Witness Statement Ref. No. 244/1

NAME OF CHILD: Adam Strain

Name: Elaine Hicks

Title: Dr.

Present position and institution:

Retired from all medical practice

Previous position and institution:
[As at the time of the child's death]
Consultant Paediatric Neurologist- Royal Belfast Hospital for Sick Children ("RBHSC").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 - April 2012]
I am unclear exactly what this question refers to, and the records and memory for this information is incomplete.
Chief Medical Officers Working Group on Care of the Acutely Ill Child report 1999
Clinical Directors Sub-committee RCPCH (Dates uncertain)
Consultant advisory appointment panels – number and dates uncertain

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:

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.

I. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) State your medical qualifications as of 1995;

MB, BCh, BAO, FRCP (London), DCH (London)

(b) State the date you qualified as a medical doctor;

04.07.1972

(c) Describe your career history before you were appointed Consultant Paediatric Neurologist - RBHSC;

see separate sheet

(d) Describe your work commitments at the RBHSC from the date of your appointment to 1995;

see separate sheet

(e) Was there a written job description for your post in 1996? If so please provide copy of the same. If not, what were the functions and responsibilities of the post? Yes but apparently no copy now exists.

See 1. (1) (d)

(f) Describe the accountability of a Consultant Paediatric Neurologist - RBHSC at that time.

To the Chief Executive of the Royal Hospitals Trust.

(g) What was your experience of renal paediatric transplant surgery in 1995?

None.

(2) Please outline in full your involvement in the case of Adam Strain, and its aftermath?

None of which I am aware.

II. INTERNAL CONTROL

(3) Were professional Codes of Conduct incorporated into the contracts of those healthcare professionals involved in the care and treatment of Adam Strain in 1995?

I do not recall whether this was so. Doctors would have been required to be registered with the General Medical Council and therefore to adhere to the concurrent GMC guidance.

III. CLINICAL/MEDICAL AUDITS

(4) In 1995, what arrangements did the RBHSC have in place for ensuring that regular and systematic medical and/or clinical audits took place?

Within the framework of the Royal Hospitals Trust. I do not remember the details.

If the RBHSC did have a system in place for conducting medical and/or clinical audits, please address the following:-

(a) Was there a Clinical Audit Committee? If so, what was its remit?

(b) What were the rules that regulated the operation of the Clinical Audit Committee?

(c) Who formed the Clinical Audit Committee?

(d) Did you play a role in connection with the Clinical Audit Committee, and if so what?

(e) Who was responsible for ensuring that medical and/or clinical audits were carried out?

(f) Who was responsible for carrying out medical and/or clinical audits?

(g) Under what procedures were medical and/or clinical audits carried out?

(h) To whom were the results of medical and/or clinical audits sent?

(i) What kinds of action could be taken on foot of the results of medical and/or clinical audits?

(5) Was there any procedure or system in place in 1995 to audit the quality, clarity and completeness of clinical case notes?

I cannot recall if this was the case in 1995.

(6) If there was no system in place for conducting medical audits in 1995, please clarify whether there was any other system in place for quality assuring the safe provision of clinical care?

I cannot comment as I cannot recall what was the situation at that time.

(7) Was there a system of independent external scrutiny in place to review patterns of performance in the RBHSC, and if so please provide details of the same?

I do not know

(8) What steps were taken to achieve the objectives outlined in **HPSS Management Plan 1995/96-1997/98** with particular reference to paragraph 4.4.11 and the adoption of a policy of clinical audit as part of a program to improve service quality and state when each such step was taken?

As (4) above

IV. RECORD KEEPING

(9) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of clinical record keeping?

According to Trust Policy I believe; I do not recall the details

If so,

(a) Provide a copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedures were being complied with by members of clinical teams;

(f) State whether there was/ is any protocol or procedure governing the destruction of any clinical records created in 1995, and if so please identify the same;

(g) Whether there is/ was any protocol or procedure governing the identity of those individuals permitted to sign for and signify safe receipt of transplant organs;

(h) Please state whether the same existed in respect of the composition and documentation of clinical and surgical teams engaged in specific operations.

(10) What procedures or protocols were in place in 1995 for monitoring compliance with professional standards for record keeping?

I do not know

V. COMMUNICATION

(11) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of communications with next of kin and the provision of information to them during, before and after surgery; and after an unexpected death?

I do not know

If so please provide:

(a) A copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so please identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedures was being complied with by members of clinical teams.

(12) Were there any procedures in place in 1995 for communication with next of kin when aspects of care had not gone to plan and had resulted in harm to the patient?

I do not remember

VI. DISSEMINATION AND INSTITUTIONAL LINKS

(13) In 1995 did the RBHSC have guidance, policy or procedures in place governing issues arising out of a serious untoward incident or an adverse incident such as the death of a patient following surgery?

I do not know - I cannot remember

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedures.

(b) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures were being complied with by members of clinical teams;

(e) How was the guidance, policy or procedures applied in Adam's case?

(14) Did the RBHSC take any steps, whether by way of an internal investigation or otherwise, to establish whether lessons could be learned from the death of Adam Strain?

I do not know.

If no such steps were taken, please explain why not?

If steps were taken, please address the following:

(a) What steps were taken to learn lessons from the death of Adam?

(b) Under what policy or procedures were these steps taken?

(c) Identify the person(s) who took steps to establish whether lessons could be learned from Adam's death?

(d) When were those steps taken?

(e) What lessons were learned from the death of Adam?

(f) What lessons were learned from the Inquest into the death of Adam?

(g) What measures were taken to review matters arising from the Inquest?

(h) What steps, if any, were taken to disseminate outcomes and lessons internally (within the RBHSC/ Trust)?

(i) What steps, if any, were taken to disseminate outcomes and lessons externally (outside the RBHSC/ Trust)?

(j) What steps, if any, were taken to assess and develop the competence of staff involved in the treatment that led to Adam's death?

(15) Dr. Taylor indicated his disagreement with the cause of death indicated on Adam's death certificate. State whether any steps were taken by the RBHSC/ Trust to address Dr. Taylor's views?

I have no knowledge of this.

If so, please address the following:

(a) What steps were taken to address Dr. Taylor's views?

(b) When were those steps taken?

(c) Who took those steps?

(d) What conclusions emerged from this process?

(16) Please state your view on whether it would have been easier to use Adam Strain's case history as a vehicle for learning had there been agreement as to the role dilutional hyponatraemia

played in Adam's death?

I cannot comment as I have no knowledge of this matter

(17) Please confirm whether or not you received a report in writing of or into the death of Adam Strain in 1995?

Not as far as I am aware.

(18) Please state whether there existed a formal approach to:

(a) Assessing and developing the competence of the staff involved in the treatment that led to Adam's death;

I do not know

(b) Disseminating outcomes and lessons learned both before and after the Inquest, within the RBHSC;

I do not know

(c) Disseminating outcomes and lessons learned both before and after the Inquest, outside the RBHSC?

I do not know

(19) With reference to Dr. Murnaghan's memorandum of 21st June 1996 (Ref: 059-001-001) please state:

(a) Was a seminar arranged? If so, please state when, where, for what purpose, who attended, what was discussed, what was recorded, and what dissemination resulted therefrom?

I have no knowledge of this matter

(b) What engagement and/ or discussions did you have with Dr. Murnaghan in the aftermath of Adam Strain's Inquest?

None as far as I am aware.

If these were recorded please provide the same;

(c) Why was your presence necessitated at this proposed seminar?

I do not know

(d) Was there any urgency in respect of holding this proposed seminar?

I do not know

(e) Did you anticipate contributing to the proposed seminar from the perspective of your

expertise in medical ethics and medico-legal matters?

I had no knowledge of this matter

(f) What medico- legal and/ or ethical issues arose from the case of Adam Strain?

I cannot comment.

(g) Did you make any contribution to this seminar and, if so, what?

None as far as I am aware

(h) To what extent were the issues to be dealt with risk management issues? And why?

I cannot comment

(i) Was this seminar to form a part of a larger clinical audit into the death of Adam Strain?

I do not know

VII. INTERNAL REVIEW

(20) Did the RBHSC conduct an internal review in respect of any of the following matters after Adam's death:

I do not know

(a) The procedures governing consent, and whether they were complied with in Adam's case;

(b) The records kept/made relating to the pre, intra and post-operative care of Adam;

(c) The records kept/ made of communications with Adam's parents;

(d) The use of equipment before and during Adam's surgery;

(e) Lessons to be learned from the treatment which preceded his death;

(f) The competence and training needs of those who cared for Adam.

If so, please address the following:

(i) What steps were taken in respect of each matter?

(ii) When were those steps taken?

(iii) Who took those steps?

(iv) What policies or procedures were used when taking those steps?

(v) What conclusions emerged in respect of any of these matters?

VIII. OTHER

(21) In respect of the clinical negligence action commenced 25th April 1996 and settled 29th April 1997 please state:

I have no knowledge of this.

(a) Why was a confidentiality clause made a term of settlement?

(b) Did the litigation restrict the scope of explanation offered to Adam's parents?

(c) Did the litigation restrict the scope of dissemination of information in respect of learning both internally and externally?

(d) Were the clinical staff involved in Adam's case kept informed of all aspects of the outcome of the clinical negligence case?

(22) Has any consideration been given to the viability of the RBHSC renal transplant facility and if so:

I do not know

(a) When?

(b) Why?

(c) By whom?

(d) What was considered?

(e) With what outcome?

(f) In light of the publication of the *'Provision of Services for Children and Adolescents with Renal Disease'* (Working Party Report in March 1995)

(23) Were any child patients transferred from the RBHSC to any other hospital in the UK for surgery before Adam's death, and if so please state:

This question is unclear: ? renal transplant surgery or any surgery? I don't have access to data in either case.

(a) Date of transfer;

(b) Hospital to which child was transferred;

(c) Age of child when transferred;

(d) Identity of Consultant in charge of child prior to transfer;

(e) Reason for the transfer;

(f) Whether there existed any policy, protocol, procedure or guidelines in relation to the transfer of children to hospitals outside of Northern Ireland for surgery.

(24) In respect of the UTV Insight documentary *('When Hospitals Kill'-* 21st October 2004) please state:

I have no knowledge of this and had no involvement

(a) What requests for information and comment were received from UTV;

(b) What information and comment were given to UTV, specifying by whom, to whom and when;

(c) Please identify those individuals engaged in this process;

(d) Who bore responsibility for this process;

(e) What internal responses were generated by any such requests;

(f) What internal responses were generated by the broadcast of the documentary;

(g) Whether any record or documentation of this process was made, and if so please provide the same;

(h) If same was created, but is now no longer available please state what became of it.

(25) Please identify those procedures and protocols governing the reporting and dissemination of information to the DHSSPS and the wider medical community in 1995 and now relating to:

I believe this would be according to Trust policy, but I cannot recall details.

(a) Unexpected/ unexplained deaths in RBHSC;

(b) Outcomes of Coroner's Inquests

and further please address the following:

(i) Identify those individuals responsible for the implementation of the same;

(ii) Was the procedure/ protocol as adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(iii) State how the Trust satisfied itself that the procedures and protocols were complied with;

(iv) To what extent were the procedures and protocols followed in Adam's case?

(v) What information was supplied in Adam's case?

(vi) Whether the procedures and protocols were consistent with guidance in both Northern Ireland and the UK in 1995.

(26) Please state what steps had been taken by November 1995 to implement the recommendations of the NCPOD report in respect of out of hours paediatric surgery.

I do not know.

(27) Please state what action you took following the Inquest into Adam's death. If you took no action please explain why.

I do not recall any involvement in the matter at any stage

(28) Prior to 26th November 1995, describe in detail your experience of dealing with children with hyponatraemia, including:

I cannot recall details.

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

(b) The number of children who were aged under 6 years;

(c) The nature of your involvement;

(d) The outcome for the children.

IX. GENERAL

(29) Please provide any further comments you may wish to make.

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

Signed: Elaine M. Hales **Dated:** 17 May 2012

Witness Statement ref 244/1

Dr Elaine Hicks

1. (1) (c)
Career history before appointment as Consultant Paediatric Neurologist.

1972 Junior House Officer Royal Victoria Hospital/RBHSC
1973 Junior Resident, Paediatrics/Medicine University Hospital of the West Indies, Kingston, Jamaica
1974 Locum General Practitioner, Holywood, Co Down
1975 Senior House Officer/Junior Tutor, Paaediatrics, RBHSC/QUB
1976 Senior House Officer, Haematology/General Medicine, RVH
1977 Registrar Paediatrics, BCH
1978 Senior registrar Paediatrics, UHD
1978 Senior registrar/Senior tutor, RBHSC/RMH
1979 Senior registrar (seconded) Neurology RVH/Claremont Street Hospital
1980 Clinical Fellow Paediatric neurology Children's Hospital, Boston, USA
1981 Clinical Fellow Neurology/neurophysiology, Children's Hospital, Boston
1982 Senior Registrar RBHSC
1983 Consultant Paediatrician with an interest in neurology EHSSB, RBHSC/RMH/Lissue hospital
1993 Consultant Paediatric Neurologist, Royal Hospitals Trust

Elaine Hicks
17 May 2012

1. (1) (d)
Work Commitments RBHSC 1983 - 1995

1983: Consultant in general paediatrics with an Interest in Neurology:
General paediatrics: Inpatients, outpatients, I in 2 acute cover including PICU.
Interest in neurology: took all referrals and provided acute on call service continuously except when away/ill, developed outpatient clinics, consultations and clinics in regional neonatal unit RMH, input into EEG department RBHSC, teaching of all types of clinical staff, undergraduates in medicine, physiotherapy, occupational therapy, speech therapy and nursing students, postgraduates in paediatrics, clinical psychology and post registration nurses. Close liaison with regional neuroscience specialities RVH
Also sessional commitment to the Paediatric Unit at Lissue Hospital, Lisburn
Multidisciplinary neuromuscular clinic in BCH.
1989: Lissue unit moves to Belvoir Park Hospital
1990: change of ward in RBHSC, general paediatric on-call for PICU rotation only (1 in 8) continued continuous neurology cover.
Developed outreach outpatient and consultation service to N, S and W Health Board areas.
1995: appointment of 2nd Consultant in Paediatric Neurology. Assumed formal 1 in 2 acute neurology rota. Ceased general paediatric duties.

Elaine Hicks
17 May 2012