Form 20

# CORONERS ACT (NORTHERN IRELAND) 1959

*Deposition of Witness* taken on Tuesday the 25th day of April 2006 at inquest touching the death of CLAIRE ROBERTS, before me MR J L LECKEY, HM Coroner for the District of GREATER BELFAST as follows to wit:-

*The Deposition of* DR ANDREW SANDS

of

who being sworn upon his oath, saith

I am a registered medical practitioner and consultant in paediatric cardiology. I graduated from the Queen's University Belfast on 1st July 1992. My professional qualifications are MPhil, MB, BCh, BAO, MRCP. May I first express my sympathy with Claire Roberts parents and wider family, having spoken quite recently with them I realize that the passage of time has done little to lessen their grief. At the time of Claire's admission I was employed by the Royal Group of Hospitals Trust. I had commenced my first substantive post as a paediatric registrar in paediatric cardiology. I was based in Allen ward in the Royal Belfast Hospital for Sick Children. I met Claire on the morning of 22nd October 1996. I was conducting a ward round with at least one senior house officer who recorded the ward round notes. It is likely also that there was a senior nurse in attendance. My recollection is that Claire's mother was also present. Claire had been admitted the previous night and the recorded notes suggested a short history of vomiting small quantities, increasing lethargy and impaired level of consciousness. As Claire was not drinking, intravenous fluids, started after admission were continued at maintenance dose. She was given (dextrose 4%/0.18% saline). This was standard fluid therapy at that time. Claire's past history of seizures and developmental delay were noted as was her elevated white cell count (16.4 thousands/U1) and slightly low serum

sodium (132mmol/1). On examination Claire's pupils reacted only sluggishly to light. She was largely unresponsive and appeared pale. She appeared to have bilateral upper motor neurone signs. I was very concerned that Claire had a major neurological problem suspected she was in "non-fitting" status epilepticus. Other recorded differentials were encephalitis or encephalopathy. My recollection is that Claire's mother felt this was not Claire's usual condition, although when unwell she would commonly be lethargic and that she expected her to improve soon. However I (and the ward team) felt that she was really very unwell. A dose of Diazepam was given rectally (5mg). I believe this was after contacting Dr Webb (consultant paediatric neurologist). I recall spending quite some time with Claire and her mother trying to get a clear history and an idea of Claire's normal behaviour. We contacted the Ulster Hospital Dundonald and requested old notes to be faxed to assist with this. Hourly CNS observations were started. I personally went to talk to the consultant paediatric neurologist on call. The paediatric consultant under whom Claire was admitted was unavailable: although I believe she was kept informed by telephone. I described Claire's problem to the paediatric neurologist and told him I thought a CT scan of brain might be required. He came and assessed Claire in Allen ward. He also saw her once if not twice more during the afternoon and prescribed further treatment. I do not recall being present in the mid-afternoon. It may be that I had teaching or other duties. However, I did not feel that Claire's condition had changed. I did administer an intravenous dose of sodium valproate as requested by the neurologist, at 5.15pm. I do not recall if Claire's care had been formally taken over by the neurology team. I note that a further serum electrolyte result is recorded in the chart although it is not clear when this was requested or taken. I was not on call that night but heard of Claire's sudden collapse subsequently. I was naturally very shocked and saddened. After her death I was asked by nursing staff to speak to Claire's mother and father on the ward. I did this on 11th November 1996 as recorded. I explained, as far as I was able, the course of events but said that I would ask Dr Steen to discuss the post-

mortem findings (of which I was not aware) as soon as possible. Further to my previous statement, HM Coroner has asked me to comment on Mr Alan Roberts' letter of 29th September 2005. Clearly I am unable to respond to some of Mr Robert' comments. However I should like to emphasize that I was very concerned regarding Claire's level of consciousness on the morning of 22/10/96. this prompted the urgent neurology referral. I have also stated that I thought a CT scan of brain may be appropriate. At the time this required the sanction of a consultant neurologist. My immediate worries for Claire were probably allayed to some degree by Dr Webb's assessment. The initial sodium result did not seem out of keeping in many hospitalized children. We do not know at what time the second test of electrolytes was requested or taken. Claire had at least one further intravenous cannula inserted before 5pm. This is often when blood samples are taken in children (to avoid another needle). With hindsight, further investigations may well have drawn attention to sodium loss or fluid retention. I have a clear recollection of quite lengthy discussions with Claire's mother on 22/10/96. Although this was as much to help me understand Claire's condition I believe that I also explained my concerns whilst avoiding alarm. I would have deferred to the senior doctor in attendance for more definitive counselling. I produce my formulation of the cause of death C7. I cannot rank accurately the causes I have given at 1(b). I agree that the fluid ~~given~~ regime for Claire between 8pm & 2a.m. was not an important issue for what happened to Claire thereafter.

4th May
TAKEN before me this ~~25th April~~ 2006

Senior Coroner for Northern Ireland

C7

THIS CERTIFICATE MUST BE DELIVERED WITH THE DECEASED'S MEDICAL CARD WITHIN FIVE DAYS TO THE REGISTRAR FOR THE DISTRICT IN WHICH THE PERSON (a) DIED OR

(b) WAS ORDINARILY RESIDENT (WITHIN NORTHERN IRELAND) IMMEDIATELY BEFORE DEATH

*FOR INSTRUCTIONS TO INFORMANTS SEE OVERLEAF*

# MEDICAL CERTIFICATE OF CAUSE OF DEATH

*Births and Deaths Registration (Northern Ireland) Order 1976, Article 28(2)*

To be signed by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the last illness of the deceased person and given to some person required by Statute to give information of the death to the Registrar. (SEE OVERLEAF)

| FOR USE OF REGISTRAR |
|---|
| Entry No ..... |
| District ..... |

Name of Deceased .....

Usual Residence .....

Place of Death .....

Date of Death ..... day of ..... 20....

Date on which last seen alive and treated by me for the undermentioned conditions ..... day of ..... 20....

Whether seen after death by me .....

Whether seen after death by another medical practitioner .....

| I | CAUSE OF DEATH | These particulars not to be entered in Death Register |
|---|---|---|
| Disease or condition directly leading to death* | (a) cerebral oedema | Approximate interval between onset and death (years, months, weeks, days, hours) |
| Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last. | (b) *Meningoencephalitis *status epilepticus *excessive anti-diuretic hormone secretion with associated hyponatraemia | |
| | (c) | |
| II | | |
| Other significant conditions contributing to the death, but not related to the disease or condition causing it. | | |

*This does not mean the mode of dying eg heart failure, asthenia, etc. It means the disease, injury or complication which caused death

I hereby certify that the above-named person has died as a result of the natural illness or disease for which he has been treated by me within twenty-eight days prior to the date of death, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

*Signature* .....

*Residence* .....

*Qualifications as registered by General Medical Council* .....

*Date* ..... 20....

The Health Service Number of the deceased should be entered here by the certifying doctor.

096-003-018

CR - PSNI

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**CORONERS ACT (Northern Ireland), 1959**

Deposition of Witness taken on the day of 20 , at inquest touching the death of , before me Coroner for the District of

as follows to wit: –

# The Deposition of DR ANDREW SANDS

of *(Address)*

who being sworn upon h[illegible] oath, saith

Mr. McCrea, I commenced in Allen Ward on 7th August 1996, as a Paediatric Registrar. It was a general paediatric medical ward. Then I had heard nothing of the death of Adam Strain or fluid management issues. I had no issue then with Claire's fluid regime. I have no recollection of knowing of a linkage between fluid management and hyperatraemia (in relation to H018 solution) and cannot remember if a blood test was specified by me on the day I examined her. Probably I examined her late morning but I cannot be more exact. What I saw was not outside my experience and I then contacted Dr. Webb. In 1996 there was not a CT scanner in RBHSC. I thought a CT scan might be necessary. I cannot recall if I was aware of the blood test results or how they were relayed to me. The reading of 132 would not have caused extreme concern. The Paediatric Consultant was unavailable. I spoke to Dr. Webb at length to his experience. At 5.15 p.m. she remained very unwell. I cannot recall if I contacted a blood test. The senior doctor I have referred to was Dr. Webb.

Andrew J Sands.

I produce my formulation of the cause of death C7. I cannot rank accurately the causes I have given at 1(b). I agree that the fluid regime for Claire between 8pm and 2am was not an important issue for what happened to Claire thereafter.

Mr McCrea: I commenced in Allen Ward on 7th August 1996 as a Paediatric Registrar. It was a general paediatric medical ward. Then I had heard nothing of the death of Adam Strain or fluid management issues. I had no issues then with Claire's fluid regime. I have no recollection of knowing of a linkage between fluid management and hyponatraemia in relation to No 18 solution. I cannot remember if a blood test was specified on the day I examined her. Probably I examined her late morning but I cannot be more exact. What I saw was outside my experience and I then contacted Dr Webb. In 1996 there was not a CT scanner in RBHSC. I thought a CT scan might be necessary. I cannot recall if I was aware of the blood test results or how they were relayed to me. The reading of 132 would not have caused extreme concern. The Paediatric Consultant was unavailable. I spoke to Dr Webb and deferred to his expertise. At 5.15pm she remained very unwell. I cannot recall if I considered a blood test. The senior doctor I have referred to was Dr Webb.

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