Witness Statement Ref. No. 264/1

NAME OF CHILD: Claire Roberts

Name: Elaine Hicks

Title: Dr.

Present position and institution:

None. Retired.

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 October 1996-August 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 attached:

Ref:	Date:	
WS-129/1	17th May 2012	Witness Statement to the Inquiry (Adam Strain)

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:

None as far as I recall

(b) Your job, role and functions;

From 1 October 1996 I reduced clinical sessions to Belvoir Park Hospital and to The Royal Maternity Hospital Belfast as I became Clinical Director of Paediatrics at the Royal Hospitals

(c) **Your responsibilities and accountability, including to whom.**

As CD I was accountable to the Chief Executive with Professional Responsibility to the Medical Director.

(2) Please confirm whether you were clinical lead of the Paediatric Directorate as at October 1996. Please include the date of your appointment to the post.

As above

(3) With reference to the Paediatric Directorate's corporate structure as diagrammatically described by Dr. Connor Mulholland (Ref:WS-243/2 p.6) please state:

(a) Whether this structure is correct as at October 1996?

As far as I recall I was included in the Subdirectorate with responsibility for Tertiary Services in RBHSC. Other wise I think it is correct.

(b) Please identify all the personnel in the posts in October 1996, in particular Nurse Manager;

As in the diagram. I believe the Nurse Manager at that time was Ms Audrey Lockhead

(c) If the diagram is incorrect in any way, please provide an accurate diagram/description.

As above

(4) Did you consult on a regular basis with the following:

(a) **Nurse Manager;** Yes, weekly with sub-directors. The purpose of this meeting was to ensure that she was involved with the weekly discussion concerning the running of the directorate.

(b) **Ward Sisters;** Yes, at monthly directorate meetings, also on occasion I attended the monthly

Sisters meeting. The purpose was to fully involve the ward sisters in the business of the Directorate. I attended the Ward Sisters' monthly meeting if there was a particular issue which they or I wished to discuss.

(c) **Consultants;** Yes, monthly directorate meetings. This meeting involved consultants in the Paediatric Directorate and other Consultants such as the Anaesthetists who worked in RBHSC. The purpose was to enable communication between consultants and with the Directorate management team.

(d) **Other clinicians?** Yes. Monthly directorate meetings included representatives of the Doctors in Training and Clinical Professions.

(5) **If so, please also confirm for what purpose you would have met, on what basis and were such meetings minuted?**

Purpose outlined for each section above. Minutes were taken of all of these meetings

(6) **Would you have expected the death of Claire Roberts to have been brought to your attention? If so how? If not, how do you explain this?**

I would not have expected the death to have been brought to my attention unless it was thought that there had been an untoward event.

(7) **Did you have any communication with Dr. Steen regarding the death of Claire Roberts in 1996-1997?**

As far as I recall I did not

(8) **Have you ever reviewed Claire Roberts' case notes, if so when and for what purpose? If so, please provide dates.**

No

(9) **How many patients died annually in 1995 and 1996 in:**

(a) **PICU;**

(b) **The RBHSC?**

I do not have this information

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

I do not have this information

(11) **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?**

For this Inquiry

(12) **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;**

(b) **How such changes were formulated and disseminated;**

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

None that I recall

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

(a) **Preventable?** Usually

(b) **Treatable?** Usually

(14) **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 do not know

(a) **Dr. Peter Crean;**

(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.**

(15) **Please specify the date, nature and content of any such reports.**

I cannot answer this

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

No

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

As far as I know I was not aware of her death

(18) **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 do not know

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

I think there was always a level of awareness as to these issues

(20) **Please specify all meetings, discussions, reviews, neuroscience grand rounds 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 do not have this information

(21) **Were minutes of the Paediatric Audit Committee/ Mortality meetings sent to the Paediatric Director/Directorate Office?**

I believe that notices of the meetings were sent, although I believe that detailed minutes of Mortality meetings were not taken.

(22) **Were minutes of neuroscience grand rounds touching upon the death of a RBHSC patient sent to the Paediatric Director/Directorate Office?**

I think not

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

(a) **Before the Autopsy report became available;**

(b) **After the Autopsy report became available.**

I do not have this information

(24) **Did the Pathologist attend the meeting(s), and if so please identify the Pathologist?** As at (23) above

(25) **Was any learning gained from any such meetings? If so what?** As at (23) above

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

I do not recall if Dr Taylor had a specific role at this time

(27) **Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for admittance of children 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.**

Yes; all admissions were discussed with and authorised by a Consultant Anaesthetist. I cannot recall if there were written guidelines.

(28) **What responsibility did the 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?**

They had the same responsibility as any consultant; that is to communicate regularly with the parents of children admitted to PICU, the frequency depending on the clinical situation, to

explain the child's clinical status, including investigations, results and treatment plans and to answer questions and provide advice and support.

(29) **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?**

No

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

(a) **Record keeping;**

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

I do not know

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

Reviewing the information on the Inquiry website, it seems that it is possible

(32) **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that to have been the cause of an investigation?**

I would have expected to be informed. I would have expected that investigations would have been led by the Medical Director or Director of Medical Administration.

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

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

(b) **Dr. Peter Crean;**

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

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

(e) **Mr. A.P. Walby;**

(f) **Mr. George Brangam;**

(g) **Miss Elizabeth Duffin.**

I do not know

(34) **Did you have any communication with Drs. Murnaghan and/or Carson regarding the death of Claire Roberts in 1996-97?**

No

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

No; that would not have been my responsibility.

(36) Please state whether you were asked for your opinion as to whether or not Claire Roberts' death should have been referred to the Coroner.

No

(37) 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?

No

(38) 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 do not know

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

To provide details of pathological findings and to determine the cause(s) of death

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

I cannot recall the exact guidelines in 1996 on all of these issues. I believe current practice at that time was as follows

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

When the Coroner was not involved

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

On any occasion, dependent on the clinical circumstances

(c) Authorisation for the same;

In my experience this course of action would be decided on after discussion between the clinician (s) and the pathologist and between the clinician and the parents/relatives

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

This would be discussed and options outlined by the involved clinician. My personal practice would have been to speak to the parents of a deceased child who had been my patient; to review the situation regarding their child's death; to outline what I believed to have been the cause or causes of death and to answer their questions as best I could. I then would advise them about the process of certification of death and at this point I would raise the issue of a post mortem examination explaining whether I felt that it would be helpful to perform this in order to gain extra knowledge of their child's illness. As I was a Neurologist, it was often the case that the brain was primarily involved in the pathological process and in this circumstance I would explain that a post-mortem limited to the brain was a possible course of action. I would try to assist and support them in making a decision in this matter. I also outlined to them the timescale involved in the procedure and in the likely availability of the result. I would endeavour to answer all their questions.

In the case of a death which was to be reported to the Coroner, I would have outlined to the parents the reason for this and explained the process.

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

No

(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;**

As (d) above

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

Yes

(41) **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 believe this was a form in use in the Royal Hospitals

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

I do not know

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

(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;**

I have no knowledge of this

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

I do not know

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

(a) **Circular ET 5/90 (as amended) January 1991?** I do not know what this is/was and I have not been provided with a copy of same with my statement request

(b) **White Paper Working for Patients 1989?** Yes

(c) **CEPOD The Confidential Inquiry into Perioperative Deaths, 1989?** Yes

(d) **Hospital Medical Audit, Kings Fund 1989 and Speciality Medical Audit-Kings Fund Centre, Charles Shaw, 1992?** I am not certain

(e) **BPA Paediatric Medical Audit 1992?** Yes

(f) **Medical Audit: A Second report, Royal College of Physicians 1993?** I am not certain

(g) **The Care of Sick Children Review of Guidelines in the wake of the Allitt Inquiry, 1994?** I am not certain

(h) **GMC Good Medical Practice 1995?** Yes

(i) **Tertiary Services for Children and Young People, BPA 1995?** Yes

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

(k) **Directive PEL (93)36?** I do not know what this is and I have not been provided with a copy of same with my statement request

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

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

(45) **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 Dr. Seamus McKaigue's initials? If so why was this note made? If not, what do these letters stand for?**

I think this likely refers to Dr Seamus McKaigue's initials. I cannot be certain of the circumstances under which this note was made; I would take it to mean that Dr McKaigue had seen the document and had advised that it should be filed.

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

I do not know

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

I have no idea

(d) **What were the usual filing procedures in relation to these matters?**

The responsible consultant would usually sign or initial a sheet and clerical staff would file it in the patient's chart

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

I do not know

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

I do not know

(48) **Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in**

1996? Yes **If so how did it affect the advices given to you or others in respect of:**

(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?**

It served to inform and highlight to management and to staff the situation regarding the above. At this stage I cannot recall details.

(49) **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;**

As an undergraduate and as a House Officer

(b) **Referral of deaths to the Coroner;**

As an undergraduate, and during post-graduate training

(c) **The principles governing post-mortem requests.**

As an undergraduate and during my postgraduate training

(50) **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 believe the Pathology department audited referrals for Post Mortem examinations and reported back via the Hospital Council

I do not recall a system for audit of referrals to the Coroner

(51) **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 was not aware of this case at the time. Having read the documents on the Inquiry website, and with the benefit of these and with hindsight, management of fluid balance in a sick child can be difficult and requires clear guidelines.

(52) **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 do not have this information

(53) **With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts?**

The topic could have been highlighted to staff.

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

I am not sure what this means. There have been enormous changes in RBHSC since 1996 as in the whole NHS, and undoubtedly many since I last worked there, almost 5 years ago.

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

I do not know

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

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

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

(c) **Whether this was available to staff in the RBHSC in October 1996;** I believe so

(d) If this was not in use or available please state what text was in October 1996. N/A

(57) In 1996 were there any guidance or procedures governing:

(a) Response to a significant error in drug administration?

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(b) The information should be given to parents in such circumstances?

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(c) The reporting of such errors/potential errors by doctors?

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(d) The giving of a first dose of an IV infusion of drugs?

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(e) The use of 'off-licence' drugs?

I believe that there was guidance and/or procedures but I have no information in my

possession and at this stage my memory for the detail is poor.

(f) **Consultant responsibility for patients;**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(g) **Cross referral of patients between consultants;**

I am not sure that there was guidance on this issue

(h) **Notification of consultant responsibility;**

I am not sure that there was guidance on this issue

(i) **Record keeping as to consultant accountability;**

I do not know

(j) **Systems for informing consultants about children in their care;**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(k) **Means by which doctors and/or could receive information regarding children in their care;**

I do not know

(l) **Handover arrangements between clinicians and medical teams;**

I do not know what this means

(m) **The testing of serum electrolytes and the recording of the same.**

I do not recall

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

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

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

I do not know

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

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

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

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(r) **Implementation and compliance with published guidance;**

I do not recall

(s) **The amendment of nursing care plans;**

I do not know

(t) **The arrangements when consultants are unavailable;**

I do not know

(u) **Communication with consultants;**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(v) **Arrangements and criteria for access to and use of CT/EEG facilities;**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(w) **The role of the Ward Sister;**

I do not know

(x) **Measuring and recording of fluid balance;**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(y) **CNS observations;**

I believe that there was guidance and/or procedures but I have no information in my

possession and at this stage my memory for the detail is poor.

(z) **Identification of medical teams;**

I do not know

(aa) **Preservation of ward round diaries, staff rotas etc;**

I do not know

(bb) **The provision of information for the Pathologist**

I believe that there was guidance and/or procedures but I have no information in my possession and at this stage my memory for the detail is poor.

(58) **Did you ever receive copy or see the signed, finalised Autopsy report?**

No

(59) **Under what circumstances would you have reported the death of Claire Roberts to:**

(a) **The Medical Director;**

If I had became aware of a concern regarding a possible serious adverse event

(b) **The Director of Medical Administration;**

If the Medical Director was not available

(c) **The Director of Nursing?**

If I became aware of a possible concern about nursing care

(60) **Did you carry out a review of the case notes of Claire Roberts in 2004-2005? If so who requested the same?**

No. I do not know.

(61) **What training was given to RBHSC junior medical staff as to the formulation of differential diagnoses in the 5 years prior to October 1996?**

There was a 2-3 day induction course twice yearly for all new junior Medical Staff in RBHSC

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

I do not know

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

No further comments.

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

Signed: Elaine M. Hicks **Dated:** 25 September 2012