' death should have been referred to the Coroner, and if so what opinion you gave.**

I have no recollection of being asked for an opinion in this respect. Given that I had no involvement in Claire Roberts' care, I consider it unlikely that I would have asked to offer such an opinion.

(12) **Please state if any advice was sought from the Coroner's office in respect of referral.**

I did not seek advice from the Coroner's Officer about a referral. Given that I was not involved in Claire Roberts' care, there would have been no reason for me to do so. I am unable to state whether anyone else sought such advice.

(13) **Please state why you did not report the death of Claire Roberts to the Coroner?**

I was not involved in the care of Claire Roberts.

(14) **Please state whether any advice was sought from you, or whether you had any input into the causes of the death included on the death certificate of Claire Roberts, and if so what advice you gave.**

I have no recollection of any advice being sought from me in this respect. As I had not been involved in Claire Roberts' care, I consider it unlikely that my advice would have been sought.

(15) **Please state whether the advice of the Director of Medical Administration, Dr. George Murnaghan, was sought in relation to referral of Claire Robert's death to the Coroner in 1996.**

I have no knowledge of this.

(16) **Did you accept the Coroner's findings:**

(a) **In the case of Adam Strain (Ref: 011-016-114)?**

Yes.

(b) **In the case of Claire Roberts (Ref: 091-002-002)?**

I was not involved in the care of Claire Roberts and am not acquainted with the details of her care. I believe I first saw the Coroner's finding only recently (as an email attachment with this Inquiry Statement) and have no reason to doubt the findings of a Coroner's Inquest. However I consider this question would be better answered by those involved in Claire's care.

(17) **Was the Arieff et al paper BMJ 1992 (Ref: 011-011-074) circulated in the RBHSC in 1996 amongst:**

(a) **Paediatric Clinicians;**

(b) **Anaesthetists?**

I have no recollection of this.

At no stage during my professional career do I recall any specific scientific publication being sent to all doctors in a hospital.

(18) **Was there a heightened awareness amongst clinicians in the RBHSC in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?**

I have no recollection of this.

(19) **Please state whether your opinion was sought as to whether or not a full or restricted post-mortem examination of Claire Roberts should be requested, and if so what opinion you gave.**

I have no recollection of my opinion being sought, for the reasons set out above. I consider it is unlikely that my opinion would have been sought.

(20) **What, in 1996, did you understand the purpose of an Autopsy Report to be?**

This would provide information on the cause of death.

(21) **Please state whether any guidelines or conventions existed in 1996 governing post-mortem examinations with specific reference to:**

(a) **When consent was required for a post-mortem examination;**

I believe it was usual to receive written consent from parents of the deceased child.

(b) **When a limited post-mortem could be requested;**

I believe it was usual to receive written consent from the parents.

(c) **Authorisation for the same;**

To the best of my recollection in 1996 it was my practice to discuss the process with the parents and for them to sign a consent form.

(d) **The information and options given to the parents of the deceased child in respect of this decision;**

At times the process of a full post-mortem examination was more than some parents could contemplate. When death was due to single organ failure a limited post-mortem (limited to that organ) was an option.

(e) **Whether parents of the deceased child should be asked for their views on whether or not the Coroner be notified;**

I believe they would have been asked for their views. I cannot recollect if there were any specific guidelines in this respect.

(f) **Whether parents of the deceased child should be asked for their views on whether a full or restricted post-mortem should be carried out;**

I believe they should have been asked for their views. I cannot recollect if there were any specific guidelines in this respect.

(g) **Whether the Autopsy report should have been shared with the parents and GP of the deceased child?**

To the best of my recollection, normal practice would have been to share the Autopsy Report with the parents and the GP in 1996. I cannot recollect if there were any specific

guidelines in this respect.

(22) What was the origin of the pro-forma consent form used for the limited post-mortem presented to Mr. Roberts for signature (Ref: 090-054-185)?

I have no recollection of this.

(23) Please specify all meetings, discussions, reviews and audits which took place touching on the death of Claire Roberts; identifying those who attended the meetings, where such meetings took place and whether a note was taken of the same.

I have no recollection of this.

(24) Please provide information detailing those meetings which took place:

I have no recollection of this.

(a) Before the Autopsy report became available;

(b) After the Autopsy report became available.

(25) Did the Pathologist attend the meeting(s), and if so please identify who the Pathologist was?

I have no recollection of this.

(26) Was any learning gained from any such meetings? If so what?

I have no recollection of this.

(27) Please state whether Dr. Taylor played any role in mortality meetings/discussions? If so what was that role?

I believe Dr Taylor was the Audit Co-ordinator for a period in the 1990's, however, I am unable to recall the exact dates.

(28) How many patients died annually in PICU in 1995 and 1996?

This information would best provided by the Belfast Trust.

(29) Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for children being admitted to PICU and, if there was doubt as to admission, whether a PICU consultant would have been asked for advice in relation to the same?

I am unable to recollect whether there were any guidelines in the RBHSC in 1996 regarding the criteria for admission to PICU.

A discussion would have taken place between the referring medical team and a member of the PICU staff regarding all admissions. The consultant in PICU would normally be involved in these discussions.

Some children may not initially require intensive care treatment. Their clinical course would be

kept under review by the medical team and often ongoing advice would be sought from the PICU consultant.

(3u) **After admission to PICU please identify the clinician who was in charge of Claire's case.**

I have no recollection of this.

(31) **Were you the consultant with accountability for the care provided in PICU to:**

(a) **All admitted patients?**

No

(b) **Claire Roberts?**

No

(32) **What responsibility did PICU consultants have in respect of communication with the parents of an admitted child, and what was his/her role in relation to the same?**

Children admitted to PICU were jointly cared for by the PICU consultant and another hospital consultant (either paediatrician or surgeon). The person best placed to communicate with the family would take the lead in discussions.

For example, if a child had complex neurological problems with multiple hospital admissions such discussions may have been best led by the Paediatric Neurologist under whose care the child was, to ensure continuity of care and information. However, day-to-day PICU management issues of that child may have been highlighted to parents by the PICU consultant, for example changes in ventilation.

(33) **Was there any appraisal of staff performance in the aftermath of Claire's death?**

I have no recollection of this.

(34) **Did any change in the training/teaching provided by the RBHSC/ Trust to clinicians result from Claire's death?**

I have no recollection of this.

(35) **With respect to the biochemistry reports (Ref: 090-030-094 *et seq*) sought and received in the course of Claire's treatment, please state:**

I was not involved in the care of Claire Roberts and am unable to answer these questions.

(a) **Whether the pro-forma notification report form was subsequently amended to communicate the timing of sample, analysis and report? If so when and upon whose instruction;**

(b) **Whether any complaints or requests were made in relation to report forms before or after the treatment and death of Claire Roberts?**

(36) **Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts and whether you would have expected statements to have been**

obtained from the nurses in respect of same?

I was not involved in the care of Claire Roberts and have no knowledge of the issues outlined in this question.

(37) **Was there an audit of the following aspects of the case of Claire Roberts:**

I have no recollection of this.

(a) **Record keeping;**

(b) **Drug prescription and administration?**

(38) **Do you think that there was an iatrogenic contribution to the death of Claire Roberts?**

I was not involved in the care of Claire Roberts and am not, therefore, able to comment.

(39) **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that care and treatment to have been investigated?**

In general terms, I would expect care and treatment to be investigated if there were concerns.

(40) **In October 1996 were you aware of:**

(a) **Circular ET 5/90 (as amended) January 1991?**

I have no recollection of this (and the Inquiry has not provided me with copies of any of the documents referred to at (a) to (e) hereof.)

(b) **A Charter for Patients and Clients (Northern Ireland Health and Personal Social Services) March 1982:**

I have no recollection of this.

(c) **Directive PEL (93)36?**

I have no recollection of this.

(d) **Welfare of Children and Young People in Hospital (HMSO 1991);**

Yes

(e) **The Paediatric Intensive Care Society (UK) Standards document, 1992.**

Yes

(41) **With reference to document (Ref: 090-006-008), please state:**

(a) **Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to the initials of Dr. McKaigue? If so why was this note made?**

I am unable to speculate on this.

(b) **Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?**

I was not involved in the care of Claire Roberts and am not, therefore, able to answer this question.

(c) **Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/her role in relation to this matter?**

I was not involved in the care of Claire Roberts and am not, therefore, in a position to answer this query.

(42) **How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?**

I am unaware of how Claire Roberts' death was categorised.

(43) **Was this classification subsequently amended in the light of the Coroner's findings at her Inquest?**

I have no knowledge of this issue.

(44) **Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996? If so how did it affect the advices given to you or others in respect of:**

I was aware that the Royal Hospitals were engaging in the King's Fund process but I have no recollection of how this affected the advice given to me or others in respect of the following areas.

(a) **Communication with patient's parents and record of the same;**

(b) **Investigation of patient's death;**

(c) **Review of medical records;**

(d) **Systematic programme of audit;**

(e) **Implementation and compliance with published guidance?**

(45) **When do you believe the following individuals become aware of the death of Claire Roberts:**

I was not involved in the care of Claire Roberts and am unable to comment.

(a) Dr. George Murnaghan

(b) Dr. Joseph Gaston

(c) Dr. Ian Carson;

(d) Mr. A.P. Walby

(e) Mr. George Brangam

(f) Miss Elizabeth Duffin.

(46) **Please provide details of any changes in patient care relevant to hyponatraemia between the**

death of Adam Strain in 1995 and the admission of Claire Roberts, including:

(a) Any changes that you made in respect of your own practice;

I endorsed the Draft Recommendations (which are already in your possession) at the time of the Adam Strain Inquest. Those Recommendations would have been consistent with my own practice.

(b) How such changes were formulated and disseminated;

I am not exactly sure who formulated the changes, however, they were subsequently endorsed by the paediatric anaesthetists, RBHSC.

(c) To what extent any such changes affected or informed your approach to the treatment of Claire Roberts, or her treatment in general.

I was not involved in the care of Claire Roberts.

(47) Please state whether you received any training or guidance (including details of the same) in respect of:

(a) The compilation and completion of death certificates;

I anticipate that I did as either a medical student or house-officer but am unable to remember any details of any such training or guidance.

(b) Referral of deaths to the Coroner;

I anticipate that I did as either a medical student or house-officer but am unable to remember any details of any such training or guidance.

(c) The principles governing post-mortem requests.

I have no recollection of receiving any training or guidance on the principles governing post-mortem reports.

(48) In respect of the Forfar and Arneil *"Textbook of Paediatrics"* please state:

The textbook by Forfar and Arneil was known to me and was commonly used in the RBHSC. I recollect that a copy was available in the PICU at some point during the 1990s but I am unable to recollect the precise date when this was first available.

(a) Whether this was known to you in October 1996;

(b) Whether this was in use in the RBHSC in October 1996;

(c) Whether this was available to staff in the RBHSC in October 1996;

(d) If this text was not available or commonly in use in the RBHSC in October 1996 please state what text was.

(49) Was there any system or process for the audit of referrals to post-mortem and referrals to Coroner? Was this system or process subject to any external scrutiny or review?

I have no recollection of this.

(50) **Did you learn any lessons from the death of Claire Roberts and with hindsight were lessons to be learned from it? If so, what were those lessons?**

I have no recollection of this.

(51) **Please identify whether any lessons deriving from the case of Claire Roberts were disseminated either before or after the Inquest. If so please state how, where, when and to whom.**

I have no recollection of this.

(52) **With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts, and if so what?** I was not involved in the care of Claire Roberts and do not have a detailed knowledge of her management. I am therefore unable to comment.

(53) **Please describe how the 'culture' within the RBHSC has changed since 1996?**

As with any large organization there will have been many changes in the last 16 years.

(54) **Was any consideration given to inviting external specialists to review the case of Claire Roberts?**

I have no recollection of this.

(55) **Please provide any further comments you think may be relevant, together with any documents or materials.**

I was not involved in the care of Claire Roberts and am, therefore, limited in my ability to assist the Inquiry in this matter.

In 1996 and for several years subsequently, my name appeared on all hospital admission slips (the yellow flimsy) when a child was admitted directly to PICU. My name also appeared on all hospital discharge summaries from PICU. This occurred irrespective of whether I had any direct involvement in a child's care.

A direct admission to PICU was either one from another hospital or from the A&E department, RBHSC. All ward transfers to PICU would have the admitting paediatrician/surgeon as the consultant in charge on the yellow admission flimsy.

A hospital discharge summary from PICU would be completed if a child was transferred directly to another hospital or died. Children transferred from PICU to the Ward and subsequently discharged from hospital would have had a final hospital discharge summary completed under the name of the ward consultant.

To the best of my recollection, this system was adopted so that a search against my name on the Patient Administration System (a computerised system for recording administrative data about patients admitted to the Trust) could track PICU admissions and discharges.

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

Signed: [signature] **Dated:** 12 September 2012