Witness Statement Ref. No. 253/2

NAME OF CHILD: Claire Roberts

Name: Alan Roberts

Title: Mr

Previous Statements, Depositions and Reports:

[Identify by date and title all those made in relation to Claire's death]

OFFICIAL USE:

List of previous statements, depositions and reports:

Ref:	Date:	
096-001-004	29/09/05	Statement
096-001-001	25/04/06	Deposition to the Coroner
096-026-356	16/03/08	PSNI Witness Statement
WS-253/1	09/08/12	Inquiry Witness Statement

Statement of Alan Roberts
Dated 03th September 2012

Re Claire Roberts and communication with medical staff

The following statement is on my daughter Claire and my communication with medical staff at the Royal Belfast Hospital For Sick Children.
Claire attended the RBHSC on Monday 21st October 1996 at 07:00pm. A doctor in A&E examined Claire and informed me that she had a viral illness. I asked the doctor about any other serious illness such as meningitis and was told that Claire did not have meningitis. The doctor advised me that as Claire was continuing to vomit she would be admitted for overnight observation.
My wife and I stayed with Claire until around 10:00pm until she was settled and in her nights sleep before leaving the hospital without any concerns being expressed by medical staff.
My wife and I arrived at the hospital at 9:30am Tuesday 22nd October 1996. We were advised by the nursing staff that Claire was much more alert and had a comfortable night. However we both expressed our concerns that morning to a nurse that Claire did not appear to be herself. Claire appeared pale and lethargic and not as responsive as usual. I recall the ward round at approximately 11:00am. I did have a conversation with a doctor during the ward round who I now believe to be Dr Sands. This conversation lasted for no more than 5 to 10 minutes. This was the only communication I had with Dr Sands or any doctor throughout Tuesday 22 October 1996. My wife and I expressed our concerns to Dr Sands that we expected to see an improvement in Claire's condition from the previous evening but were concerned that there had been no improvement. The discussion with Dr Sands gathered information about Claire's character and her past history. My wife and I explained to Dr Sands that Claire had early infancy epileptic seizures, that she had no seizures for over 3 to 4 years and was off all anti epileptic medication for almost 2 years.
The extent of the conversation with Dr Sands was minimal and did not raise any concerns or alarms for Claire's well-being. Dr Sands advised my wife and I that he thought Claire had a viral illness and she may be experiencing some type of internal fitting. At that time my understanding was that the viral illness Dr Sands referred to was nothing more than a stomach bug.
The internal fitting was not discussed or explained in any detail by Dr Sands and I assumed it was related to Claire's tummy bug. Dr Sands said he would speak to another Doctor. Dr Sands did not express any concerns regarding Claire's condition to me during the ward round. Non fitting status or non convulsive status epilepticus was not mentioned or discussed with me by Dr Sands. During the ward round Dr Sands did not inform me or discuss with me any possibility of infection in the brain or encephalitis.
Dr Sands did not discuss or inform me of any medication type or dose Claire was to receive,(diazepam).
I was certainly not informed during the ward round or throughtout Tuesday 22 October 1996 by Dr Sands or any Doctor or nurse that Claire was being treated for a possible virus of the brain or encephalitis. My understanding throughtout Tuesday 22 October 1996 was that Claire had a tummy bug.
Dr Sands did not inform or discuss with me that he had added encephalitis/encephalopathy to the ward round note or that he thought it likely that Claire was admitted to hospital with meningo-encephalitis.

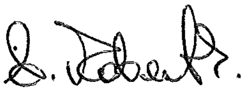
Dr Sands did not mention or discuss meningo-encephalitis with me at any time during the ward round or any time thereafter.
Grandparents visited Claire around 01:00pm. My wife and I went into Belfast for some personal items for Claire and lunch, returning to the hospital shortly after 02:00pm.
I left the hospital around 02:45pm to collect my two sons from school.
I returned to the hospital with my two sons 06:30pm and was informed by my wife that Claire had had a seizure around 03:30pm. Claire was sleeping when I arrived at the hospital. At 06:30pm I discussed this seizure with my wife and our understanding was that if Claire had been experiencing some form of internal fitting from early morning, as described by Dr Sands, then the seizure at 03:30pm could have been a build up of that and this was a form of release. My thoughts at 06:30pm were still that Claire had a stomach bug but if this was to be a return of Claire's epilepsy the next few days would mean a stay in hospital for further tests.
My wife also informed me that a doctor had examined Claire at 05:00pm and that he had prescibed medication for Claire. I assumed that the medication administered to Claire was to counteract her tummy bug and the seizure at 03:30pm and that it was having a sedation effect as Claire was asleep.
The nursing care from 06:30pm to 09:30pm was general and without alarm or concern. The nursing staff did not discuss or mention non fitting status, non convulsive status epilepticus or inform me or discuss with me any possibility of infection in the brain or encephalitis.
When my wife and I left the hospital at 09:30pm we believed that Claire was settled, in her nights sleep and that the next day would see a big improvement. No concerns were expressed by the nursing staff at 09:30pm.
I received a telephone call from RBHSC at 03:45am Wednesday 23rd October 1996 stating Claire was having breathing difficulties (call by Dr Bartholome) and that my wife and I should make our way to the hospital.
At around 04:30am my wife and I met Dr Steen and Dr Webb in PICU who informed us that there was a build up of fluid around Claire's brain and pressure was being applied to her brain stem. Claire was being sent for a CT scan to confirm this. My wife and I were brought into PICU to see and be with Claire. Dr Steen and Dr Webb reassured us that everything possible had been done for Claire and nothing more could have been done.

Following the CT scan at approx 06:00am we met with Dr Steen and Dr Webb in a room next to PICU. Dr Steen explained that the virus from Claire's stomach had spread and travelled into Claire's brain and caused a build up of fluid. Pressure was being applied to Claire's brainstem and this was cutting off her essential body function. We asked Dr Steen if it was possible for any type of surgery or to drill into Claire's skull to drain the fluid, or relieve the pressure build up. Dr Steen informed us that was not possible. We asked if everything possible had been done for Claire and if anything else could have been done. Dr Steen informed us that everything possible had been done for Claire and nothing more could have been done. We never questioned the accuracy of Claire's diagnosis or the quality of the treatment she received. We accepted the explanation given by both doctors. Dr Steen advised us that Claire was brain dead, she was being kept alive by the life support equipment and brain stem tests would be carried out and repeated again 12 hours later. Claire was moved to a small side room within PICU with her family around her and remained on life support until 18:45. At 19:00 Dr Steen brought my wife and I into a small office in PICU, expressed her sympathy on our loss and explained that the hospital would carry out a brain only post mortem to try to identify the virus responsible for the brain swelling

and Claire's death and that there would be no need for an Inquest.
Dr Steen said the hospital and doctors needed to carry out the post mortem so that they could learn from Claire's death. My understanding at that time was an Inquest would only be held into a death which was suspicious or required further investigation. I accepted Dr Steen's guidance and signed for the authorisation of a limited brain only post mortem.
During our time in PICU the only reason given to my wife and I by Dr Steen and Dr Webb for the build up of fluid leading to Claire's death was a virus. There were no discussions about hyponatraemia, sodium levels or fluid management.

My wife and I had a meeting on 3 March 1997 with Dr Steen to discuss the post mortem results. Dr Steen informed my wife and I that the post mortem had identified a viral infection in Claire's brain responsible for the brain swelling but the virus itself could not be identified. Dr Steen explained to my wife and I how an entrovirus starts in the stomach and can then spread to other parts of the body, as in Claire's case. During that meeting Dr Steen did not discuss Claire's sodium levels, hyponatraemia or fluid managemant.

Alan Roberts
03-09-2012



06-09-2012.