Witness Statement Ref. No: **257/2**

NAME OF CHILD: Claire Roberts

Name: Margaret Jennifer Roberts

Title: Mrs

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:**	
WS-257/1	09/08/12	Inquiry Witness Statement

Statement of Jennifer 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.
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.
I arrived at the hospital at 9:30am Tuesday 22nd October 1996. My husband and I 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 throughout Tuesday 22 October 1996. My husband 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. 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 husband 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 husband and I went into Belfast for some personal items for Claire and lunch, returning to the hospital shortly after 02:00pm.
Grandparents informed us that a doctor had been to see Claire, I now believe that was Dr Webb. Grandparents were relieved that Dr Webb informed them that any serious illness such as meningitis had been ruled out. I also recall my mother telling me that Dr Webb had handed Claire a pen and was told that that would not interest Claire and he should try a piece of paper, to which Claire responded to. I recall at 03:25pm I was with Claire when she had her first seizure. I recall informing a nurse who asked me to note the seizure on a hospital sheet. I recorded this seizure and its duration. I was concerned as this seizure was unlike any seizure Claire had ever had. Claire slept after this seizure. At approx 04:15pm I went for a coffee to the hospital shop. On my return to Allen ward at 04:30pm I was informed by a another parent that a Doctor had been to see Claire. At 05:00pm Dr Webb arrived on Allen Ward, I had a discussion with Dr Webb at approximatley 05:00pm Tuesday 22 October 1996, this was a general and brief conversation lasting no longer than 10 minutes. I gave Dr Webb a general overview of Claire's history and expressed my concerns that Claire had had a seizure at 03:25pm that afternoon.
Dr Webb WS 138-1 page 20 states that following his discussion with Claire's mother he felt more certain that Claire had experienced focal seizures affecting her right side on the day of admission to hospital.
I did not inform Dr Webb that Claire had experienced any type of seizure or seizure activity on the day of admission and my understanding is that Claire did not have any seizure or seizure activity during Monday 21 October 1996, as she was at school that day and under the supervision of adults. Claire had no seizures at home on returning from school or on her way to the hospital or at the hospital. This is contrary to what Dr Webb states in his WS 138-1 page 66 (45b).
Dr Webb WS 138-1 page 66 question 45 states however when he spoke to me later on that afternoon he obtained a history of a definate seizure affecting Claires right side the previous day and he was in no doubt that she had indeed had a convulsive seizure on Monday the day of admission.
I do not agree with Dr Webb's witness statement.
Dr O'Hare WS 135-1 page 6 (11d) states however, the GP, the SHO and I, who took the inital history, appear not to have elicited the history of focal signs with right sided stiffing on the day of admission. This is first recorded the following day by Dr Webb.
I also informed Dr Webb that Claire had had a smelly poo on the Sunday but did not indicate that this was symptoms of diarrhoea or any continuous bowel movement. I also informed Dr Webb that Claire had visited her cousin on Saturday 19 October and that he had had a tummy upset that week. I only regarded this as a thread of information and attached little significance to the remark. I feel that the issue around Claires bowel movements has been greatly exaggerated and are perfectly explained within the hospital A&E admission note which states "no diarrhoea" 090-012-014.
Dr Webb WS 138-1 page 66 question (46a) states Claire's symptoms had included loose bowel motions and vomiting over the two days prior to admission.
I disagree, Claire did not have loose bowel motions and vomiting over the two days prior to admission. What two days is Dr Webb referring to? Claire's first vomit was on the day of admission at around 3:30pm Monday 21 October 1996, on returning home from school.
There was no communication with Dr Webb with regard to Claire's diagnosis. No concerns

were expressed by Dr Webb about Claires condition to me, or what his treatment plan was. Dr Webb and I discussed the previous medication that Claire had been on when she was younger. I recall discussing Eplim with Dr Webb but do not recall if he proposed to give Claire Eplim. Any type or dose of medication prescribed by Dr Webb was not discussed or explained to me (ie. Phenytoin, Midazolam or Sodium Valproate) No medical terminology was used when talking to Dr Webb.

Dr Webb did not express any concerns regarding Claires clinical condition to me. He certainly did not mention conditions like encephalitis, meningo-encephalitis or non convulsive status epilepticus. 05:00pm was the only time I spoke to Dr Webb throughout Tuesday 22 October 1996.

My husband arrived at the hospital with our two sons around 06:30pm and I informed him that Claire had had a seizure at 03:30pm. Claire was sleeping when they arrived at the hospital, and we encouraged the boys to let Claire sleep and rest. At 06:30pm I discussed this seizure with my husband 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.

I also informed my husband that a doctor had examined Claire at 05:00pm and that he had prescibed medication for Claire.

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.

I left the hospital at 09.30pm I recall going to the nurses station to say that Claire was settled and asleep for the night, that we would be returning the next morning. My only concern was that the bed sides were secure, in case Claire would waken and get out of bed. The staff replied "ok" and "see you in the morning". My cousin, (a nurse from Scotland, rang Allen Ward as we were leaving, the nurse passed the phone to me and I spoke to my cousin, saying that Claire was settled for the night and that we were leaving the hospital with Claire's two brothers.

My husband received a telephone call from RBHSC at 03:45am Wednesday 23rd October 1996 stating Claire was having breathing difficulties (call by Dr Bartholome) and we should make our way to the hospital.

At around 04:30am my husband 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 husband 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 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 us 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.
During our time in PICU the only reason given to my husband 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 husband and I had a meeting on 3 March 1997 with Dr Steen to discuss the post mortem results. Dr Steen informed us 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 us 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.

Jennifer Roberts
3 September 2012
J Roberts
6/9/12