Witness Statement Ref. No. 270/1

NAME OF CHILD: **Claire Roberts**

Name: Ian Carson

Title: Dr.

Present position and institution:

- Retired since 2006
- Non-Executive Chairman, Regulation & Quality Improvement Authority (2006 to date).

Previous position and institution:
[As at the time of the child's death]
Medical Director, Royal Belfast Hospital for Sick Children ('RBHSC') - **INCORRECT**
Medical Director, Royal Group of Hospitals & Dental Hospital HSS Trust

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-March 2012]

Nothing outside my role as Deputy CMO up to my retirement in April 2006, and my appointment as Chairman, RQIA (June 2006 to present date).

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-077/1	8th July 2005	Department Witness Statement (Adam Strain)
WS-077/2	14th 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

(b) Your job, role and functions; None

(c) Your responsibilities and accountability, including to whom you reported and who reported to you. None

(2) Please detail any changes in clinical and corporate governance in the Royal Group of Hospitals/RBHSC as and between 1995-1997 and 1997-2004 in respect of:

(a) The reporting, investigation, analysis and learning from adverse clinical incidents;

None that I can recall

(b) The referral of deaths to the Coroner.

None that I can recall

(3) After the death of Adam Strain was any indication given that the Medical Director and/or Director of Medical Administration should be informed of any future deaths involving hyponatraemia, and if so by whom?

Not that I can recall

(4) In 1996, what steps were being taken to ensure overall understanding and clarity of lines of responsibility and accountability in clinical care?

Other than any advice provided by professional bodies, such as Royal Colleges, specialty organisations, the 'medical defence organisations' and the General Medical Council to individual practitioners, I cannot recall any other steps being taken by the Health & Social Services, including Trusts, apart from what may have been included in a job description or contract of employment.

(5) In 1996, what steps were being taken to encourage staff to report adverse events so that lessons could be learned?

Apart from advice given by senior doctors, particularly those involved in postgraduate training to doctors in training - none that I can recall

(6) Please provide your views on whether any deficiencies in the dissemination of information in respect of Adam's death in 1995 and the lessons learned from his Inquest could have played a role in the death of Claire and, if so, to what extent.

This is outside my area of expertise – unable to comment.

(7) When did you first become aware of the death of Claire Roberts?

I am unable to recall, but as far as I am aware, it was not before 2004/2005.

(8) 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?

Deaths (even unexpected deaths) in the Royal Group of Hospitals were not formally reported to the Medical Director as a routine.

(9) Did you carry out a review of the case notes of Claire Roberts in 2004-2005? If so, who requested the same and what was the outcome?

No

- I do not have this information.

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

Not that I can recall

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

No

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

(a) PICU;

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(b) The RBHSC?

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(13) Please specify all investigations into the treatment and death of Claire Roberts.

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(14) 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.

Other than the changes adopted by the paediatric anaesthetists in regard to intravenous fluids, I am not aware of any other changes – I suggest that you contact the Paediatric Directorate, RBHSC

(15) 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 have access to this information – This would initially have been the responsibility of the clinicians involved in the care of Claire Roberts, and subsequently members of the Clinical Directorate management team.

I was not a member of staff in the RBHSC, I suggest that you contact the Paediatric Directorate, RBHSC

(a) Dr. Peter Crean;

(b) Dr. Elaine Hicks;

(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.

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

I do not have access to this information – I was not a member of staff in the RBHSC, I suggest that you contact the Paediatric Directorate, RBHSC

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

This is outside my area of expertise. This would be a matter for the clinicians (medical and nursing) directly involved in the patient care of Claire, and for experts in the field.

(18) What steps were taken in 1996 to ensure that lessons learned from audit and inquests were translated into changes in clinical practice?

Nothing formal as far as I can recall.

(19) In 1996, what arrangements were in place to monitor deaths to identify areas of concern?

Nothing formal as far as I can recall.

(20) In 1996, what systems were in place to identify and manage the poorly performing clinician?

Apart from arrangements for 'doctors in training' there was nothing formal in place, as far as I can recall. It was not until Nov 1997 that the Royal Hospitals HSS Trust put in place a formal procedure "Medical Excellence: Maintaining good medical practice: the conduct, health and performance of doctors working within the Royal Hospitals

Trust".

(21) Describe the monitoring of litigation in 1996 in order to utilise the information to improve clinical practice and policies.

Nothing formal as far as I can recall.

(22) In 1996, what systems were in place to monitor the quality of clinical care?

Nothing formal as far as I can recall. There would have been opportunities to discuss quality of care through the formal 'contract negotiations' with 'purchasers/commissioners' such as the four Health Boards and GP Fundholders.

(23) Was the Arieff et al paper BMJ 1992, (Ref: 011-011-074) circulated in the RBHSC in 1996 amongst healthcare professionals.

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

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

I was not a member of staff in the RBHSC, I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(25) 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 access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(26) Were minutes of the Paediatric Audit Committee/ Mortality meetings sent to the Medical Records Committee and/or the Audit Department of the Royal Group of Hospitals?

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(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.

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(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?

I do not have access to this information – I suggest that you contact the Paediatric

Directorate, RBHSC

(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?

This question would be better addressed to the Trust Director of Nursing Services, and /or the Nurse Manager within the Paediatric Directorate. In cases involving HM Coroner, the Director of Medical Administration would usually have sought statements from nursing staff involved in a patient's care.

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

(a) Record keeping;

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(b) Drug prescription and administration?

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

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

This is outside my area of expertise. This would be a matter for the clinicians (medical and nursing) directly involved in the patient care of Claire, and for experts in the field.

(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?

This is a matter of judgement. I would have been reliant on the advice of the Clinical Director (following discussion with the consultant/senior doctor in charge of the patient).

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC; or, you need to contact the individuals directly.

(a) Dr. George Murnaghan;

(b) Dr. Peter Crean;

(c) Dr. Joseph Gaston;

(d) Dr. Elaine Hicks;

(e) Mr. A.P. Walby;

(f) Mr. George Brangam;

(g) **Miss Elizabeth Duffin.**

(34) **Did you have any communication with Drs. Murnaghan, Hicks, Webb or Steen regarding the death of Claire Roberts in 1996-97?**

Not that I can recall

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

Not that I can recall

(36) **Please state whether the input of the Director of Medical Administration, Dr. George Murnaghan, was sought in respect of any matter relating to the death of Claire Roberts.**

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC; or, you need to contact Dr Murnaghan directly.

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

An autopsy is a medical exam of the body of a person who has died. The purpose of the report is to inform the clinician who may have requested the autopsy, or HM Coroner if they requested the autopsy, and the family in regard to questions about the person's illness or the cause of death.

(38) **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;**

In 1996, consent was required for all post-mortems, excluding those required by HM Coroner.

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

I do not recall the guidance on 'limited post-mortem' requests, however this could be requested by the doctor, or by the relative, and was annotated on the consent form.

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

I am unable to recall any guidelines, other than professional conventions that would have been in existence at that time.

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

I am unable to recall any guidelines that would have been in existence at that time.

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

I do not recall any guidance on this matter. Relatives would be informed when

a referral was going to be made to HM Coroner, and that they may require a post-mortem to be conducted, and that this did not require consent from the next of kin. Relatives would not normally be asked for their views on whether or not the Coroner be notified.

(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 do not recall any guidance on this matter.

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

I do not recall any guidance on this matter.

(39) 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)?

This looks like the old Eastern Health & Social Services Board (EHSSB) form which was widely used by hospitals in the EHSSB area before Trust specific forms were introduced

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

Not that I can recall. I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC

(41) 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 do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC; or, the clinicians directly involved.

(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 have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC; or, the clinicians directly involved.

(42) In October 1996 were you aware of:

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

I cannot recall what this Circular refers to.

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

Yes

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

I would have been aware of CEPOD reports in general. I am unable to recall the specifics of the 1989 report.

(d) **Hospital Medical Audit, Kings Fund 1989 and Speciality Medical Audit-Kings Fund Centre, Charles Shaw, 1992?**

Not that I can recall

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

Not that I can recall

(f) **Medical Audit: A Second report, Royal College of Physicians 1993?**

Not that I can recall

(g) **The Care of Sick Children Review of Guidelines in the wake of the Allitt Inquiry, 1994?**

I would have been aware of Allitt Inquiry in general, and I may have been aware of the Review of Guidelines at the time, but I am unable to recall any recommendations as to how these might have been implemented in Northern Ireland.

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

Yes

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

Not that I can recall

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

Yes

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

I may have been at the time, but I cannot recall how this would have been implemented.

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

Not that I can recall

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

I may have been aware of this document, but I cannot recall any of the specific recommendations.

(43) 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 do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

(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 do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC.

(46) **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 of the Royal Hospitals HSS Trust's participation in the Kings Fund Organisational Audit, but I cannot recall the outputs or outcomes that resulted.

(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?**

(47) **Please state whether any training or guidance (including details of the same) was provided to clinicians in respect of:**

(a) **The compilation and completion of death certificates;**

I do not have access to the details of training or guidance, however instruction on this matter was included in the undergraduate curriculum when I was a student (I'm not sure of the present arrangements).

At that time, this subject would usually be covered during induction of junior doctors either corporately, but more usually at individual ward level.

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

Undergraduate medical curriculum, and at induction of new staff

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

It was apparent following the Human Organs inquiry, chaired by John O'Hara, QC, in 2001, that there were many short-comings in regard to consent for post-mortem. I was responsible, during my tenure as Deputy Chief Medical Officer (DHSSPS) for implementing all 20 of the Inquiry's recommendations, including issuing new regional guidance and standardised consent forms across Northern Ireland.

(48) 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?

Not that I can recall. The Laboratory Directorate/Pathology Department may have audited referrals.

(49) 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 involved in the care of Claire Roberts. I was not a member of staff in the RBHSC, and I was not aware of her death (as far as I can recall) until after I had left the employment of the Royal Hospitals HSS Trust.

(50) 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 was not involved in the care of Claire Roberts. I was not a member of staff in the RBHSC, and I was not aware of her death (as far as I can recall) until after I had left the employment of the Royal Hospitals HSS Trust.

(51) With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians:

(a) **After the death of Adam Strain;**

Possibly, but I doubt if there was sufficient awareness of the significance of the contributing factors.

(b) **After the death of Claire Roberts.**

This is outside my area of expertise. This would be a matter for the clinicians (medical and nursing) directly involved in the patient care of Claire, and for experts in the field

(52) Please describe how the 'learning culture' within the Royal Groups of Hospitals/RBHSC has changed since 1996?

I left the Royal Hospitals HSS Trust in 2002, however with the development of Clinical Governance in the late 90s, I think that there is greater awareness of the benefits of 'open reporting' of adverse events including 'near misses', and the contribution that they can make to patient safety.

(53) In 1996, what steps were being taken to achieve a change in the culture within the Royal Group of Hospitals/RBHSC?

The 1990s were a very challenging time for the Royal Hospitals HSS Trust, financial pressures, savings targets and insecurity regarding capital development, and endless discussions about 'service reorganisation' were at the forefront of the organisation's attention. Professional leadership was essential to maintain clinical commitment and development of a progressive and forward-looking culture in the Trust. It wasn't easy!

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

I was not involved in the care of Claire Roberts. I was not a member of staff in the RBHSC, and I was not aware of her death (as far as I can recall) until after I had left the employment of the Royal Hospitals HSS Trust.

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

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

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

(f) Consultant responsibility for patients;

Apart from advice from the General Medical Council, and other professional bodies and any reference in individual consultant contracts of employment, I do not have

access to further information – I suggest that you contact the Trust.

(g) Cross referral of patients between consultants;

I do not have access to this information – I suggest that you contact the Trust

(h) Notification of consultant responsibility;

Apart from advice from the General Medical Council, and other professional bodies and any reference in individual consultant contracts of employment, I do not have access to further information – I suggest that you contact the Trust.

(i) Record keeping as to consultant accountability;

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

(l) Handover arrangements between clinicians and medical teams;

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

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

Apart from advice from the General Medical Council, and other professional bodies and any reference in individual consultant contracts of employment, I do not have access to further information – I suggest that you contact the Trust.

(o) Investigation of patient's death;

Other than guidance on the role of HM Coroner, I cannot recall any other guidance.

(p) Review of medical records;

Apart from advice from the General Medical Council, and other professional bodies and the random inclusion of 'chart reviews' as part of the clinical audit process, I do not have access to further information – I suggest that you contact the Trust.

(q) Systematic programme of audit;

Medical (and subsequently) Clinical Audit was in place prior to 1996. It was professionally led, and while advocated by the General Medical Council, and other professional bodies, and included in consultant contracts of employment, it was

sporadic and could not cover every area of practice in a systematic fashion.

(r) Implementation and compliance with published guidance;

I do not have access to this information – I suggest that you contact the Trust

(s) The amendment of nursing care plans;

I do not have access to this information – I suggest that you contact the Trust

(t) The arrangements when consultants are unavailable;

'Out of hours' cover is usually governed by 'on-call rotas'. Annual leave and Professional Study leave are usually governed by similar arrangements. Longer periods of leave usually require the appointment of a 'locum doctor'. Advice is available from the General Medical Council, and other professional bodies; and there may be reference to local arrangements in individual consultant contracts of employment. I do not have access to any further information – I suggest that you contact the Trust.

(u) Communication with consultants;

Apart from advice from the General Medical Council, and other professional bodies and any reference in individual consultant contracts of employment, I do not have access to further information – I suggest that you contact the Trust.

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

I do not have access to this information – I suggest that you contact the Trust

(w) The role of the Ward Sister;

I do not have access to this information. This is a nursing professional issue – I suggest that you contact the Trust

(x) Measuring and recording of fluid balance;

I do not have access to this information – I suggest that you contact the Trust

(y) CNS observations;

I do not have access to this information – I suggest that you contact the Trust

(z) Identification of medical teams;

I do not have access to this information – I suggest that you contact the Trust

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

I do not have access to this information – I suggest that you contact the Trust

(bb) The provision of information for the Pathologist

I do not have access to this information – I suggest that you contact the Trust

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

Not that I can recall

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

I was not a member of staff in the RBHSC, nor did I have a management role in the RBHSC (my responsibilities were 'trust-wide'). However, if the death had been reported to me in Oct 1996, and it was suspected that there were matters of concern, then I might have reported the death to:

(a) The Chief Executive;

- If I had decided to conduct an independent investigation.
- If (in conjunction with the Director of Human Resources) I felt that it was necessary to 'suspend' a doctor pending a referral to the Occupational Health Service, or prior to an independent investigation as above, or to the administration of disciplinary procedures.
- If I suspected that it was necessary to report a medical doctor to the GMC.
- If I felt that the reputational risk of the Trust was at risk.

(b) The Director of Medical Administration;

I would have anticipated that the Director of Medical Administration (DMA) might have known before myself, particularly if the case had been referred to HM Coroner. However, if this were not the case, I might have asked him to co-ordinate a preliminary investigation in conjunction with the Clinical Director (if that was appropriate).

(c) The Director of Nursing?

It would have been likely that the nursing team would have already informed the Director of Nursing (DN). However, if a preliminary investigation co-ordinated by the DMA produced evidence to suggest that there were nursing issues potentially contributing to a death, then the DN would have been informed and involved in any subsequent action.

(58) ***"Every adverse incident, including deaths whether expected or unexpected, provide an opportunity for learning. Medical professionals have used 'morbidity and mortality case conferences' for many years"*** **(Ref: WS-077/2 p.21). In respect of this statement please state:**

(a) What learning was derived from Adam Strain's death, Inquest and litigation in respect of fluid management and the dangers of hyponatraemia?

The specific issues in relation to complex paediatric nephrology, transplantation and clinical biochemistry are outside my area of expertise, but briefly I think there is learning around:

- the planning of major surgery

- the monitoring of perioperative fluid balance
- the use of appropriate intravenous fluids
- the communication between healthcare professions, and with families.

(b) **How was Claire Roberts death used as an opportunity for learning?**

This would be a matter for the clinicians (medical and nursing) directly involved in the patient care of Claire. I suggest that you contact the Paediatric Directorate, RBHSC.

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

I was not a member of staff in the RBHSC, I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC, or the Clinical Tutors responsible for junior doctor training.

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

I do not have access to this information – I suggest that you contact the Paediatric Directorate, RBHSC, or the Clinical Tutors responsible for junior doctor training.

(61) **Do you have access to:**

(a) **First, second and third Clinical Audit reports to Trust Board;**

No

(b) **First and second Health and Safety reports to Trust Board;**

No

If so, please provide copies of the same.

I suggest that the Inquiry make contact with the Trust directly.

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

Many of the questions directed to me in the above Witness Statement would appear to presume that at the time of Claire Robert's death, I :

a. was a paediatrician working in the RBHSC, or

b. had a management role specifically in the RBHSC.

Neither of these was the case. As a consequence, many of my responses are unable to provide the information requested.
I left the employment of the Royal Hospitals HSS Trust in 2002, and was succeeded in my role as Trust Medical Director by Dr Michael McBride.

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

Signed: **Dated:** 4 Sept 2012