

WRC 1 - MEDICAL NOTES FROM RBHSC - Claire Roberts

Decease

WRC 1

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

3/23/88
3/23/88

Name

Claire Roberts

Confidential

1g 10 m
500mg 5ml
850mg 5ml

7/2/88

HOSPITAL No.

REGISTRATION

Surname and First Names (in block letters)

Roberts Claire

Date of Birth

10.1.87

Address (in block letters)

Sex

F.

Telephone No.

School

Religion-Inpatient and Special Outpatient only

Changes of Address

1.

2.

3.

IMMUNISATION

DATE

B.C.G.

Heaf

Mantoux

Small Pox

Diphtheria

Pertussis

Poliomyelitis

Tetanus Toxoid (1)

(2)

(3)

Booster Dose

Tetanus (A.T.S.)

Family Doctor

1. McMillan

2.

Person to be notified in an Emergency:-

Name

Parents SA

Address

Telephone No.

Occupation of Father

Affix Blood Group Reports in this space

Date of Admission

Date of Discharge

Diagnosis

Code

4/9/87

18/9/87

Seizures

780-31

The ROYAL
HOSPITALS

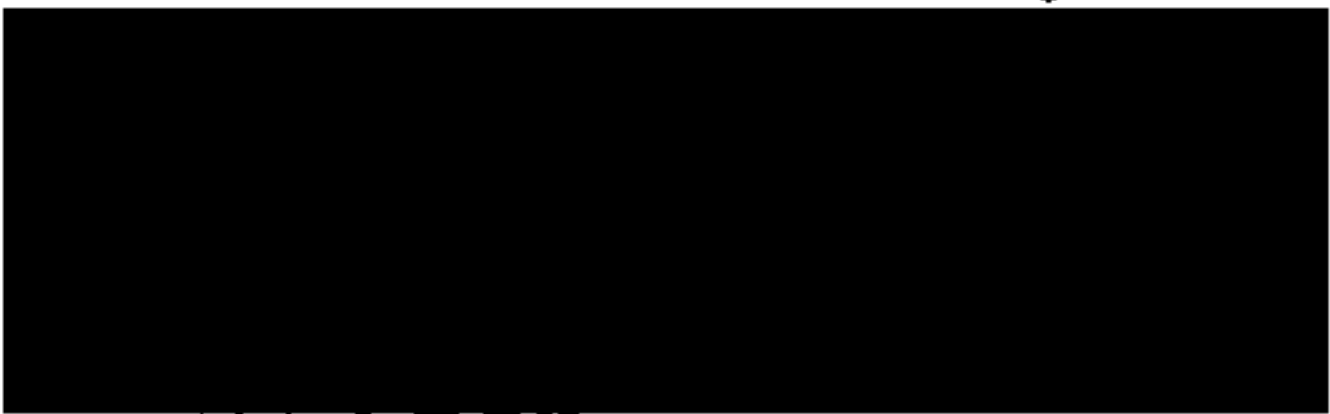
THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

CH328770

Our Ref - DW/AMCA

Date of Dictation - 28.2.97

Date of Typing - 21.3.97

Mr & Mrs Roberts,


Dear Mr & Mrs Roberts,

re - Claire

My sincere condolences after the loss of your daughter Claire.

In summary the findings were of swelling of the brain with evidence of a developmental brain abnormality (neuronal migration defect) and a low grade infection (meningoencephalitis). The reaction in the covering of the brain (meninges) and the brain itself (cortex) is suggestive of a viral cause. The clinical history of diarrhoea and vomiting would be in keeping with that. As this was a brain only autopsy it is not possible to comment on other abnormalities in the general organs. No other structural abnormality in the brain has been identified.

With kind regards.

Yours sincerely,

*Ordered
15.4.95*

.....
DR. DAVID WEBB
CONSULTANT IN PAEDIATRIC NEUROLOGY

c.c. R.B.H.S.C.

PATRON: HRH The Duchess of Kent

The Royal Victoria Hospital
The Royal Maternity Hospital
The Royal Belfast Hospital for Sick Children

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL
HEALTH AND SOCIAL SERVICES TRUST

180 Falls Road, Belfast BT12 6BE Northern Ireland
Telephone: 01232 240503

Monday 21 October 1996

3:00pm Claire arrived home from school
(Note from teacher in Claire's school diary stating sickness)
6:30pm GP Dr D Savage calls to examine Claire
7:15pm Claire is admitted to A&E Belfast Royal Hospital
8:00pm Claire admitted to Allen Ward (Blood test, IV fluid given)
10:15pm Claire settled and asleep, we leave hospital

Tuesday 22 October 1996

9:30am Jennifer and I arrive at hospital
11:00am Speak to Dr Sands. Express concern at Claire's response
12:30pm Grandparents arrive, we go for lunch
1:00pm Dr Webb examines Claire with grandparents present
1:30pm Jennifer and I return to hospital
3:00pm I leave hospital to collect boys from school
4:00pm Dr Webb examines Claire with Jennifer present
5:00pm Dr Webb examines Claire with Jennifer present
(6:00pm I return to hospital with boys
9:00pm) Casual nursing care
9:30pm Jennifer calls into nurse's office to inform them that we were leaving hospital, as Claire was settled and asleep.

Wednesday 23 October 1996

3:45am We receive telephone call from Hospital asking us to return
4:15am Meet Dr Steen/Dr Webb who advise us that Claire is going for a CT scan



Alan Roberts
12 April 2006

Dictated: 05.03.97
Typed: 06.03.97

CH: 328770

Dr. McMillin
The Surgery
220 Knock Road
Belfast
BT5 6QD

Dear Dr. McMillin

RE: Claire Roberts [REDACTED]
DOB: 10.01.87

Claire's post-mortem results are now available. The cerebral tissue showed abnormal neuronal migration, a problem which occurs usually during the second trimester of pregnancy and would explain Claire's learning difficulties. Other changes were in keeping with a viral encephalomyelitis meningitis. Doctor Webb and myself have since seen Claire's parents and discussed the post-mortem findings with them. They are obviously both finding this an extremely difficult and traumatic time but do not want any further professional counselling at present, however they know our doors open and we will be happy to see them if they want to discuss things further with ourselves. Mr. Roberts wanted a short summary of the post-mortem report which Dr. Webb will send to him shortly. If there are any concerns at all please do not hesitate to contact us.

Yours sincerely

DR. HEATHER STEEN
CONSULTANT PAEDIATRICIAN

/mg

(3)

DEPARTMENT OF NEUROPATHOLOGY
AUTOPSY REPORT

Autopsy No.: NPPM 114/96

Name :	ROBERTS, Claire	Hospital No.:	328770
Age :	9 1/2	Hospital :	R.B.H.S.C.
Sex :	F	Ward :	I.C.U.
Pathologist :	Dr. Herron	Date of Admission :	22/10/96
Clinician :	Dr. Webb/ Dr. Steen		
Date of Necropsy :	24/10/96	Date of Death :	23/10/96
Time of Necropsy :	11.30 am	Time of Death :	6.25 hrs
Restrictions :	Brain only		

ANATOMICAL SUMMARY

CODES

History of recent diarrhoea and vomiting, cerebral oedema (brain weight 1606 g), brain stem necrosis. Subacute inflammation meninges in perivascular space.

History of epileptic seizures since 10 months of age. Neuronal migration disorder.

CLINICAL SUMMARY

She was well until 72 hours before admission. She had visited her cousin who had vomiting and diarrhoea. She had similar symptoms and 24 hours prior to admission started to vomit. Her speech became slurred and she became increasingly drowsy. She was felt to have subclinical seizures. She was treated with rectal Diazepam, intravenous Phenytoin and intravenous Valproate. She also had Acyclovir and Cefotaxime. Her serum sodium dropped to 121 and there was a query of inappropriate ADH secretion. Her fluids were restricted but she had respiratory arrest at 3 am on 23/10/96. She was intubated and transferred to intensive care where a CT scan showed cerebral oedema. Brain stem criteria was fulfilled at 6 am.

In her past history she had iatrogenic epilepsy since 10 months and mental handicap.

BRAIN DESCRIPTION

The fixed brain weighs 1606 g. There is no cortical venous thrombosis and there is no meningeal exudate. There is symmetrical brain swelling with effacement of gyri. There is uncal prominence but no necrosis.

On sectioning of the brain the presence of diffuse brain swelling is confirmed. There is no evidence of cortical necrosis, either laminar or focal. There is white matter swelling with effacement of the IIIrd ventricle but no evidence of shift at the midline. The paraventricular structures including the mammillary bodies show no evidence of necrosis. There is no basal ganglia or diencephalon lesion. On sectioning of the brain stem there is no evidence of brain stem haemorrhage to suggest Leigh's disease. The cerebellum is unremarkable.

HISTOLOGY

Multiple sections from frontal, parietal, temporal cortex, deep white matter, routine sections from basal ganglia, periventricular grey matter, hypothalamus, mammillary bodies, brain stem and cerebellum have been examined.

Cortex and White Matter The sections show that there is focal meningeal thickening and a cellular reaction in the meninges and perivascular space in the underlying cortex. There is no cortical necrosis but in the deep white matter focal collections of neurones are present arranged in a rather haphazard manner.

Basal Ganglia The sections show no pigmentation or calcification and there is generally good neuronal preservation.

Periventricular Grey Matter, Hypothalamus and Mammillary bodies There are focal collections of neuroblasts in the subependymal zone suggestive of a migration problem. There is generally good neuronal preservation and no vascular proliferation is present in the periventricular grey matter and mammillary bodies. However small foci of necrosis are present in the periventricular grey matter which are probably a consequence of cerebral oedema.

Hippocampi The sections show no displaced neurones or Ammon's horn sclerosis. There is some rarefaction and occasional ischaemic neurones are present in the pyramidal cell layer. No tumour has been identified.

Cerebellum The sections show no significant cell loss in Purkinje cell or granule cell layer. There is no cerebellar cortical dysplasia and the dentate nuclei are preserved.

Brain Stem The sections show focal haemorrhagic necrosis. There is no myelinolysis.

COMMENT:

In summary, the features here are those of cerebral oedema with neuronal migrational defect and a low grade subacute meningoencephalitis. No other discrete lesion has been identified to explain epileptic seizures. The reaction in the meninges and cortex is suggestive of a viral aetiology, though some viral studies were negative during life and on post mortem CSF. With the clinical history of diarrhoea and vomiting, this is a possibility though a metabolic cause cannot be entirely excluded. As this was a brain only autopsy, it is not possible to comment on other systemic pathology in the general organs. No other structural lesion in the brain like corpus callosal or other malformations were identified.

11/2/97

10-1-87



6
Secretary ext. 2049

18th November 1996

Mr. & Mrs. Roberts
[REDACTED] [REDACTED]

Dear Mr. & Mrs. Roberts

I wish to drop you a short note following the recent sad death of your beloved daughter Claire. It was an extremely traumatic time for your family and I am sure you still have many questions to ask. I would be delighted to meet with you both at any time in the future to discuss any queries you might have. Post-mortem results will not be available until after Christmas and even then I may not be able to answer all your questions.

Staff of Allen Ward and Intensive Care have repeatedly commented on the wonderful family support which you had at this time and I hope the closeness of your family bond will be of some comfort to you along with your faith.

I have included a leaflet from the Meningitis Research Foundation on death, I know meningitis was not Claire's problem but when I read the leaflet I thought some of the comments in it were very real and perhaps would be of help to you. Please do not hesitate to contact my secretary to arrange an appointment.

Yours sincerely

.....
DR. HEATHER STEEN
CONSULTANT PAEDIATRICIAN

/mg

Mallusk

7

PROVISIONAL ANATOMICAL SUMMARY

file

Autopsy No.:	NPPM 114/96	Hospital No.:	328770
Name :	ROBERTS, Claire	Hospital :	R.B.H.S.C.
Age :	9 1/2	Ward :	I.C.U.
Sex :	F	Date of Admission :	22/10/96
Pathologist :	Dr. Herron	Date of Death :	23/10/96
Clinician :	Dr. Webb/ Dr Steen	Time of Death :	6.25 hrs
Date of Necropsy :	24/10/96		
Time of Necropsy:	11.30 am		
Restrictions :	Brain only		

ANATOMICAL SUMMARY

CODES

History of acute encephalopathy, brain to be examined after fixation.

8 full rev
- S McK
22/11

96187

CLAIRE ROBERTS

[REDACTED]

DOB 87-01-10 HOSP NO. 328770

DATE OF ADMISSION 96-10-23

DATE OF DISCHARGE 96-10-23

DAYS IN ICU 1

DIAGNOSIS: RESPIRATORY ARREST

ICU DISCHARGE SUMMARY

Claire was admitted to the Paediatric Intensive Care Unit on the 23.10.96 from Allen Ward because of respiratory difficulty and Cheyne Stokes breathing. She was intubated and ventilated, pupils fixed and dilated. A CT scan showed severe diffuse hemispheric swelling with complex effacement of basal cisterns. Brain stem tests were performed with a diagnosis of brain death. Ventilation was withdrawn after discussion with parents at 18.45 hrs. on the 23.10.96.


S. Mannam,
SHO,
ICU,
1.11.96

C.C. DR ALLEN'S SEC for DISCHARGE 22/11/96

Falls Road,
Belfast, BT12 6BE
Tel. 01232 240503

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

HOSPITAL No.

~~21352~~ 328770

Discharge/Transfer Advice Note

Dear Doctor H. C. Hillen

I wish to advise you that your patient was
admitted to hospital and is now being
discharged/transferred.

Referral No.

Contract No.

*
TICK
OR
DELETE
AS
APPROP.

Your Patient *Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Name Blaine Roberts

Address.....
.....

.....Postcode.....

D.O.B. 10/01/87 Ward Knee Male* ☐ Female* ☒

↑ Please place addressograph label here on all 4 sheets ↑

	ADMISSION	TRANSFER	DISCHARGE
DATE	<u>21/10/96</u>	<u>22/10/96</u>	
CONSULTANT NAME	<u>H. Stan</u>	<u>H. Stan</u>	
WARD	<u>ALLEN</u>	<u>Allen</u>	

PRINCIPAL DIAGNOSIS ON TRANSFER /DISCHARGE * *delete as appropriate	CODE
OTHER DIAGNOSIS	
OTHER DIAGNOSIS	

	DATE
PRINCIPAL PROCEDURE	
SECONDARY PROCEDURE	
SECONDARY PROCEDURE	

DRUGS ON DISCHARGE (IF MORE THAN 8, use a separate sheet FOR ALL DRUGS)

DRUG (approved name in caps)	DOSE & FREQUENCY	LENGTH OF COURSE	ADDITIONAL INFORMATION FROM PHARMACIST

COMMENTS

Method of Admission

Emergency

Waiting list

Outpatients

Review Arrangements Further Summary Letter Yes ☐ No ☐

Yours sincerely (signature) Date

Name in Block Letters..... Consultant ☐ Senior Reg ☐ Reg ☐ SHO ☐ JHO ☐

Signature for Pharmacy

13

Complications

1.

2.

CR - PSNI

Consultants Initials

096-025-205

ALL POINT PRESS HARD

Dear Doctor H. Hillen
I wish to advise you that your patient was admitted to hospital and is now being discharged/transferred.

*
TICK
OR
DELETE
AS
APPROP.

Patient's Name *Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Name Blaine Roberts

Address [REDACTED]

Postcode [REDACTED]

D.O.B. 10/01/81 Ward Knee Male* ☐ Female* ☒

⌞ Please place addressograph label here on all 4 sheets ⌞

Referral No.

Contract No.

	ADMISSION	TRANSFER	DISCHARGE
DATE	<u>21/10/96</u>	<u>12/11/96</u>	
CONSULTANT NAME	<u>H. Stoen</u>	<u>H. Stoen</u>	
WARD	<u>AKEN</u>	<u>AKEN</u>	

PRINCIPAL DIAGNOSIS ON TRANSFER/DISCHARGE * *delete as appropriate	CODE
OTHER DIAGNOSIS	
OTHER DIAGNOSIS	

	DATE
PRINCIPAL PROCEDURE	
SECONDARY PROCEDURE	
SECONDARY PROCEDURE	

DRUGS ON DISCHARGE (IF MORE THAN 8, use a separate sheet FOR ALL DRUGS)

DRUG (approved name in caps)	DOSE & FREQUENCY	LENGTH OF COURSE	ADDITIONAL INFORMATION FROM PHARMACIST

COMMENTS

Method of Admission

Emergency

Waiting list

Outpatients

Review Arrangements Further Summary Letter Yes ☐ No ☐

Yours sincerely (signature) Date

Name in Block Letters Consultant ☐ Senior Reg ☐ Reg ☐ SHO ☐ JHO ☐

Signature for Pharmacy

Complications 1.
2.

14

Consultants Initials

096-025-207

ROYAL HOSPITALS
CASE MIX PROFORMA

HOSPITAL No.

243-5232770

Dear Doctor Mr. Allen

I wish to advise you that your patient was admitted to hospital and is now being discharged/transferred.

*
TICK
OR
DELETE
AS
APPROP.

Patient's Name *Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Name

Address.....

D.O.B. 10/11/37 Ward Male* ☐ Female* ☐

↑ Please place addressograph label here on all 4 sheets ↑

	ADMISSION	TRANSFER	DISCHARGE
DATE	21/10/96	12/11/96	
CONSULTANT NAME	H. Allen	12/11/96	Date coded and entered in CIS (/ /)
WARD	ALLEN	12/11/96	Coding performed by

PRINCIPAL DIAGNOSIS ON TRANSFER/DISCHARGE * *delete as appropriate	CODE
OTHER DIAGNOSIS	
OTHER DIAGNOSIS	

	DATE
PRINCIPAL PROCEDURE	
SECONDARY PROCEDURE	
SECONDARY PROCEDURE	

DRUGS ON DISCHARGE (IF MORE THAN 8, use a separate sheet FOR ALL DRUGS)

DRUG (approved name in caps)	DOSE & FREQUENCY	LENGTH OF COURSE	ADDITIONAL INFORMATION FROM PHARMACIST

COMMENTS

Method of Admission

Emergency

Waiting list

Outpatients

Review Arrangements

Yours sincerely

Name in Block Letters.....

Further Summary Letter Yes ☐ No ☐

(signature) Date

Consultant ☐ Senior Reg ☐ Reg ☐ SHO ☐ JHO ☐

CODING VERIFICATION

CONSULTANTS INITIALS

AMENDED BY

Consultants Initials

Complications 1.
2.

CR - PSNI

16

096-025-208

EASTERN HEALTH AND SOCIAL SERVICES BOARD

New Belfast DISTRICT

10

HOSPITAL/COMMUNITY LIAISON: GENERAL SERVICES

FACILITY

NAME

CH 326770

ADDR

CLAIRE ROBERTS

S 10/01/87

Wd/Dept

CONSULTANT

GEN. PRACT.

Date of Adm.

Date of Disch.

School

Date of Birth

DIAGNOSIS/CONDITION

TREATMENT RECEIVED

NURSING TREATMENT REQUIRED

MEDICATION ON DISCHARGE

AIDS/EQUIPMENT

ORDERED - YES/NO

OTHER SUPPORTING SERVICES REQUIRED

YES/NO

FURTHER RELEVANT INFORMATION

MESSAGE BY TELEPHONE TO

(YES/NO)

SIGNED

(SISTER/CHARGE NURSE)

DATE

REFERRAL ACTION TAKEN

CR - PSNI

096-025-209



Surname ROBERTS

Forename(s) CLAIRE

Sex F

DOB 10/01/87

Address [REDACTED]

Postcode [REDACTED]

Tel. No. [REDACTED]

GP Name M.I. MCMILLAN

Address COMBER HEALTH CENTRE

NEWTOWNARDS RD
COMBER

Postcode BT23 5BA

Tel. No. [REDACTED]

A&E No 96AEC213536

Hospital No 328770

Day/date/time registration MONDAY 21/10/96

18:57

Referral/Clinic [REDACTED]

No previous episodes 00 / 00

Type of transport PRIVATE TRANSPORT

Type of place/location [REDACTED]

Cause of injury [REDACTED]

Intent [REDACTED]

Type of activity [REDACTED]

Day/date/time of accident MONDAY 21/10/96
18:30

Accompanied by Name MRS ROBERTS

(MOTHER)

Initial referral/attendance GP REQUEST & LETTER

NURSING ASSESSMENT

Triage

Nature of complaint LETHARGY, VOMITING AND PALE.

Triage nurse SN T BLUE

Triage site

19:03

Triage time

Immunisations 1ST 2ND 3RD TTb

Medication NONE

Initial assessment:

H/O OFF FORM AND LETHARGY. G.P. REFERRAL WITH H/O

SEIZURE. APYREXIC O/A. PALE AND DROWSY O/A.

H/O MENTAL HANDICAP.

Observations:

Time	T	RR	HR	BP	AVPU	Pupils	SaO2
19:03	36.9	24	96			PEARL.	

Priority SOON

Named nurse

CA Jackson

Dressing

Analysis

Un-bag >

Pain scale 0 1 2 3 4 5 (circle)

Implementation and evaluation:

Guid - 7.5
S/B Medical Reg

Admit Allen ward

CA Jackson

CR - PSNI

18

20-45

Referral to: no ref Hospital

Date 4/12/98

13

Consultant Department

Please arrange: Emergency Admission
Normal / Urgent / Semi Urgent Appointment for O.P Clinic/
Domiciliary Visit.

Details of Patient:

Surname Roberts

Mr./Mrs/Miss

Forenames Clavi

Previous Surname

Date of Birth 6 1 87

Address

Occupation

Phone No.

Postcode:

Hospital Number:

Date of Last Attendance at
this Hospital

Date of Last Attendance at any
other Hospital

Name of Hospital:

Reason for Referral 9yr old girl with severe learning disabilities
and par history of epilepsy

History/Examination: Fit for 3yr - warned off
epilepsy 18 mths ago

No speech since coming home
very lethargic at school today

Provisional Diagnosis: vomited x 3 - speech slurs
speech slurs earlier

Past History: 1/5 pale, pupils reactive - does not like light
no neck stiffness, Temp
Stiff Tone 74 R side plantar T14/50
L plantar 14

Present Medication: none

Known Allergies: ? Further fits
? underlying infection

Other Relevant Information: I would appreciate
your opinion

Doctors Signature [Signature] (Cypher No.) E998

DOCTOR'S OR PRACTICE STAMP

Castlereagh Medical Centre
220 Knock Road
Belfast
BT5 6QF
Tel. [Redacted]

Name: _____ A&E No: _____
MEDICAL NOTES (Please write time and sign all entries) In event of injury specify precise mechanism.
Time (2) 7.15pm Doctor's name (print) Jani Puturchean

9 year old girl. No learning difficulties
No epilepsy - no fits for three years, off
antiepileptic medication.
today vomiting (-non-bilious) since this evening.
otitis media, cough, pyrexia.
Speech very slurred, hardly speaking.

HA Hb

WBC

Dif P L E M

3B Blood Bank

3C

ea

Creat

Glucose

pH

PaCO2

PaO2

BXS

U Urine

IA Culture(s) specify

7E Drowsy/tired

neck stiffness

Ears not

H&T to

Pharynx - unable to

examine?

Soft

Non-tender

mass

licks

BS

Lymphadenopathy

PERLA

170 resurgent

AE good

Nil add

R

L

B

T

S

K

A

++

++

++

++

++

Plantar b R+ (but see GP letter)

No apparent limb weakness, tone

Doctor's signature

Time

ray
interpretation
pecialists (print name) _____ Specialty _____ Bleep _____ Time _____
Doctor's signature _____ Time _____

cription/IV fluids	Dose	Time	Route	Signature	Given by	Time

at generic drug names

come (one only)
Home
Report GP _____ days
Review A&E _____ / _____ / _____ am/pm
Review Fracture Clinic
Review _____ Outpatients
Review Other Hospital (_____)
Admit Allen Ward
Observation bed
Admit Fracture/Ortho
Transfer _____ Hospital
Refused Treatment
Left Before Treatment
Died in A&E

Primary diagnosis

Encephalitis?

Code

14

Additional diagnosis

2

3

Code

Code

Treatment

Code

Treatment

Code

Treatment

Code

Health Visitor Yes/No

Decision to admit time

20.45

Time left department

CR - PSNI

096-025-212

CASE NOTE DISCHARGE SUMMARY

Dear Doctor	TICK OR DELETE AS APPROPRIATE	Patient Name: Mr. M. J. J.
I wish to advise you that your patient was admitted to hospital and is now being discharged/transferred.		Name: Mr. M. J. J.
Referral No.		Address:
Contract No.		Postcode:
		DOB: 10/1/78 Ward: P.E. Male: ☒
Please place addressograph label here on all correspondence		

	ADMISSION	TRANSFER	DISCHARGE
DATE	23/10/96	23/10/96	23/10/96
CONSULTANT NAME	Dr. C. C. C.		
WARD	P. E. C. U.		

PRINCIPAL DIAGNOSIS	CEREBRAL INFARCT	DATE	
OTHER DIAGNOSIS	STATUS EPILEPTICUS	DATE	
OTHER DIAGNOSIS	HYDROCEPHALUS	DATE	
PRINCIPAL PROCEDURE	VENTILATED	DATE	
SECONDARY PROCEDURE	CRANIOTOMY	DATE	
SECONDARY PROCEDURE	CT SCAN	DATE	

DRUGS ON DISCHARGE (IF MORE THAN 8, use a separate sheet FOR ALL DRUGS)

DRUG (approved name in caps)	DOSE & FREQUENCY	LENGTH OF COURSE	ADDITIONAL INFORMATION FROM PHARMACY

COMMENTS: Admitted to ICU from A&E ward because of hypoxia, difficulty and noisy breathing. Tracheostomy performed. Pupils fixed and dilated. On admission, severe diffuse haemiparesis, swelling with complete effacement of lateral ventricle. P. E. C. U. later referred with a diagnosis of brain death. Ventilator withdrawn after discussion with parents at 1845 hrs on 23/10/96.

Method of Admission
Emergency ☒
Waiting ☐
Outpatient ☐

Review Arrangements Further Summary Letter Yes ☒
Yours sincerely (signature) Date 23/10/96
Name in Block Letters (M. J. J.) Consultant ☐ Senior Reg ☐ Reg ☐ SHO ☒

CR - PSNI

Complications 1.
2.

Consultant

UNDAH

TRUST

THE ULSTER, NORTH DOWN & ARDS HOSPITALS TRUST
THE ULSTER HOSPITAL
DUNDONALD
BELFAST BT16 0RH
NORTHERN IRELAND

TEL NO: ([REDACTED]

FAX NO: ([REDACTED]

FAX COVER SHEET

ADDRESSEE: J. R. NEIL STEWART, S.H.O.
ALAN WARD, RBHSC

COMPANY:

FAX NO: [REDACTED]

NO. OF PAGES TO BE FAXED: 4
INCLUDING COVER SHEET

FROM: S. ELARBY / NY

DATE: 22.10.96

TIME: 2.45 PM

DEPARTMENT: CHIEF
DEVELOPMENT CENTRE EXT NO: 2.82.7

3.15 PM

ADDITIONAL MESSAGE:

CR - PSNI

22

PLEASE CONTACT ME IMMEDIATELY IF ANY PAGES ARE ILLEGIBLE

096-025-214

CG/JC/U87 06831

2 August 1996

Clinic: 1.8.96

Dr. McMillin
220 Knock Road
Belfast BT5 6QF

Dear Dr. McMillin,

Claire Roberts [REDACTED] dob 10.1.87

It was nice to meet with Allan and Jennifer Roberts, Claire's parents, and to continue discussion about Claire's behaviour. Parents find that Claire's performance at school doesn't seem to reflect her true potential. Part of this is because Claire is so active, easily distracted, inattentive.

I began by opening up the issue of attention deficit hyperactivity disorder, describing it as problems with

1. Planfulness i.e. reflection,
2. Selectivity i.e. vigilance and awareness,
3. Inhibition including resistance to distraction,
4. Continuity i.e. sustaining mental effort and
5. Monitoring, the ability to detect error and correct.

Because of Claire's learning disabilities I don't think that attentional difficulties are the central issue but if present they certainly could have an impact on her quality of life and ability to learn. In addition parents know that children with attentional problems are emotionally volatile.

While it is difficult to tease apart the different aspects of Claire's behaviour a trial with stimulant medication such as Ritalin would not be unreasonable. The advantage of using Ritalin is that within 1 or 2 days it would be clear whether it would be helpful. If the family want to proceed I would suggest the following plan.

Prescribe one week of small white pill as a placebo and one week of Ritalin 10 mg tablets taken at breakfast with food. One member of the family would have to give the tablets while their spouse was blinded and an independent observer. While giving the Ritalin I would suggest starting with just 5 mg i.e. half a tablet for the first 2 days and then moving up to a full dose. The effects should be evident for at least 3-4 hours. Parents know major side effects are decrease in appetite, difficulty getting to sleep (I wouldn't expect it at these doses) and possibility of motor tics. They also know Ritalin is not an addictive drug given at these doses but if given in too high dose the child seems more spacey and disorientated.

- 2 -

Claire Roberts

I would be pleased to continue contact with the Roberts if they want to go ahead with the trial. It is easiest to call me Monday and Wednesday mornings between 8.30 and 9.00 at the Ulster Hospital - Belfast 484511 Extension 2828.

Yours sincerely,

Colin

Dr. C. Gaston, MB ChB FRCP(C)
Consultant Community Paediatrician

cc: Family

P.S. There is a very small risk of inducing seizures with Ritalin or indeed any of the stimulant medications.

Didn't try ~~deleting~~ blind trial
phone call: Sept 19th: well, now focused on Ritalin. Some
worse off R....

Plan 1 more wk Ritalin long am. + 41.75 call

phone call: Friday Sept 20th '96

Day well: Ritalin long am.

Stay: then x 1/2 Parents to call

family pleased + not pressing for more R...

phone call Oct 2nd: Day month, vicious, pacing. Agitated/unsettled
Somnia after Ritalin
?? greater social awareness

Had 100s

Part 2 on a 10% 2g/25mg. N to call 5 days later...

- 2 -

Claire Roberts

Other medications which may be more useful for obsessive behaviour include the SSRIs. I described this to mother as the same group as Prozac. I have been very pleased with SSRIs used in children with depression and some with obsessive problems.

As you can see I am just beginning to open these issues up with the family. I would be very pleased after they have received this letter to meet with parents and continue this discussion as they see fit. I will leave the door open here.

Yours sincerely,

Dr. C. Gaston, MB ChB FRCP(C)
Consultant Community Paediatrician

cc: Family

*ph. - call July 22nd - Claire showing attention
behaviour. constantly on the go. Parents coming in A.I.
for discussion re. therapeutic.*

CG/JC/U87 06831

30 May 1996

Clinic: 30.5.96

Dr. McMillin,
220 Knock Road
Belfast BT5 6QF

Dear Dr. McMillin,

Claire Roberts

[REDACTED] dob 10.1.87

It was nice to meet Claire on first occasion at the Thursday morning clinic at the Ulster, May 30th. Claire, 9 years 5 months, is known to have moderate learning difficulties and history of seizures from 6 months to 4 years of age. She has been off Epilim for the past year and seizure free.

Most of the consultation was discussing Claire's behavioural problems with Mrs. Roberts.

The family and school both feel that Claire is not achieving her potential because of her "scattiness". It may take all morning to settle her for seat work at school and she bounces around both physically and verbally. In addition she has become obsessed with paper and in the past had similar obsessions with toilet brushes and soap.

Claire appears to have difficulty both planning and reflecting as well as selecting her choices and resisting distraction. She also has trouble sustaining mental effort and monitoring her actions.

All of these traits are part of attentional difficulties. I think it would be very difficult to rate her behaviour using one of the classic scales for attention deficit hyperactivity disorder. Having said this I am using them less and less these days and feel it is legitimate to describe her as having attentional difficulties.

I think Claire's family have several therapeutic options and I just began to discuss these with Claire's mother, Jennifer, today. One reasonable option would be to consider a brief trial with stimulant medication. This may be Ritalin or perhaps Pemoline or Amphetamine. All 3 medications, while chemically different, have a similar side effect profile. I didn't discuss this in detail but many children have decreased appetite and some difficulty sleeping in the first week or two, if the child has motor tics they may be exacerbated with treatment.

- 2 -

Claire Roberts

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Yours sincerely,

Dr. C. Gaston, MB ChB FRCP(C)
Consultant Community Paediatrician

cc: Family

phone call July 22nd : Claire showing attention seeking
behaviour constantly "on the go". Parents coming in Aug 196
for discussion re therapeutics.

CHILDREN'S HOSPITAL

HOSPITAL
NUMBER

1-3
5 0 7

NAME

ROBERTS CLAIRE

UNIT
NUMBER

4-13
3 3 8 7 7 0

ADDRESS

14-15

BIRTH SURNAME

SEX M - MALE
F - FEMALE

16
15

DATE OF BIRTH

17-22
1 0 0 1 8 7

OCCUPATION

NOTE: Where patient is a 'child', 'at school'
or a 'housewife' please state occupation
of head of household

23
D

MARITAL STATUS

1 - Single 2 - Married 3 - Widowed
4 - Other 5 - Not Known

24
1

RELIGION

1 - Church of Ireland 2 - Presbyterian 3 - Methodist
4 - Roman Catholic 5 - Jewish 6 - Other (specify)
7 - Not Known 9 - None

25
1

DATE OF ADMISSION

26-31
2 1 1 0 9 6

ADMISSION TYPE

1 - Immediate 2 - Waiting List 3 - Other Hospital
4 - Booked (Non Maternity) 5 - Booked (Maternity)
6 - Born in Hospital

32
1

DATE PLACED ON WAITING LIST OR BOOKED (NON MATERNITY)

33-38

ACCIDENT

1 - Home - Burns 2 - Home - Scalds 3 - Home - Falls 4 - Home - Poisoning, Inhalation
5 - Home - Poisoning, Other 6 - Home - Other 7 - RTA 8 - School
9 - At Work 10 - Sport 11 - Civil Disturbance 12 - Assault
13 - Other 14 - Not Applicable

39
1 4

CONSULTANT

DR H.J. STEEN

40-43
6 7 7 8

No. OF FORM IN BATCH

44-46

OWN DOCTOR

DR MCMILLAN
COMBER HEALTH CENTRE
NEWTOWARDS RD
COMBER
BT23 5BA
TELEPHONE:
[REDACTED]

RELATIVE OR OTHER PERSON
FOR CONTACT IN EMERGENCY
MRS ROBERTS

[REDACTED]

MOTHER

TELEPHONE:

[REDACTED]

PREVIOUS ATTENDANCES

YES/NO

WARD

Allen

ADMITTED BY

DPD

TIME

2 1 1 4

(u)

ENT DEPARTMENT - EXT 3548

26 March 1990

UN 328770

Dr Majors
Associate Specialist in Paediatrics
Ulster Hospital
Dundonald

Dear Joan

re Clare Roberts

dob 10.1.87

Clare was first seen in December '87. At that time there was evidence of catarrh in each middle ear, this was confirmed by free field testing and by tympanometry. I saw her subsequently on three other occasions and on each occasion her hearing was normal. I discharged her from further attendance. She was last seen at the clinic on 24.6.88.

Yours sincerely

D ADAMS
CONSULTANT ENT SURGEON

/dmg



THE ULSTER HOSPITAL

DUNDONALD — BELFAST BT16 ORH

Telephone: [REDACTED]

2nd March, 1990

JM/JC/U8706831

Secretary to
Mr. D. Adams, FRCS,
Consultant ENT Surgeon,
R.B.H.S.C.

Dear Madam,

re: Claire Roberts, [REDACTED] (DOB 10.1.87)

I would be very grateful if you could forward me
a copy of the hearing assessment carried out by
Mr. Adams on the above child. She attends the
Developmental Clinic at the Ulster Hospital.

Yours faithfully, *Thanking you*

Jean Major

Dr. J. Major, M.B., D.C.H.,
Associate Specialist in Paediatrics

WUH 349

ENT DEPARTMENT - [REDACTED]

24 June 1988

UN 328770

Dr McMillen
220 Knock Road
Belfast

Dear Dr McMillin

re Claire Roberts [REDACTED]

This child attended again on 24.6.88. Her mother was happy that the hearing was normal.

On examination, both TM's looked normal. tympanograms were normal. It would appear that the catarrh which was previously in the ear has now settled spontaneously.

Yours sincerely

D ADAMS
CONSULTANT ENT SURGEON

DMG

30



THE ULSTER HOSPITAL

DUNDONALD — BELFAST BT16 0RH

Telephone: [REDACTED]

VG/JMcC/U8706831

9 February 1988

Dr McMillin
220 Knock Road
Belfast

Dear Dr ~~McMillin~~ *Claire*

RE: Claire Roberts [REDACTED]

I saw Claire on 4 February 1988. She has had no fits since September. She is on Epilim 2.75mls bd.

Physically she is thriving and indeed her tone was normal, her reflexes were brisk and equal. Physical examination revealed no abnormalities apart from the fact that she was not strange, which I felt she should have been at this age, with me. She is also attending Children's Hospital because there had been some doubt about her hearing, which has improved, although still not supposedly normal. She does suffer from catarrh. Mum in fact thinks she is very well.

Her speech is undoubtedly slow, she whispers 'ba bà', but makes no real 'ba ba' sounds or indeed any others. She knows her hair and her toes but not other parts of her body. She waves good bye and claps hands. She tends to grind her teeth, she sits well and she gets into the crawling position but doesn't really move forwards, but may go backwards. She has good pincer grip, she is not really standing with support. I felt there was definitely some concern about her developmental delay and have arranged to review her in another 2 months time. I told mum that she certainly had made progress, but there were still some areas which gave cause for concern.

Yours sincerely

Valerie

Dr V Gleadhill
Consultant Paediatrician

✓cc Dr Hicks Consultant Paediatric Neurologist
Royal Belfast Hospital for Sick Children

file

AUDIOLOGY CLINIC - [REDACTED]

7 December 1987

UN 328770

Dr K Monaghan
220 Knock Road
BELFAST
BT5 6QD

Dear Kyren

RE: Claire Roberts [REDACTED]

DOB 10.1.87

Thank you for referring Claire. I note that she has failed 2 Health Visitor screening tests of hearing. Her parents feel that she does have a slight hearing loss. She has no other ear symptoms. She is babbling. I note that she suffers from fits and is on Epilin.

On examination today there is evidence of catarrh in each middle ear. This was confirmed by free field tests of hearing and by tympanometry.

I have arranged to see her again in one month's time.

Yours sincerely

DAVID A ADAMS
CONSULTANT ENT SURGEON

DAA/PT

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

507

SURNAME ROBERTS		FIRST NAMES CLAIRE		4 UNIT NUMBER 328770
10 1 Male 2 Female 2	11 DATE OF BIRTH 15 10.01.87	23 DATE ADMITTED 27 04.09.87	CONSULTANT Dr Hicks	
ADDRESS [REDACTED]		46 DATE DISCHARGED 50 18.09.87	LENGTH OF STAY-DAYS 51 53 2	
FINAL DIAGNOSIS OF PRINCIPAL CONDITION CAUSING ADMISSION Salaam seizures		OTHER MAIN DIAGNOSIS [Signature]		
CODE 55 58 780.3		CODE 59 82		
OTHER MAIN DIAGNOSIS CODE 63 68		PRINCIPAL OPERATION CODE 67 69 70 74		
OTHER MAIN OPERATION CODE 75 77				

Dr McMillan,
Woodstock Road,
BELFAST 5

Dear Dr McMillan,

This 8 month old girl was admitted to Allen Ward on 4th September. The diagnosis was that of epilepsy.

At 6 months of age she had 2 episodes of twitching with no associated pyrexia, although she was snuffly at the time and was treated with Amoxil, but did not have an LP. One episode lasted about 2 minutes, the other about 10 minutes. Following discharge from hospital at that time she had 3 further convulsions over a 3 day period. This consisted of eye rolling, generalised jerking, she had a harsh cry and snorting and each attack lasted about 3 minutes. Following admission to hospital at that time she had 2 further absence attacks with no associated twitching. She was discharged from hospital and, 2 weeks later, readmitted having had 6 generalised convulsions within the one day, each lasting a minute with associated cyanosis. At that stage, on 24/8/87 she was started on Tegretol. On 2/9/87 she had 4 convulsions within the one day, these were tonic/clonic seizures lasting a few seconds. She was admitted to hospital and given Diazepam and Phenytoin. At that stage, investigations including cerebral ultrasound, U&E, calcium, blood count, urine for amino acids, reducing substances, EEG and magnesium were all normal. CSF showed a traumatic tap and the protein was raised, but was probably in keeping with trauma. She was started on Tegretol 35mgs bd and her drug levels were 6.2. She has had two 3 in 1 vaccinations prior to this. Her development, according to the Health Visitor's assessment, up to the age of 6 months, was very satisfactory. At that time, she was rolling from a supine to prone position. She was reaching for objects, using both hands. However, there was no mention of her transferring. She was also sitting momentarily and weight-bearing and had full head control.

Claire Roberts

On admission here she appeared a well-nourished child, head circumference was 43cms, just below the 50th centile. Fundoscopy, extra-ocular movements, cranial nerves all normal. Gag reflex present, she had a normal suck. She had head control, although she had poor trunk control for her age. She had no stabilising reflexes and could only roll from a semi-prone position. She looks at her hands, but makes no effort to reach and take objects. However, when placed in her hands, she would look and make an attempt to put them in her mouth. Prone, she could lift her head and chest, but was not able to lift on to her forearms. She could weight-bear on her lower limbs for a long period of time. Limb reflexes were normal. Plantar responses were equivocal. Her tone appeared otherwise normal, apart from poor trunk control and poor ability to lift her head when prone. Hearing appeared normal.

Investigations:- U&E, LFT, CPK all normal. Her blood pyruvate was marginally raised, there was no elevation of amino acids and urine for amino acids and reducing substances was negative. CAT scan was normal. Repeat CSF again was blood-stained with a raised protein, but eventually we got a clear sample, with a normal protein of 0.42g/l with no cells. Hb was 10.6g/dl, and WCC 13thous/ul. Wood's light investigation was also negative.

Following admission for 2-3 days she had no further seizures and began to play with some toys. However, she was still unable to sit. Subsequently however she did have attacks which clinically appeared like Salaam attacks. She had generalised flexion of her arms and legs lasting a few seconds. She also had some episodes of staring. Her EEG was not diagnostic of hypsarrhythmia, but did show an abnormality. Her EEG was repeated and, because of the appearance of the EEG, Dr Hicks decided to change her to Epilim and to wean her off Tegretol. Again her frequency of convulsions settled. Her mum began to get the impression they were occurring when she awoke from sleep. She had been getting 2-3 per day and, on discharge, she was having one every second or third day.

Following discharge, her mum rang to say that the seizure frequency had again increased and, because her Epilim levels were in the mid-therapeutic range, her dose was increased from 100mgs bd to 110mgs bd. To date, there appears to be no known cause for her epilepsy. It would appear to be idiopathic. She should not have any further 3 in 1 vaccination. She will be reviewed for developmental follow-up and assessment in response to therapy.

Yours sincerely,

M HANLON
Paediatric Registrar

34

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

507

SURNAME ROBERTS		FIRST NAMES CLAIRE		UNIT NUMBER 328770
1 Male 2 Female 2	DATE OF BIRTH 10.01.87	DATE ADMITTED 04.09.87	CONSULTANT Dr Hicks	
ADDRESS [REDACTED]		DATE DISCHARGED 18.09.87	TYPE OF DISCHARGE 1 Discharge to other hospital 2 Discharge--other 3 Died--No P.M. 4 Died--P.M. 5 Transfer--same hospital 2	
FINAL DIAGNOSIS OF PRINCIPAL CONDITION CAUSING ADMISSION Salaam seizures CODE []		OTHER MAIN DIAGNOSIS CODE []		
OTHER MAIN DIAGNOSIS CODE []		PRINCIPAL OPERATION CODE [] DATE []		
OTHER MAIN OPERATION CODE []				

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Yours sincerely,

M HANLON
Paediatric Registrar

CHILDREN'S HOSPITAL

HOSPITAL
NUMBER

5 0 7

NAME

ROBERTS CLAIRE

UNIT
NUMBER

328770

ADDRESS

BIRTH SURNAME

DATE OF BIRTH

OCCUPATION

NOTE: Where patient is a 'child', 'at school'
or a 'housewife' please state occupation
of head of household

MARITAL STATUS

1 - Single
4 - Other

2 - Married
5 - Not Known

3 - Widowed

RELIGION

1 - Church of Ireland
4 - Roman Catholic
7 - Not Known

2 - Presbyterian
5 - Jewish
9 - None

3 - Methodist
6 - Other (specify)

DATE OF ADMISSION

ADMISSION TYPE

1 - Immediate
4 - Booked (Non Maternity)
6 - Born in Hospital

2 - Waiting List
5 - Booked (Maternity)

3 - Other Hospital

DATE PLACED ON WAITING LIST OR BOOKED (NON MATERNITY)

ACCIDENT

1 - Not Accident
4 - Other
6 - Civil Disturbance

2 - Road Traffic
5 - Assault (other than 6)
7 - Industrial

3 - Home
8 - Sports

CONSULTANT

DR E HICKS

No. OF FORM IN BATCH

OWN DOCTOR

DR MCMILLEN
WOODSTOCK RD

TELEPHONE:

RELATIVE OR OTHER PERSON
FOR CONTACT IN EMERGENCY

TELEPHONE:

PREVIOUS ATTENDANCES

YES/NO

WARD

AW

ADMITTED BY

JL

TIME

14:52

37

Name of Patient:

CLARE ROBERTS

Date:

9/15/87 31

Dear Dr./Mr.

David,

I would appreciate it if you could
test the hearing of this 9/12 girl
who suffers from fits and attends St. Helens
- Medico-Epilepsy.

She has failed the hearing test
carried out by the H.V. on 2 occasions.

Thanks,

Yours sincerely,
Kyrre Hoighe.

Mr. Thomas

section overleaf being giving to patient for completion.

Fold Here

Please fold and seal this section of form and fill in top

Details of Drug Therapy and known Sensitivities

Doctor's Name:

DR. W. P. MCMILLAN

Address:

COLINVIEW,
220, KNOCK ROAD,
BELFAST,
BT5 6QD.

(Rubber stamp recommended)

M.R. 48

D8877510 100m 5/87 Gp 14672 N&K

17

REQUEST FOR OUT-PATIENT CONSULTATION/EMERGENCY ADMISSION*

FOR
DOCTOR'S
USE
ONLY

Clinic requested: E.N.T

of Dr./Mr. D. ADAMS.

NORMAL
~~*Not for immediate~~

If patient has attended THIS hospital before,
HOSPITAL NUMBER (IF KNOWN):

HEALTH SERVICE NUMBER:
(Shown on Patient's Medical Card)

*Please arrange for my patient to be given an appointment at the clinic shown.

*Please arrange for my patient's immediate admission.

*An ambulance is not required/is required on medical grounds.

*Sitting case/stretching case.

*Delete as necessary

FOR HOSPITAL USE

Clinic:

Date of appointment:

Time:

TO BE COMPLETED BY THE PATIENT (Block Capitals)

This form when completed must be sent to the Hospital. You will be notified by post when to attend.

Surname:
-Mr./Mrs./Miss

First Names: CLAIRE MARGARET

Surname at Birth:

ROBERTS

Telephone No.

Address:

Date of
Birth:

10/1/87

Occupation
or School:

DETAILS
OF
PREVIOUS
HOSPITAL
ATTEND-
ANCE

1 At the Hospital to which you are now being referred

(a) Date and Year: October 1987

(b) Hospital No. (if known)

(c) Consultant: DR HICKS

(d) Clinic or ward: ALLEN

328770

2 At any other Hospital in Northern Ireland

(a) Hospital: DUNBOYNE & ROYAL BELFAST

(b) Date and year: JULY 87 - SEPT 87

(c) Hospital No. (if known)

(d) Consultant: DR GLEADHILL & DR HICKS

(e) Clinic or ward: AIKEN NURSERY & ALLEN WARD

Woods light -ve

Mossan - NAD

While in hospital a couple of episodes of ? absence attacks - frozen animation for ~ 2 secs. Discharged 9/8/87 no further episodes having occurred over previous ~~2~~ 48 hrs.

Reviewed 24/8/87 having had further seizures on day of review (6 in all) & several over previous 3/52. We started her on TEGRETOL 36 mgms b.d. & she had no further fits. Discharged 30/8/87.

Further fits 2/9/87 (4 in all)
"Not as good a baby" Jan. Floppy - difficult to differentiate between sides ? $\odot$ side $\downarrow$ Tends to hold $\odot$ arm pronated. Rather glazed look. Drowsy
Thank you for taking her

Regards

Valerie

Complete & Bring

CONFIDENTIAL

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

Audiology Clinic

(If there is a choice of answer, please circle the correct one:—

e.g. (NO) YES SOMETIMES)

SURNAME OF CHILD: ROBERTS FIRST NAMES: CLAIRE MARGARE

DATE OF BIRTH: 10-1-87 SEX: FEMALE TELEPHONE NO: [REDACTED]

ADDRESS: [REDACTED]

NAME & ADDRESS OF FAMILY DOCTOR:

N.H.S. Number:

By whom were you referred to the Audiology Clinic? Please give name and address:

[REDACTED] (HEALTH VISITOR)

Is your child attending (or has he attended) any of the following:—

	<u>Date first went there</u>	<u>For how long each day</u>	<u>If Residential</u>
Play group			
Nursery School			
Normal School			
School for the Deaf			
Partially Hearing Unit			
Other Special Unit (Please give details)			

IF OVER 16, STATE HOW EMPLOYED:

PARENTS

Father's Occupation:—

Mother's Occupation:—

At home all day. ✓
Goes out to work.
If so, how many hours a day?

What is your main worry about your child and in what way do you most want to help?

42

38
What is your own main worry about your child and in what way do you most want help?

Are there any other problems and difficulties which may be relevant?

PRESENT COMPLAINT

Do you think your child is deaf? ☒ NO YES Since when?
Does he respond to:— NORMAL SOUNDS LOUD NOISES
YES ☒ YES

NO NO

☒ SOMETIMES SOMETIMES

Have there been any other hearing tests? NO ☒ YES
Where and approximate dates:—

AUGUST 87

Is your child wearing or has he ever worn a hearing aid? ☒ NO YES
If so, what type?

Do you think your child is:— Late in talking? NO YES
Difficult to understand NO YES SOMETIMES

Did he start to talk and then leave off? NO YES At what age?

Can you think of any cause for these troubles?

Has he suffered from: Frequent colds? Earache?
Sore throats? Running ears?

43

FAMILY HISTORY

Have you any other children? Please give age of each one and say whether Boy or Girl:—

[REDACTED]

Are any of them deaf? [REDACTED]

Do any of them suffer from trouble dating from birth such as cleft palate or heart abnormality? NO

Is there any history of deafness in the family?

[REDACTED]

Were any of the other children late talkers:—

Is there any family history of late talking:—

[REDACTED]

On Mother's side:

Is the child

Adopted?

To be Adopted?

Fostered?

Please give names of foster parents and Authority responsible:—

MOTHER'S HEALTH DURING PREGNANCY OF THIS CHILD

[REDACTED]

DETAILS OF BIRTH

[REDACTED]

PROGRESS AFTER BIRTH

Feeding habits in early months:— Normal Slow Difficult

Sleeping habits, first year:— Normal Drowsy Cried a lot

Has your child:— Been vaccinated or immunised? NO YES Please give details

Twice 3 in 1 VAC

Had any infectious disease?

NO

YES

HAS NOT HAD 3RD IS NOT ALLOWED TO HAVE WHOPPING COUGH DUE TO HAVING FITS.

Had any other illnesses, accidents or injuries? YES

Been admitted to hospital?

NO

YES

Which hospital and for what reason?

ULSTER HOSPITAL & BELFAST ROYAL FOR SICK CHILDREN

If your child has been under any other Doctors for investigation, would you please give details:—

GLEADHILL ULSTER HOSPITAL & DR HICKS BELFAST ROYAL

Has your child been away from you for more than a few days?

YES

HAS HAD EEG, TWICE C.A.T. SCAN, BLOOD TEST ETC.

GENERAL DEVELOPMENT

At what age did your child: Sit up? Walk? 10 MONTHS NOT VERY STEADY

When did he:— Start to babble, saying "Dad-dad-dad-dad", "Ba-ba-ba"?

Start to say first words?

Use hand to hold a spoon to feed?

Which hand does he prefer to use? Right Left Either

Are movements:— Normal? Is he clumsy with:— Hands?

Unsteady?

Feet?

At what age was he dry during the day?

Have you any worries about your child's behaviour?

NO

If attending school, do you consider he is:—

Having difficulties?

Getting on well?

Ahead of others in class?

Are there any subjects in which he:—

Is outstanding?

Finds particular difficulty?

Has he had an intelligence test?

NO

YES

If so, where?

Has he had his eyes tested?

NO

YES

What was the result?

45

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

AUDIOLOGY CLINIC

Name..... Claire Roberts Hospital No. 328770 Date of Birth..... 16.1.87

Address..... Sex..... Age.....

Referred by..... School.....

Family Doctor..... Religion.....

Date of Attendance..... 4/12/87 @ 11

C 20

Date
7/12/87

	<u>LEFT</u>	<u>RIGHT</u>
Distraction Rattle	55-60 db	55 db.
S	65 db	55-60 db
chime bar	? 60 db	60 db
voice	60-65 db	60-65 db.

$\frac{11}{12}$

Referred GP - failed screening tests.
may have hearing loss, but responds
to loud sounds.

No clear symptoms
Babble

Putt fits
(on Epilim).

Ears Tug. dull, green.

Distraction level 50-60 dBA.

Tt grams - flat.

? ECG 6. See r

46

8180

San TMS / Sink

T. gams - Name

- final assessment

11-3-88

Man feels v. much better than to search & values. Poured least into the
TMS sat. 2/3 ago

Mother thinks hearing normal: sex x 1 3/2 @ 11 MP
San TMS

24680

T. gams ✓

D.

Date

38

48

Date

49

CR - PSN

096-025-241

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
4/9/87	(5/12)
	Referred from GP.
	P/c convulsions. F.T. S.D. / Maternal cousin E.H.
① Started ② ③	① Started at (5/12) ? seizure x 2 no documented pyrexia 1-2 minutes > twitching 10 minutes Smelling Aphasia No C.P. Rr Anx 11
④ ⑤ ⑥	② OPD - 3 fits following discharge 1/day 7th day, levere Eyes Rolling Shaking Hand. cry Sneezing Admitted 4/8/87 last seizure H/C 43cm
	Admission - 2 episodes Absence no twitching
	③ 2 1/2 doses. 6 generalized convulsions in one day Readmitted apnoea x 1 minute 3rd another day. 1/3 days Went tegretol 24/8/87
CR - PSNI	④ 4/9/87. 4 fits one day admitted tonic clonic 10.5 am 096-025-242

DATE

CLINICAL HISTORY, EXAMINATION AND PROGRESS

Tests

ultrasound

- Normal 8/3/87

Ca/E (Ca/Alb)

2BC

- HB 11.3

HBe 11.8

53% Ly

4% Mo

urine

A/B

7/8

+ 25/8.

42% Ly

Normal

urinary

sugar

EEG

2/8

my

CSF

24/8/87

Initially clear

adjusted - blood.

WBC 30.

RBC 72,000

pH 7.16

pO₂ 4.1

Kantharidin very slight

No bacteria.

Rx

Tegretol

1.75ml

BD.

35mg

BD.

- about 10kg.

level 6.2

Vocal

Triple x 2.

Exam.

LMA normal

H/C

43cm

Zosterella

Sutures

Fundi (A)

eye motion (R)

DEEL.

51

Cranial normal

096-025-243

CR - PSNI

Set A eye movements - no hypertension

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Suck normal.
	- Head control normal
	- Trunk control poor - cannot sit unsupported
	forward.
	- No lateral reflexes.
	- Both semi-prone
	- Looks at hands
	- Will not reach but holds objects when placed
	in hands no transfer but will
	bring hands together & puts attempt to
	mouth.
	Uses (2) better than (1).
	- <u>Phone</u> lifts head & upper chest, attempt
	to lift on forearm
	no press up
	- Weight bears E support to sitting
	- Kicks both legs equally
	- Reflexes seen equal & normal in limbs.
	Plantars equivocal.
	- <u>Tone</u> (1) a little floppy to (2)
	trunk poor tone
	otherwise normal.
	- Turns head to sound

CR - PSNI follows laterally not upwards.

22

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	<u>Imp</u>
	Fits x 4/12 since age 6/12
	Developmental regression - 4/12 development
	<u>Spoke</u> to Mum:-
	Showered Health visitor back -
	Dev. wound to 6/12 - at 6/12
	- reaching for objects & using both hands
	no action of transfer
	- Had been reaching & grasping at 4/12
	- sitting unsteadily at 6/12 & weight bearing
	- started 5/12
	Could feel regression since 6/12 but probably
	... heard until Y&W
	• Had 2 brief episodes yesterday - lasting few minutes
	clenching hands, stiffening, slight jerking
	noticed before onset of fit.
	• Mum describes some but recently extends arms
	& can bend forward.
	Also describes twitching of eyes & face.
	Can cry - strongly after episode.
	Mother also knows it is going to happen because she

feels stiff form.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
7-9-87.	No further seizures / twitching episodes Alert & well otherwise ? May need AED later. CT scan, EEG, Inac, Ca⁺⁺, u/e, plasma amino acids Urine for AAs & organic acids, fasting pyruvate & lactate, FBP, Tox screen. Tegretol levels later. RAY.
() 8-9-87.	Well for CT scan tomorrow. Consent ✓. Verbal EEG report - ? outside normal limits. RAY.
9.9.87	CT scan. Only had 1.0m atropine for pre-med. Methohexitane 225mg orally. Satisfactory sedation No problems. Infusion (Ser. Reg. Anaesthetics).
9-9-87.	No problems. No further seizures. Afebrile. For Tegretol levels & Tox screen later. Inac ✓. Dr. Hicks to speak to mother on Friday. RAY.
10/9/87.	Behaves normally. No further seizures. Alert. Afebrile. Good head control. Fixes eyes. Hearing ✓. Tone ↓ esp in lower limbs. Sitting post. CVR RS - Clear. Await results of Tox ? Home soon. As before RAY.
11.9.87	G named ? Home later + Neuro (results) Enth

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
11/9/82	EES not Kybs any other
	CT normal
	Had repetitive seizures yesterday lasting few seconds
	arms & legs flexed - like seizure
	lying on the floor.
	Starting episode this morning
	2 P Tegretol
	2 new clonazepam
	Playing with letters across car - reading & writing
	starting rattle
	using left letter then right.
	starting rattle right hand
	MNO
	Change to Epilim & new Tegretol.
	200mg & 250mg B.D (100mg B.D)
	New Tegretol. 1.75mg daily x 1/52 ?
	old dose x 1/52 1 1/52
	then stop
	Sleep EES on Monday
	MNO
	high sleep
12.9.82	1/2 EES, shows deterioration
	- hypsarrhythmia start ACTH 40mg/d
	- not quite hypsarrhythmia repeat in 3.
	NO hypsarrhythmia

46.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
17/9/87	No seizures since 15/9/87 Much brighter this morning Weaning off Tegretol only 3mg once only For Epilin levels tomorrow

P. Burns

19/87	• Mom feels she is brighter since starting Epilin. • 2 day fit free until last night - didn't last as long. + mom did not feel it was a seizure. seem to be precipitated by light being switched on & wake from sleep. Head been throbbing
-------	--

	• Mom feels fits occur when she is waking for sleep.
--	---

	• Head been getting 2-3/day as some improvement.
--	---

	check Epilin levels. today
--	----------------------------

	• Stick floppy. Discharge on Epilin 100mg BD.
--	--

	• Weaning off Tegretol.
--	-------------------------

ALLEN WARD IN-PATIENT	
REVIEW	15/9/87
WHEEL	MD Burns
	9/9/87
WHEEL	PICK/RDHSC
WHEEL NURSING 18/9/87	

to get 3.1.

MAHON

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
2/7/85	Motor range up. Claire is still having seizures on alternate days. DW Reg. Advised to ↑ Epilim by 10-15mg daily. Was taking 2.5mls Epilim B.D. Advised to ↑ this to 2.75mls (110mg) B.D. R/S to be arranged. (Tegretol as before). L. Mackle.
	See on list 40/4 0/10 W. 10/10 0/10

58

45

000000

3P

DATE

CLINICAL HISTORY, EXAMINATION AND PROGRESS

53

53

59

CR - PSNI

096-025-251

TREATMENT FORM

[illegible]

TREATMENT FORM

[illegible]

CLINICAL HISTORY, EXAMINATION AND PROGRESS

DATE

11/10/96. 9 year old admitted via A+E
8pm.

PC Vomiting at 3pm and every hour since
Slurred speech + Dravay.
Off from yesterday, loose motions 3 days ago.

HPC Severe learning difficulties
Seizures 6 mo - 1yr - Controlled by Me Valproate
Age 4 - x1 seizure
Anti convulsant gradually weaned until
Epilepsy stopped.

HES Speech - ca. speech in sentences, meaningful
Hearing @

V. Vision @
FM Scrambling - feed herself & supervise.
Cannot dress herself

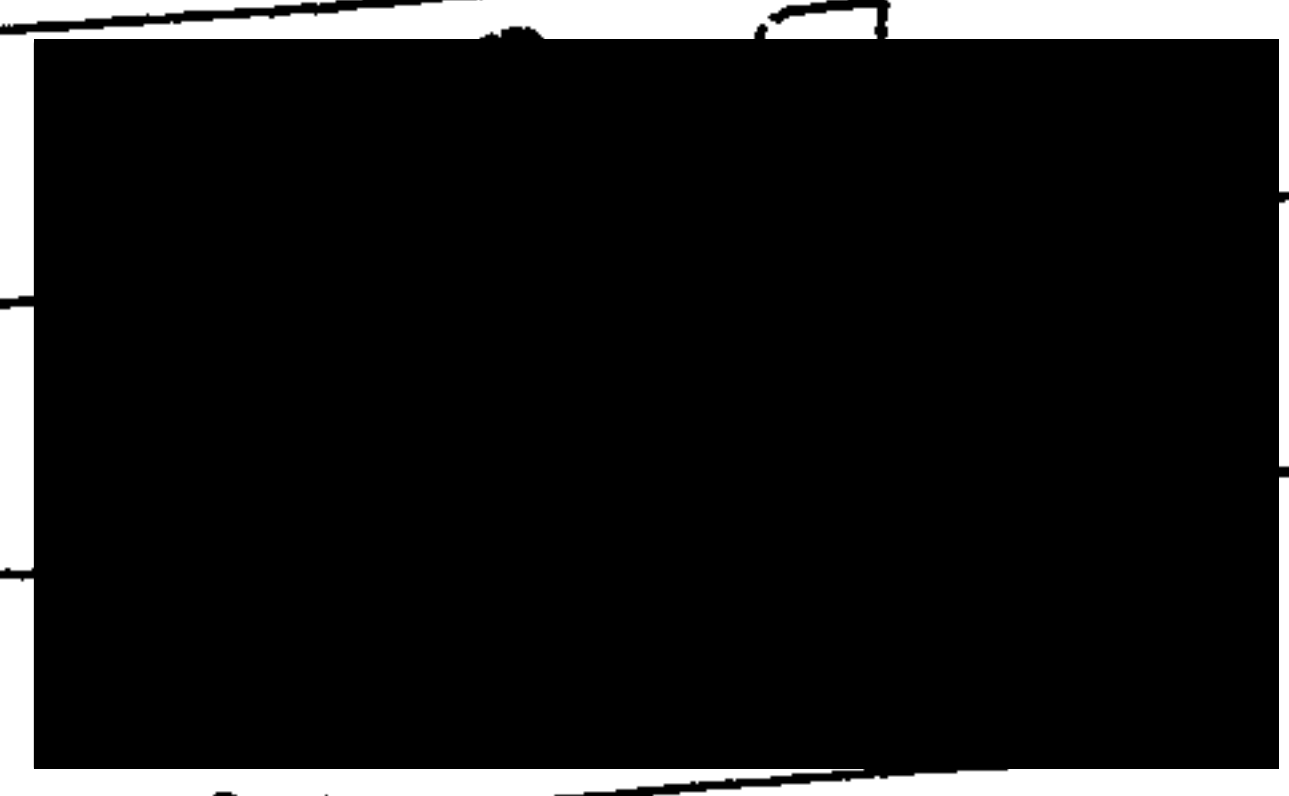
Grossly Walk, Rm. UP + Down stairs. Favours left side & body
- Torbank. Special school. Discharge

- Dr. Gaston. U.K.D., previously 2 mths

Recently had Rivastigmine - Dry mouth. The became
agitated, Dry mouth.

OH nil

PH



all nil

15

CLINICAL HISTORY, EXAMINATION AND PROGRESS

DATE

9/6

37°

Cos. I + II 80/min.

Re. clear

Abd 187k. NBT tender No mass.

Cos. Fundi normal, Discs NBT blurred.

PERLA

Abd VII - IX - X -

POS, Sit-up + Stairs Vacantly, ? Ataxic

Power not assessed

	R.	L.
Tone - upper limb	Coarse	↑ tone
lower limb	↑ tone	↑ tone

	R.	L.
Reflexes DJ	++	+
TJ	++	+
ES	++	+
AK	++	++
AS	++	+
P	↓	↓
clonus	+	+

Sene - not responding to parent's voice / intermittent
responding to deep pressure

W. Elaine Robert.

CLINICAL HISTORY, EXAMINATION AND PROGRESS

DATE

1. Viral illness
2. ~~Endotheliosis~~

10/11

BC -
WCC -
BCx -
Viral illness, $\pm$ LP - afebrile.

11/11

iv fluids,
iv drug? An. $\pm$? Seizure. Activity.

Re-assess after fluids.

1/3/12

12/11/11

Slightly more responsive - No change.
Observed + least An. 1/3/12

Na 132. $\downarrow$

Hb 10.4

K⁺ 3.8.

PCV .31

U 4.5

WCC 16.5 $\uparrow$

Gluc. 6.6.

platelet. 422.000

Cr 36.

Cl. 96.

No report CS (no)

22/10/16

WPC. Dr. Santos

Admitted? Viral illness

Usually very active, has not spoken to parents as per normal

watching. No vomiting.

Vagueness/Vocal (apparent to parents)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	No seizure activity observed. Attended by Gaston (UHD) 6mths old seizures and IV for this - NAD. HTC - Dat 132 - FBC - WCC 116.4. plate 6.6. Sp Afebrile. On IV fluids. Pale colour. Little response compared to normal. CNS Reflexes sluggish to light. GCS Difficult to see fundi. Nostr. difficult to Slur. long tract signs. full see Imp. Non fitting status. / encephalitis / encephalopathy Plan. Rectal Diazepam de West Now de Gaston re PNHx
22.10.96	Neurology - Thank you
4pm	9yr old girl with known learning difficulties - Parents not available. - Grandmother Hx - vomiting + listless yesterday pm - followed by prolonged period of poor responsiveness - ON NO AED. - Note requested to improve following rectal diazepam 5mg at 12.30pm
	Sp Afebrile. No meningism. Pale Responsive - Eye opening to voice, Non verbal, withdraws from painful stimuli. Reduced movements Rt side? Posturing all 4 limbs. Mildly increased tone both arms Reflexes asymmetrically brisk -

10/01/87

Female

EHSSB

CONSULTANT

WD/OP

DATE

CLINICAL HISTORY, EX

22.10.96

- Convulsions - sustained both arms

for 10 min.

- Lift up arms after + back to bed.

Not staying conscious.

- Pupil - 5mm

After clonic phase. No pupillary response.

Fixed pupils + irregular movements of face (H).

Imp - I saw some a clear picture of prodrome + yesterday's episodes.

Her findings today are probably long standing but this needs to be.

checked with notes. The picture is of a severe epilepsy.

Not possibly restricted in nature. I note in the history notes.

Notes i) of drug if Phenytoin 18mg/kg stat followed by

25mg/kg 12hrly with blood levels 6 hrs after loading

done

ii) Notes of blood

iii) CT removed at the local centre

D.L.L.

22/10/96

2.30 pm

24 kg Phenytoin 18mg/kg - loading dose = 18×24
= 632mg

24 kg Phenytoin 2.5mg/kg 12hrly = 60mg 12hrly either IV
or orally

Check levels at 9pm.

T.H. Blair

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS	
10/96	J.B. DE W220	
	Still in labor	
	1. MIDAZOLAM	0.5 mg/kg STAT DOSE = 0.5 x 24 = 12 mg IV stat
	2. MIDAZOLAM	2 mg/kg/min = 2 x 24 mg/min = 48 mg/min = 48 x 60 mg/hr = 2880 mg/hr = 2.88 mg/hr INFUSION = 69 mg/24 hrs.

12.50

- Gauri has had a loading dose of phenytoin + a further
of maintenance. She continued to be largely unresponsive.
The response to phenytoin has taken to deep sleep but she
+ does have some grimace - but no indication
she has intention. monitoring + various movements.

- Discovered from man - looked with camera on him who said is
S.I.T. report. Close had been around on Sunday & Monday
Monday. He had been told was on. No thing is it under
signing.

- Pos. 1. Low to medium + high α - 4:45 - 5:15 (10 to 15 min)
2. U.S. and middle? α - 4:45 - 5:15 (10 to 15 min)

4) Total 11. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 8

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
12/10/96	Ne 121.
13-30	K 3.3 Phenylin 23.4 mg/l (10-20)
	Urea 2.9
	Creat 33.
	Hypnatremic - ? Fluid overload & low Na Fluids.
	? SIADH.
	Imp - ? Need for 4 NaCl in Fluids
	- Ohs Reg - ↓ Fluids to 2/3 of present volume - 4mls/hr.
	- Send urine for electrolytes.
	<i>Michael Smith</i> (SIB)
~ 3AM	called to see
	had been stable when suddenly she
	had a respiratory arrest and developed fixed
	dilated pupils
	when I saw her she was Cheyne-Stokes
	and requiring O ₂ via face mask
	Saturation with logging in high 90's
	Good volume pulse
	I attempted to intubate - not successful
	Anaesthetic colleague came and intubated
	her orally with 6.5 tube
	Transferred to PICU.

DATE

CLINICAL HISTORY, EXAMINATION AND PROGRESS

9.24 am 9 1/2 yr old girl c learning difficulties admitted 32 hours ago
 c level of consciousness.
 s B Dr Webb. - acute encephalopathy ? aetiology.
 Covered c Acyclovir + cefotaxime.
 Loaded c phenytoin. + Valproate added in @ 1700 hrs.
 Pipm - phenytoin level = 23.4 Na^+ 121 K^+ 3.3.
 Fluids restricted to 2/3rd maintenance.
 Obs otherwise stable.

2.3 am. Reg asked to see because of resp difficulties
 Cheyne - Stoke breathing
 - Intubated + transferred to ICU.
 At present intubated + ventilated
 has had some Midazolam but it is no longer running
 Pupils fixed + dilated
 Bilateral papill oedema L & R.
 No response to painful stimuli.
 BP 90/65 HR = 100/min.
 Plan - Mannitol stat.
 - Dopamine infusion.
 - urgent CT scan. H&S 56m
 Osmol - 269

23.10.96

9.40 AM

Neurology

- S.I. ALH - hyponatraemia, hyperosmolality, 1 cerebral oedema
 + convex primary generalized epileptic seizures
 - Pupils fixed + dilated showing minimal response
 - No eye movements.
- for CT scan

shk

6

DATE CLINICAL HISTORY, EXAMINATION AND PROGRESS

23.10.96 0530 CT Brain P. Kennedy (Radiology Reg)
There is severe diffuse hemispheric swelling, with complete effacement of the basal cisterns. No focal abnormality is identified.
Henry

23.10.96 6Am Brain stem and cranial examination!
• Pupils 6mm unresponsive
• Dolls eye movements
• Corneal reflex - No response
• Jaw clonus words in both EEs - no reaction
• No response (none or weakness) to deep suprachiasmatic pain
• Hyperventilating

CT Cranial Irradiation
Under no sedation, primary medication
Under findings consistent with brain stem lesion
No evidence of intracranial mass effect

23/10/96 0710 P. Kennedy (Radiology Reg)
McHAIGUE

9 yr. old girl admitted to PICU from Allen Ward.
suffered a respiratory arrest was initially bagged and intubation performed by Dr Clarke (SpR) on the ward.
at the time of intubation vomiting was noted in oropharynx - liquid material no solid material following intubation trachea was sucked out

DATE

CLINICAL HISTORY, EXAMINATION AND PROGRESS

material was aspirated.

oral ET tube then changed to nasal ET tube in PICU.

Initially admitted to hospital with decreased level of consciousness with the clinical picture of acute encephalopathy. Status epilepticus subsequently developed requiring phenytoin, valproate and midazolam. serum Na also noted to be low $\downarrow$ 121 presumably on basis of SIADH.

In PICU ^{hyper}ventilated and given manual 0.5 g/kg

pupils fixed and dilated.

BP ~ 95 systolic peripheral dopamine infusion commenced.

arterial line @ doublet pedis and

@ ant. jug. triple 5/8.

then transferred for CT scan

Transfer uneventful.

CT scan shows severe cerebral oedema.

1 set of brain stem tests performed by Dr Webb / Dr Steen. serum Na also checked at same time. (133 — blood gas analyser PICU no resp. effort with ABGs)

pH 7.13 pO_2 124.5 pCO_2 79.2

Plan: maintain circulatory support as Claire is a potential organ donor.

— dopamine infusion to maintain SBP ~ 100 mmHg.

— close check on serum Na and serum osmolality and urine output.

DATE

CLINICAL HISTORY, EXAMINATION AND PROGRESS

if serum Na > 150 and osmolality > 300 then commence desmopressin.

- will need conc K infusion.

- maintenance fluids with Dextrose 4% / Saline 0.18%.

- ventilate to PaO_2 35.

Dr Wells / Dr Stan have discussed Claire's clinical condition with her parents. They initially appear to be giving consent for organ donation but Dr Wells will speak again to both parents at ~ 10⁰⁰.

check CXR shows central line and ET tube in good position. There is some mottling of both hilar regions more so on the R side. There has been a deterioration in ABGs. PaO_2 76 on FiO_2 0.6. I would be concerned that this picture could be explained by pulmonary aspiration or early neurogenic pulmonary oedema. Any potential transplant centre should be alerted to possibility of pulmonary aspiration.

Lab. Sample at time of brain stem tests

Na 129 K 3.6 Cl 94 urea 3-7.

glucose 7.2 osmolality 274.

Ogro.

check 2 hole U+Es

change maintenance fluids to 0.9% saline.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
23/10/96	Hypertensive BP 70/30 $\bar{c}$ D.I. given HPPF 300mg Needs DDAMP. to limit pressure Appears B.S. Dead informally But only 7 hrs post arrest. Na⁺ 129 (from 121.) flain - Maintain BP > 100 - DDAMP. RJR
18-25.	- Diagnosis of Brain death protocol completed. No spontaneous resp - CO₂ 70mmHg. Discussed w parents - agree that ventilation should be withdrawn Consent for limited p.m given. HSSlein
23/10/95 18 ⁴⁵ M.Y.A.G.P.	ventilation discontinued at 18⁴⁵. J.H. Kain
	Death certificate issued - cerebral oedema 2° to status epilepticus.
24/10/95 12 PM	Gp informed. (M) M. Kain
11.11.96 3.35 pm	- spoke @ length with Mr & Mrs Roberts earlier today. They are naturally still trying to come to terms with what happened to Alice. I talked through the events before her death and also talked generally with them. They are naturally anxious to discuss the PM results with someone. I will pass this on to Dr. Steen ASAP C. Kain

096-025-265

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

NURSING ADMISSION SHEET

Consultant: *Dr McMillin*

220 Knock Rd BT5

Birth

Telephone No.

Unit No

SOCIAL DATA

SLEEP

sleeps for most of night

HYGIENE

Requires assistance for hygiene

EATING AND DRINKING/BABY FEEDING

Osteemik 7oz x 6
Milupa Spoon feeds

MILESTONES/MOBILITY

Behind in development

74

INFECTIONOUS DISEASES

None

Contact within last month

None

Immunizations

Has to get 3rd 3 in 1 - but has not to get last whooping cough immunization.

ALLERGIES

None Known

MEDICATION

Teperetol

VISTING PROBLEMS

None

Mother Resident/Non-Resident

Non resident

Room No.

PARENTS/PATIENTS UNDERSTANDING OF ILLNESS/REASON FOR ADMISSION

GNOSIS

Convulsions

Weight

7.78 Kgs.

Birth Weight

7lbs 9oz

Height

Condition of Head

Carotid in scalp

Condition of Skin

good

General Appearance

Appears Healthy although behind in development.

OTHER RELEVANT INFORMATION

INFORMATION OBTAINED FROM

By

Designation

Date

Time

CHECK LIST 0 - 48 hrs

DISCHARGE PLANNING

Has child toy with him/her

Authorised person to whom patient may be discharged

Is child wearing own clothes

Out Patient Appt.

NEEDED

DONE

Relatives spoken to by Sister

Discharge Letter

Health Visitor

Tel

Medication

Name

Health Visitor

Social Worker

Tel

District Nurse

Time

Social Worker

75

Hospital Social Worker

Transport

CR - PSNI

Other

096-025-267

10

10

096-025-268

SPECIFIC PROBLEMS AND AIMS OF CARE

Patient's Problems	Aim of Care	Nursing Action to be Taken	Prescriber Date	Discontinuer Date
1. Parental Separation	To encourage good bonding between parents to child during the stay in hospital.	1. Encourage parents to visit child as often as possible & encourage them to be involved in nursing care.		
2. CAT SCAN	To prevent aspiration	1. Nurse by O2 & suction	8/9/87	
3. A		2. Obtain consent from parents	8/9/87	
4. Parental anxiety	Minimize	3. Give pre-medication of amyl nitrite up by doctor	8/9/87	
		4. Explain all procedures and keep up to date with progress & results.	8/9/87	

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ROYAL BELFAST HOSPITAL
FOR SICK CHILDREN

NURSING NOTES

Consultant

Date		Signature
4 th September 1987	Patient of Dr Hicks transferred from Ulster Hospital for investigation of convulsions. On admission patient appeared very irritable however there were no seizures noted either in afternoon or early evening. Patient keen for spoon feeds and bottle feeds - NB - PS does not take a 10pm feed - was seen by registrar this afternoon.	J M Eard C. Graham
8am.	No fits observed overnight. Slept all night.	
5/9/87	Intravenous cannula removed from scalp this morning. Feeding well, no fits observed. Mother visited. 2 seizures this afternoon.	J Beattie J Beattie
	Agitated this evening until 6.45 pm. Mother visited and child settled and fed well for her. No fits noted this pm.	J R Gibson
6/9/87	Fed and slept well. Good for no seizures this am.	PS D. Osborne
8pm	Parents visited; no seizures observed.	J Beattie
7/9/87	Feeding well. No seizures observed. Snuggly this am.	P. Smyth
	am. Mother visited. Fasting from 10am for blood test. Attempt EEG - unsuccessful.	J Beattie J Beattie
	Feeding well; settled from 7pm.	
8/9/87	No seizures observed.	M. Burnside
	Feeding well. No seizures observed.	
	1. D. G. and Fluids. No seizures observed.	

Date		Signature
	In very good form. Awake all evening. Parents present.	
	Fasting from 12 AM ~~for~~ slept well.	L. Lavery.
9/9/87.	Went for CAT scan this Am. Returned @ 11.45 Am.	J.B. Gibson
	Fed fairly well.	
	pm In good form. Eating well	C. Fulton
	Parents visited.	
10/9/87	Slept very well	M. Bunsie
	Very settled morning. Keen for feeds. Mum visited.	P. Lavery
	pm Very irritable. Eating and drinking well. Rash noted behind ears? chickenpox. Seen by Dr.	
	Parents present.	B. McCover
11.9.87	No further rash.	J. Alexander
	a.m. Short seizure 10am - drowsy afterwards. On good form since. Keen for feeds. Rash remains.	L. Lavery
	B.N.O x 2 days. Flushed pinkish. This afternoon	
	Seizure at 6.30pm. both arms and legs jerking and eyes rolling. Increased	
	Saliva from mouth. Seizure lasted	
	5 minutes. Irritable and drowsy after seizure. Anticonvulsants changed.	C. Kelly
	No seizures observed. Slept well.	L. Lavery
12.9.87.	Good form, no seizures this a.m. feeding well	A. Miller
	LPV	
	For sleep by morning.	
13/9/87	No seizures observed.	L. Lavery
	1 seizure recorded at 8.15 AM, irritable and unsettled the am	
	No seizures observed.	L. Lavery
14/9/87.	for EEG this pm. Remained awake for most of morning. feeding well. No seizures observed.	A. Miller

U100 145.

1. *Phragmites australis* (Cav.) Trin. ex Steud.

5

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

RECORDS OF ATTACKS OBSERVED

NAME OF PATIENT: Claire Roberts AGE 8/12 NO. 328770

Date	Time	Exact description of attack	Duration	State afterwards	Initial
8/9/87	4.50pm	Eyes staring for approx 10 seconds. Tearing of arms and legs for several minutes	6 minutes	irritable +.	A. Mulrocks

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

RECORDS OF ATTACKS OBSERVED

NAME OF PATIENT: Clair Roberts

AGE 8 1/2

NO. 328770

Date	Time	Exact description of attack	Duration	State afterwards	Initial
19/8/87	2.40pm	Eyes staring legs + arms straight out. moving in Salaxum type seizures	4-5 mins	drowsy + vacant.	P. McCay
19/8/87	10am	Eyes staring - no limb movements.	30secs	asleep	Y. McEntee
	6.30pm	Eyes rolling, both arms and legs jerking saliva from mouth.	4-5 mins	limbless + drowsy	C. Kelly
2/9/87	8.45pm	Eyes rolling, sharp intake of breath, left arm jerking, jerking body movements.	2 min.		A. Hon/L. Vole
	11.20am	Eyes rolling, jerking of arms and legs x 10. Saliva + following sneaking following seizure + cross.	2-3 mins ~~2-3 mins~~	Intractable + Drowsy.	P. McCay
1/9/87		Staring eyes, body arching backwards in spasmodic movements. stiffening of limbs, shouting sounds and salivary at mouth.	3-4 min	Intractable H.	A. Hon
	8.05am	Vacant episode staring into space while in cot.	4-5 secs	settled	P. McCay
	8.20pm	Vacant episode while sitting on nurse's knee	4-5 secs	settled	
8/9/87	7.00am	Shouting, spasmodic jerking of limbs sharp intake of breath. Shouting at end of seizure.	1-2 min	intractable and anxious	A. Hon

CR - PSNI

096-025-275

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RECORDS OF ATTACKS OBSERVED

NAME OF PATIENT: Claire Roberts

AGE 10-7-87 NO. 328770

Date	Time	Exact description of attack	Duration	State afterwards	Initial
7-9	1:30 pm.	Snorting , (L) hand clenched. -(R) Arm out stretched, continued to give a slight cry throughout. Colour - Pale, eyes staring. Sweating -	1½ mins.	Winging, Drowsy. Twitching every 30 secs.	D. Osborne
	3:20pm	Grunting . Both arms stiffening + relaxing . Hands clenched . Both legs twitching . Eyes staring. Sneaking . Moaning throughout	1½ mins	Drowsy- winging	anglowe,

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CR - PSNI
096-025-276

238
12/10

N.I.H.A.

Hospital. 12-HOUR RESPIRATION PULSE AND TEMPERATURE CHART

Physician or Surgeon

Ward

Surname and First Names

Sex

Age

Hospital No.

DR Hicks

Allen

Clara Roberts

F

7/12

328770

Day

Day of Disease

4/9/57

10

6

2

10

6

2

10

6

2

10

6

TEMPERATURE

C° F°

41.0 105.8

40.5 104.9

40.0 104.0

39.5 103.1

39.0 102.2

38.5 101.3

38.0 100.4

37.5 99.5

37.0 98.6

36.5 97.7

36.0 96.8

Day of Disease

F° C°

105.8 41.0

104.9 40.1

104.0 40.0

103.1 39.5

102.2 39.0

101.3 38.5

100.4 38.0

99.5 37.5

98.6 37.0

97.7 36.5

96.8 36.0

PULSE

140

130

120

110

100

90

80

70

60

140

130

120

110

100

90

80

70

60

RESPIRATION

50

45

40

35

30

25

20

15

10

50

45

40

35

30

25

20

15

10

Motions

Urine, ozs.

R.B.H.S.C. 17.

REGULAR PRESCRIPTIONS

74

	Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration								Method and other Instructions	SIGNATURE	Discontinued		
				AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12			Other Times	Date	Initials
G	22/10	PARALYTIC	2mg													
H																
I																
J																
K																
L																
M																
N																
O																
P																
Q																
R																
S																
T																
U																

REGULAR PRESCRIPTIONS

DRUG SENSITIVITY

	Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration								Method and other Instructions	SIGNATURE	Discontinued	
				AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12			Other Times	Date
V															
W															
X															
Y															
Z															

DIET

Date	Details	Initials

TAKE HOME DRUGS INDICATE BY LETTER

096-025-279

CR - PSNI

Name of Patient	Age	Hospital Number	Consultant
-----------------	-----	-----------------	------------

EASTERN HEALTH & SOCIAL SERVICES BOARD
ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
PRESCRIPTION SHEET

PARENTERAL DRUGS
REGULAR PRESCRIPTIONS

75 DRUG SENSITIVITY

Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration								Method and other instructions	SIGNATURE	Discontinued		
			AM 8	AM 8.30	MD 12	PM 12.30	PM 3.30	PM 6	PM 8.30	MN 12			Other Times	Date	Initials
A	Penicillin	500mg										IV	[Signature]		
B	Amoxycillin	500mg										IV	[Signature]		
C	Chloramphenicol	500mg										IV	[Signature]		
D	Hydrocortisone	50mg										IV	[Signature]		
E	Hydrocortisone	50mg										IV	[Signature]		
F	Hydrocortisone	50mg										IV	[Signature]		

DRUGS-ONCE ONLY PRESCRIPTIONS

Date Given	DRUG (Block letters please)	DOSE	Time of Admin.	Method of Admin.	SIGNATURE	Given by Initials
22/11/75	Penicillin	500mg	12.30	IV	[Signature]	[Initials]
22/11/75	Amoxycillin	500mg	12.30	IV	[Signature]	[Initials]
22/11/75	Chloramphenicol	500mg	12.30	IV	[Signature]	[Initials]
22/11/75	Hydrocortisone	50mg	12.30	IV	[Signature]	[Initials]

Ward	Name of Patient			Age	Hospital Number	Consultant
BLK 1	CLARKE ROBERTS			6/10/75	10000	[Signature]

[illegible]

REGULAR PRESCRIPTIONS

DRUG SENSITIVITY

--	--

[illegible]

DIET	
Details	Initials
CR - PSNI	

TAKE HOME DRUGS
INDICATE BY LETTER

Name of Patient	Age	Hospital Number	Consultant
CLAIRE ROBERTS	9 ¹⁰ /12	328770.	Dr Steen.

[illegible]

FAMILY NAME: [REDACTED]

FIRST NAME: [REDACTED]

LIKES TO BE CALLED: [REDACTED]

CHILD'S ADDRESS: [REDACTED]

TELEPHONE NO: [REDACTED]

AGE: [REDACTED]

D.O.B: [REDACTED]

BIRTHWEIGHT: [REDACTED]

RELATIONSHIP TO CHILD: [REDACTED]

ADDRESS: [REDACTED]

TELEPHONE NOS. [REDACTED]

WORK: [REDACTED]

WITH WHOM DOES THE CHILD RESIDE: [REDACTED]

RELATIONSHIP TO CHILD: [REDACTED]

WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD: [REDACTED]

TELEPHONE NO: [REDACTED]

NAME OF SCHOOL/PLAYGROUP/NURSERY: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

DATE: 23-10-96 TIME:

REASON FOR ADMISSION:

Respiratory arrest

ACCOMPANIED BY: Nurse Doctor

WHY DO THE PARENTS THINK THE CHILD HAS BEEN ADMITTED:

Due to Respiratory arrest and needing further care

MEDICAL DIAGNOSIS:

? Viral

PREVIOUS RELEVANT HISTORY/ADMISSIONS:

Heretofore. Handicapped. Severe learning difficulties. Epilepsy (no seizures in past 3 yrs). No hospital admissions for approx 8 yrs. Admissions on baby + toddler with seizures.

CONSULTANTS:

Dr. Steen

HOSP. NO:

PARENT(S), CARER(S) RESIDENT:

PARENTS

WHERE:

AT HOME

LIKES TO BE KNOWN AS:

A LAW & JENNER

DO THEY WISH TO PARTICIPATE IN THE CARE OF THE CHILD?

yes when possible

SOCIAL ARRANGEMENTS:

Parents staying in Room 2.

NAME AND AGE OF SIBLINGS:

[REDACTED]

ADDRESS: *200 W. 11th St.*

Combs, H/L

FILE NO:

NAME OF HEALTH VISITOR:

ADDRESS:

DATE NO:

CURRICULAR WORKER / OTHER CONTACTS:

DATE OF AGE

ADMINISTERED

DATE

1ST.....

DATE

2ND.....

DATE

3RD.....

MEASLES: *11/11/11* RUBELLA

YES/NO

BOOSTERS: *11/11/11* POLIO

YES/NO

(FILE COPY)

B.C.G. *11/11/11*

DATE OF *11/11/11*

200 W. 11th St.

DISEASES:

None known

ALLERGIES:

None known

CURRENT MEDICATIONS AND METHOD OF ADMINISTRATION:

ANY LOOSE TEETH:

OTHER PROSTHESIS:

SIGNATURE OF NURSE TAKING HISTORY:

DATE:

WARD FACILITIES - TICK BOX WHEN EXPLAINED TO PARENTS

PARENTS ACCOMMODATION WITH NO SMOKING POLICY

☐

PARENT INFORMATION

☐

PARENT SHOWER / TOILET FACILITIES

☐

TELEPHONE

☐

DINING ROOM FACILITIES

☐

SOCIAL WORKER

☐

92

PAEDIATRIC INTENSIVE CARE UNIT PATIENT ASSESSMENT

NAME:- Clare Roberts DOB:- 32/10/78 HOSP. No:- 328770 DATE & TIME:- 22/10/17 NURSE'S SIGN:- [Signature]

RESPIRATORY:

Had Respiratory arrest on
Allen Wd.
Being bagged on admission

PAIN/SEDATION

On admission

Maintaining own airway

Method

Size & length of tube

O2 Therapy

Method

Secretions

Specimen to lab.

:- Yes/No

:- Self/oral airway/ET tube/tracheostomy

:-
7

:- Yes/No

:- Facemask/headbox/ventilator/T-piece

:- Type & amount

:- Yes/No

On admission

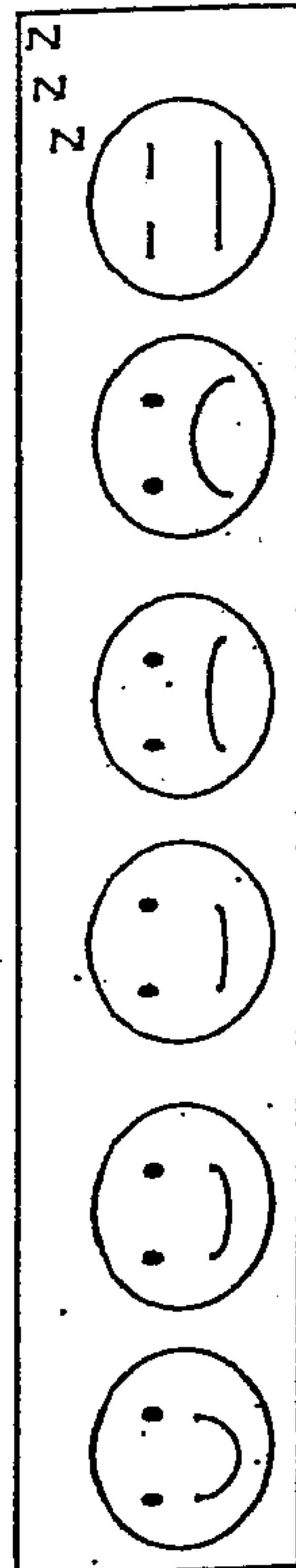
Pain relief

Mode

:- Yes/No Sedation/analgesia/paralysis

:- PCA/infusion/epidural/oral or rectal preparation/intermittent

Use pain scale if appropriate



CARDIOVASCULAR

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NEUROLOGY

GCS 3.

CR : PSNI

On admission

Colour/perfusion

Cardiac rate

Cardiac rhythm

Blood pressure

Drug therapy

Pacing wires insitu

Pacing box

:- Pallor/cyanosis/well perfused

:- Bradycardic/tachycardic/normal

:- Sinus rhythm/arrhythmia

:- Hypotensive/hypertensive/normal

:-

:- Yes/No

:- Sensing/pacing

On admission

CNS status

Coma scale

ICP monitor

:- Conscious/unconscious/irritable/drowsy

:-
3

:- Yes/No - Type

Temperature:- 37

Heart Rate:- 140

Respirations:- 18

Blood Pressure:-

89/51

Weight:- 25 kgs.

NUTRITION / HYDRATION

HYGIENE/MOBILITY/WOUND CARE

CR - PSNI

On admission

N11 By Mouth

Type of fluids insitu

B.M. Stix

Central line sites

Peripheral line sites

Arterial line site

Nasogastric tube insitu

Gastrostomy tube insitu

ELIMINATION

Urinary Catheter Size

07

On admission

Catheterised :- Yes/No

Urinalysis :-

Date of last bowel motion :-

Wound Drain :- Yes/No

P.D. Cannula :- Yes/No

Chest Drain :- Yes/No

Colostomy :- Yes/No

Ileostomy :- Yes/No

Site:-

Site:-

Day No:

Day No:

Midazolam infusion

:- 4

Day No:

:- Rt subclavian

Rt dorsol

Day No: 1

:- Yes/No

:- Yes/No

On admission

Skin intact

Sites of

(1) Wounds

(2) Skin Breaks/Pressure Sores

(3) Condition of Mouth

(4) Condition of Eyes

(5) Condition of Hair/Nails

Paralysed

Spontaneous Movements

Any Immobilising Injuries

/Fractures

Site/s

PSYCHOLOGICAL/SOCIAL/CULTURAL

hearing difficulties
Epileptic

On admission

Comforter

Toys

Religion

Baptised

CIRCUMSTANTIAL

NAME: Claire Roberts

HOSP. No. 328710

INTENSIVE CARE UNIT

Patient

DATE 22/10/96

52

SUMMARY: 9 1/2 yr old girl with recurring dyspnoea and Epilepsia admitted to Allen ward 32 hrs ago with ↓ level of consciousness due to ? aetiology. Had sudden respiratory arrest at 3.00 PM. CT scan showed severe swelling.

ASSESSMENT OF CONDITION/NEEDS

GOALS AND PLANNED CARE

(A) Respiratory (1) 2 3 4 5

No spontaneous respirations

Needs ventilatory support. 62% O₂.

BP 115 Pressure 10/3.

Secretion needed.

(1) 2 3 4 5

Case of ventilated patient

To maintain blood gases within normal limits.

Secretion 3-4 hrs.

(B) Cardiovascular

(1) 2 3 4 5

Hypertension

Dopamine infusion running

Transferring to

(1)

Requires dopamine to maintain blood pressure

Record BP, HR, temp.

(C) Pain/Sedation

(1) 2 3 4 5

NIL

(1)

Post-pain free

(D) Neurology

(1) 2 3 4 5

GCS 3

No response at all. Pupil size 7 and not

reacting to light.

(1)

Record CNS observations hourly

Report any signs of severe deterioration

(E) Nutrition/Hydration	1	(2)	3	4	5	1	(2)	3	4	5
N/S/G/W/O/R normal, I.V. fluids being, Record intake/output K/LC infection secondary to surgery										
(F) Elimination	1	(2)	3	4	5	1	(2)	3	4	5
Bowel normal, well, Catheterized, Sigmoidectomy 11 Pro										
(G) Hygiene/Mobility/ Wound Care	1	(2)	3	4	5	1	(2)	3	4	5
All care given, Skin intact 11 Pro										
CR - PSNI										
II PSYCHOLOGICAL AND SOCIAL/CULTURAL	1	2	3	4	5	1	2	3	4	5
Family present										
III CIRCUMSTANTIAL										

23/10/96

Chana Roberts

MORNING:

(A) Ventilation changes as per chart. Secretions increased and minimal.

EVENING:

(A) Ventilation as per chart. 2pm - 6pm.

NIGHT:

(B) B/P at 6am 120/80 mmHg given further 100mls B/P 120/80 mmHg. Temperature 37.5 on heady blanket.

(B) B/P at 2pm. 150/80 mmHg given. Temperature 37.5 on heady blanket.

(C) Rousers from 1pm.

(C) no change

(D) GCS 3. No response to light. Pupils 7 not reacting to light.

(D) no change.

(E) I.V. fluid as per chart.

(E) fluids changed to 5% SALINE

(F) Urine output commenced. One 200ml urine. No blood.

(F) Urine output decreased.

(G) All care given.

(G) All care given.

SIGNATURE:

CP1 FORMS

SIGNATURE: P. Walker

SIGNATURE:

MORNING:

EVENING:

2pm - 6pm

NIGHT:

111 Prisoners taken out
deceased 6:15pm

Don't anticipate raised
feels in area - concrete agreed

SIGNATURE:

CP1 FORMS

SIGNATURE:

SIGNATURE:

Clean Records

MORNING:

EVENING:

NIGHT: 2/10/2008

Admitted from A&E at 3am
following respiratory arrest.
Intubated and ventilated.
Went to CT Scan which showed
diffuse swelling. Brain stem
not visible.
1 for organ donation.

SIGNATURE:

SIGNATURE:

SIGNATURE:

SIGNATURE:

HOSP. NO. 328770

D.O.B. 10-01-87

[illegible]

NEXT OF KIN / THOSE LIKELY TO VISIT:-

DATE	RELATIVE SEEN	COUNSELLOR	EXPLANATION	EVALUATION
22/10/19	Parents	Dr Sreeni DR WEBB	Explained that Chloe had trouble with her breathing and needed to have ventilatory support now.	Explained to parents that babies brain had swollen and that CT scan and brain stayed flat. showed babies brain had died.
	Parents	Dr Sreeni DR WEBB	Following CT Scan Dr Sreen and Dr Webb explained that Chloe had swelling of the brain and could possibly be brain dead.	Only the ventilator keeping her heart beating. Parents were distressed but understood the explanation. As baby her brain had swollen, was explained, was probably caused by car

REGULAR PRESCRIPTIONS — DRUG RECORDING SHEET

OTHER TIMES

0100 hrs

0200 hrs

0300 hrs

0400 hrs

0500 hrs

0600 hrs

0700 hrs

0800 hrs

0900 hrs

1000 hrs

1100 hrs

1200 hrs

1300 hrs

1400 hrs

1500 hrs

1600 hrs

1700 hrs

1800 hrs

1900 hrs

2000 hrs

2100 hrs

2200 hrs

2300 hrs

2400 hrs

meds

meds

102

INTENSIVE CARE UNIT

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

WD/ ~~IR~~ *IR* CONSULTANT

ONCE ONLY DRUGS

[illegible]

Roberts Charles

[illegible][illegible]

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

(Consent forms to be affixed to back of sheet)

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

12		
11		
10		
9		
8		

CH 328770

Page: 92

CHILDREN'S HOSPITAL
Neurology
Allen, Prof, IV.
FALLS ROAD
BELFAST

(1759)

Surname ROBERTS
Forename CLAIRE
Age/DOB 39 10/01/57 Sex F
Hosp.No. 228770 -328770
Specimen CSF

C.S.F. CULTURE..... NO GROWTH IN 48 HOURS

* FOR FURTHER INFORMATION, IF REQUIRED...Phone 4150

Page 1 of 1

CH 328770

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CHILDREN'S
Allen Ward

FALLS ROAD
BELFAST

(4827)

Surname ROBERTS
Forename CLAIRE
Age/DOB 09 10/01/87 Sex F
Hosp.No. 328770
Specimen BLOOD

BLOOD CULTURE..... NO GROWTH IN 7 DAYS

M.

* FOR FURTHER INFORMATION, IF REQUIRED... Phone 4150 Page 1 of 1

CH 328770

Page: 94

CHILDREN

Allen, Mary

FALLS ROAD
BELFAST

(3396)

Forename CLATRE

Age/008 09 10/01/87 Sex F

Map. No. 829770

Specimen URINE (Direct)

UP THE MICROSCOPY.

Neutrophils	per ul.	Present (occasional)
Erythrocytes	per ul.	Nil
Epithelial cells	per ul.	Present (occasional)
Casts	per ul.	Nil
Crystals		Nil
Organisms		Nil
.....		Nil

* FOR FURTHER INFORMATION, IS REQUIRED

CHILDREN'S HOSPITAL
Neurology
Allen, Prof, IV.
FALLS ROAD
BELFAST

(3396)

Surname ROBERTS ICU
Forename CLAIRE
Age/DOB 09 10/01/87 Sex F
Hosp No. 329770
Specimen CSF

Idren

CEREBRO-SPINAL FLUID ANALYSIS.

Appearance.....	Bloodstained
Supernatant.....	Straw coloured.
Protein (g/l).....	95.0
(Normal range.....	0.15-0.45)
Globulin.....	Present(+++)
Erythrocytes (cells/uI).....	300000
Leucocytes (cells/uI).....	4000
Cytology.....	Mostly Lymphocytes

CLIVE

* FOR FURTHER INFORMATION, IF REQUIRED, Phone 4150 Page 1 of 1

Authorised by: PVC

REGIONAL VIRUS LABORATORY

Telephone Direct 894628 or 240503 Ext 2662 / 2712

Fax No 439181
LAB No 3829396

Authorised by: PVC
REGIONAL VIRUS LABORATORY

Telephone Direct 894628 or 240503 Ext 2662 / 2712

Fax No 439181
LAB No 3829396

ROBERTS

DATE OF BIRTH 10.01.87 Sex F

Royal Belfast Hospital For Sick Childr
180 Falls Road
Belfast

ADDRESS
WARD ALLEN WARD
HOSPITAL CH
HOSP NO 328770

PATII
ADDRI
WARD
HOSP
HOSP

IgM

MUMPS Negative
MEASLES Negative
HERPES SIMPLEX Negative
HERPES ZOSTER Negative
CMV Negative

No significant antibody detected.

No si

REPORT DATE
30-Oct-1996

SPECIMEN
Serum

31811

SPECIMEN DATE 21.10.96
RECEIVED 22.10.96

Authorised by: PVC

Telephone Direct 894628 or 240503 Ext 2662 / 2712

Fax No 439181

LAB No 3829396

REPORT
31-Oct

REGIONAL VIRUS LABORATORY

Authorised by: PVC

Telephone Direct 894628 or 240503 Ext 2662 / 2712

Fax No 439181

LAB No 3829396

REGIONAL VIRUS LABORATORY

CHILDREN'S HOSPITAL
Allen Ward

PATII
ADDRI
WARD
HOSP1
HOSP

FALLS ROAD
BELFAST
(1719)

Surname ROBERTS
Forename CLAIRE
Age/DOB 09 10/01/87 Sex F
Hosp.No. 328770
Specimen URINE(M.S.S.U.),

URINE CULTURE..... NO SIGNIFICANT GROWTH
..... < 10,000 orgs/ml

No si

REPORT
31-Oct

* FOR FURTHER INFORMATION, IF REQUIRED, Phone 4150

Page 1 of 1

REGIONAL VIRUS LABORATORY

Telephone Direct 394628 or 240503 Ext. 2662/2712

Fax No. 439181
LAB No. 3829398

Apply

all

M

PATIENT Claire Roberts
ADDRESS
WARD ALLEN WARD
HOSPITAL CH
HOSP NO 328770

DATE OF BIRTH 10.01.87 Sex F

Royal Belfast Hospital For Sick Children
180 Falls Road
Belfast

ADENOVIRUS	21.10.96		21.10.96
Q FEVER	(40	MYCOPLASMA PNEUMONIAE	(40
PLGV	(40	INFLUENZA A VIRUS	(40
	(40	INFLUENZA B VIRUS	(40

No significant antibody detected.

REPORT DATE
31-Oct-1996

SPECIMEN
Serum 31811

SPECIMEN DATE 21.10.96
RECEIVED 22.10.96

Authorised by:- PVC
REGIONAL VIRUS LABORATORY

Telephone Direct 894628 or 240503 Ext 2662 / 2712

Fax No 439181
LAB No 3829396

R.B.H.S.C.
ALLEN WARD

R.E
IN

DR ML

	SERUM	VALUE
GST	Sodium	= 132* mmol/l
	Potassium	= 3.8 mmol/l
E	Chloride	= 96* mmol/l
So	Urea	= 4.5 mmol/l
Pc	Creatinine	= 36* umol/l
Ch	Glucose	= 6.6 mmol/l
Ur		
Cr		
Se		

Date of Specimen 21\10\96
Lab.No. 19924
Date of Report 22\10\96

No Lin 20553
Report 23\10\96

10/96 ANIL EPILEPTIC PHENYTOIN

Date of Specimen
Lab.No. 20996
Date of Report 24\10\96

Lab.No. 07068
Date of Report 22\09\87
Lab.No. 03627
Date of Report 15\09\87

Date of Specimen 07\09\87
Lab.No. 03621
Date of Report 14\09\87
Lab.No. 05817
Date of Report 10\09\87

Lab.No. 00437

Admission
Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F.
Hosp.No. 328770

ADULT RANGE
(135 TO 145)
(3.5 TO 5.0)
(98 TO 108)
(3.3 TO 8.6)
(40 TO 110)
(4.0 TO 8.0)

G.S.Nesbitt
R.V.H. BIOCHEMISTRY

G.S.Nesbitt
R.V.H. BIOCHEMISTRY

CLIN. CHEM. BCH

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

CR - PSNI

096-025-304

R.V.H. BIOCHEMISTRY

R.B.H.S.C.
INTENSIVE CARE UNIT

DR P.M.CREAN

Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F
Hosp.No. 328770

GSN

SERUM		VALUE	ADULT RANGE
Sodium	=	139 mmol/l	(135 TO 145)
Potassium	=	3.0* mmol/l	(3.5 TO 5.0)
Chloride	=	103 mmol/l	(98 TO 108)
Urea	=	3.4 mmol/l	(3.3 TO 8.8)
Creatinine	=	34* umol/l	(40 TO 110)
Ser.Osmolality	=	287 mmol/kg	(285 TO 290)

Date of Specimen 23\10\96
Lab.No. 20553
Date of Report 23\10\96

G.S.Nesbitt
R.V.H. BIOCHEMISTRY

23/10/96 ANTI EPILEPTIC PHENYTOIN

CLIN. CHEM. BCH

Date of Specimen
Lab.No. 20996
Date of Report 24\10\96

R.V.H. BIOCHEMISTRY

Lab.No. 07068
Date of Report 22\09\87
Lab.No. 03627
Date of Report 15\09\87

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

Date of Specimen 07\09\87
Lab.No. 03621
Date of Report 14\09\87
Lab.No. 05817
Date of Report 10\09\87
Lab.No. 00437
Date of Report 08\09\87

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

PICU

NAME : ROBERTS
SEX : F
D.o.B. : 10/1/87
HOSP NO. : VCH328770
HOSP/WARD : PICU
DOCTOR : DR MCKEL

CLAIRE

Date/Time Recd : 23/10/96 4:20
Date/Time Vcted : 23/10/96 4:38
Lab No.: 2387
Auth. : P.B.

ASSAY	RESULT	NORMAL RANGE
PHENYTOIN	19.2 mg/L	(10.0-20.0)

No time stated on form.*

23/10/96 ANTI EPILEPTIC PHENYTOIN

CLIN. CHEM. BCH

Date of Specimen

R.V.H. BIOCHEMISTRY

Lab.No. 20996

Date of Report 24/10/96

Lab.No. 07068

Date of Report 22/09/87

R.V.H. BIOCHEMISTRY

Lab.No. 03627

Date of Report 15/09/87

R.V.H. BIOCHEMISTRY

Date of Specimen 07/09/87

Lab.No. 03621

Date of Report 14/09/87

R.V.H. BIOCHEMISTRY

Lab.No. 05817

Date of Report 10/09/87

R.V.H. BIOCHEMISTRY

Lab.No. 00437

Date of Report 08/09/87

R.V.H. BIOCHEMISTRY

R.B.H.S.C.
INTENSIVE CARE UNIT

DR P.M.CREAN

ML

	VALUE
SERUM	
Sodium	= 152* mmol/l
Potassium	= 2.8* mmol/l
Urea	= 3.3 mmol/l
Calcium	= 2.69* mmol/l
Ser.Osmolality	= 313* mmol/kg

Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F
Hosp.No. 328770

ADULT RANGE

(135 TO 145)
(3.5 TO 5.0)
(3.3 TO 8.8)
(2.10 TO 2.57)
(285 TO 290)

Date of Specimen 23\10\96

Lab.No. 20996

Date of Report 24\10\96

Lab.No. 07068

Date of Report 22\09\87

Lab.No. 03627

Date of Report 15\09\87

Date of Specimen 07\09\87

Lab.No. 03621

Date of Report 14\09\87

Lab.No. 05817

Date of Report 10\09\87

Lab.No. 00437

Date of Report 08\09\87

G.S.Nesbitt
R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.B.H.S.C.
ALLEN WARD

R.
AL DR A HICKS

DF

Surname ROBERTS
Forename CLAIRE
Age/DOB 10/01/37 Sex F
Hosp.No. 328770

SERUM
Valproate

VALUE
74 mg/l

ADULT RANGE
(50 TO 100)

↑ to 2.75 MLS B.D. re 110mg B.D.
From 100mg B.D.

KAM.

Date of Specimen 18/09/87
Lab.No. 07068
Date of Report 22/09/87
Lab.No. 03627
Date of Report 15/09/87

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

Date of Specimen 07/09/87
Lab.No. 03621
Date of Report 14/09/87
Lab.No. 05817
Date of Report 10/09/87
Lab.No. 00437
Date of Report 08/09/87

R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY
R.V.H. BIOCHEMISTRY

R.B.H.S.C.
ALLEN WARD

DR A HICKS

Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F
Hosp.No. 328770

PLASMA AMINOACID PROFILE

PLASMA
Threonine 71↓ umol/L
Serine 128✓
Glutamine 653✓
Glycine 231↓
Alanine 274✓
Valine 211↑
Cystine 13↓
Methionine 20✓
Isoleucine 55↑
Leucine 127↑

PLASMA
Tyrosine 47↓ umol/L
Ph.alanine 81✓
Taurine ----
OH-Proline ----
Glut.Acid ----
Citrulline 30
Proline 145↓
Ornithine 105✓
Lysine 110↓
Histidine 96✓
Arginine 17↓

Date of Specimen 07\09\87
Lab.No. 03627
Date of Report 15\09\87

R.V.H. BIOCHEMISTRY

Date of Specimen 07\09\87
Lab.No. 03621

R.V.H. BIOCHEMISTRY

Date of Report 14\09\87
Lab.No. 05817

R.V.H. BIOCHEMISTRY

Date of Report 10\09\87

Lab.No. 00437

R.V.H. BIOCHEMISTRY

Date of Report 08\09\87

R.B.H.S.C.
ALLEN WARD

R
ADR A HICKS

R
A D

Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F
Hosp.No. 328770

URINE

****AMINOACID CHROMATOGRAPHY****

Normal aminoacid excretion.

****QUALITATIVE URINE ANALYSIS****

pH = 6.5
Protein = -ve
Ketoacids = -ve
Phenylketones = -ve
Reducing Subst. = -ve
Sulphur Compds. = -ve
Mucopolysaccs. = -ve

PL

Date of Specimen 07\09\87

Lab.No. 03621

Date of Report 14\09\87

Lab.No. 05817

Date of Report 10\09\87

Lab.No. 00437

Date of Report 08\09\87

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.B.H.S.C.
ALLEN WARD

R
A DR A HICKS

Surname ROBERTS
Forename CLAIRE
Age/DOB 10\01\87 Sex F
Hosp.No. 328770

106

BLOOD
S Blood Pyruvate = VALUE
Blood Lactate = 0.11 mmol/l
0.7 mmol/l

ADULT RANGE
(0.04 TO 0.08)
(0.33 TO 1.33)

Initial - QL

Date of Specimen 07\09\87
Lab.No. 05817
Date of Report 10\09\87
Lab.No. 00437
Date of Report 08\09\87

R.V.H. BIOCHEMISTRY

R.V.H. BIOCHEMISTRY

R.S.H.S.C.
ALLEN WARD

DR A HICKS

Surname ROBERTS
Forename CLAIRF
Age/DOB 10/01/37 Sex F
Hosp.No. 328770

SPEC. NOT SEPARATED K, PO4, GLUC, LDH INVALID, SV

SERUM	USUAL VALUES	SERUM	USUAL VALUES
Na	142 mmol/l (135-145)	T.Bil	2* umol/l (3-18)
K	---	Alk.P	28.2* U/l (35-120)
Cl	106 (98-108)	GGT	30 (7-46)
CO2	23 (22-30)	AST	44* (10-40)
T.Pr	64 g/l (55-80)	ALT	21 (10-45)
Alb	47* (30-45)	LDH	76 (120-400)
Gluc	---	CK	21 (30-140)
Urea	3.9 mmol/l (3.3-8.8)	Iron	6.7 umol/l (6.0-30.0)
Creat	25* umol/l (40-110)	TIBC	58.7 (45-72)
Urate	0.18 mmol/l (0.15-0.50)	%Satn	10* (20-55)
Chol	4.8 (3.3-7.0)	Ca	1.74* mmol/l (2.10-2.50)
		Phos	2.10* (0.80-1.55)

Date of Specimen 07/09/87
Lab.No. 00437
Date of Report 08/09/87

R.V.H. BIOCHEMISTRY

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL NO.

D.O.B.

ASTHMA PATIENTS RESPIRATION LABS HERE

(Consent forms to be affixed to back of sheet)

11		↑
10		↑
9		↑
8		↑
7		↑

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
ALLEN WARD
CONS.

NAME ROBERTS CLAIR
HOSP. NO CH 00326770
AGE/DOB 10.01.87 SEX F

100

TEST	RESULT	UNITS	REF. RANGE
HAEMOGLOBIN	10.4	g/dl	12-13
ERYTHROCYTES	3.75	MILLIONS/UL	4.0 - 6.5
P.C.V.	.311		0.36-0.54
M.C.V.	82.7	FL	30-99
M.C.H.	33.4	g/dl	30-36
M.C.H.	27.7	pg	27-33
LEUCOCYTES	16.5	THOUSANDS/UL	4-11
PLATELETS	422	THOUS./UL	150-500

M.

LAB. ACC. NO. 022
DATE OF SPECIMEN 21/10/87
DATE OF REPORT 22/10/87

DATE OF REPORT 23 10 88

VERIFIED BY ALAN KEARNEY

CR - PSNI

096-025-313

Date of Report

Report signed by

JB-C9499

121

WMA 317

HAEMATOLOGY

upwards

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
WARD - INTENSIVE CARE UNIT
CONS - MCKE

NAME ROBERTS CLAIR
HOSP NO 00328770
AGE / DOB 6 SEX F

109

ABO GROUP A
RH(D) GROUP POSITIVE
DIRECT COOMBS NEGATIVE

NO ERYTHROCYTIC ANTIBODIES DETECTED

DATE OF BIRTH NOT GIVEN

LAB ACC NO 96/018630
DATE OF SAMPLE 23 10 96
DATE OF REPORT 23 10 96

BLOOD BANK
DEPARTMENT OF HAEMATOLOGY
VERIFIED BY ALAN KEARNEY

[REDACTED]

[REDACTED]

Date of Report 8/9		Report signed by		HAEMATOLOGY	
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150

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
INTENSIVE CARE UNIT
CONS.

R
I
C:

NAME ROBERTS
HOSP. NO CH 00323770
AGE/DOB 10.01.57

CLAIRE

SEX F

110

TEST	RESULT	UNITS	REF. RANGE
HAEMOGLOBIN	10.5	G/DL	12-18
ERYTHROCYTES	3.86	MILLIONS/UL	4.0 - 6.5
P.C.V.	.307		0.36-0.54
T M.C.V.	79.5	FL	80-99
H M.C.H.C.	34.2	G/DL	30-38
E M.C.H	27.2	PG	27-33
P LEUCOCYTES	5.54	THOUSANDS/UL	4-11
M PLATELETS	389	THOUS./UL	150-500
M			
M			
L			
P!			

C+

8

Supplied by: [REDACTED]

Date of Report: 8/9 Report signed by: [REDACTED] WMA 317

HAEMATOLOGY

150

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
INTENSIVE CARE UNIT
CONS.

NAME ROBERTS
HOSP. NO CH 00323770
AGE/DOB 10.01.87 SEX F

CLAIRE

TEST	RESULT	UNITS	REF. RANGE
HAEMOGLOBIN	10.2	g/dl	12-18
ERYTHROCYTES	3.66	MILLIONS/UL	4.0 - 6.5
P.C.V.	.293		0.36-0.54
M.C.V.	80.1	fl	90-99
M.C.H.C.	34.8	g/dl	30-38
M.C.H	27.9	pg	27-33
LEUCOCYTES	7.35	THOUSANDS/UL	4-11
PLATELETS	406	THOUS./UL	150-500

2/10

8/9

Date of Report		Report signed by		HAEMATOLOGY	
8/9					

150

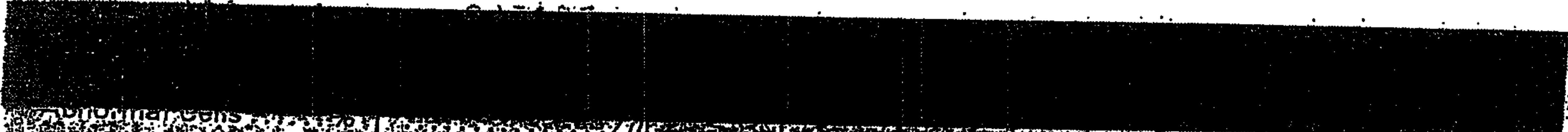
ROYAL VICTORIA HOSPITAL
INTENSIVE CARE UNIT
CONS.

NAME ROBERTS
HOSP. NO CH. 00328770
AGE/DOB 10.01.87 SEX F

CLAIRE 112

TEST	RESULT	UNITS	REF. RANGE
HAEMOGLOBIN	12.7	g/dL	12-13
ERYTHROCYTES	4.58	MILLIONS/UL	4.0 - 5.5
P.C.V.	.364		0.36-0.54
M.C.V.	79.5	fL	80-90
M.C.H.C.	34.9	g/dL	30-35
M.C.H	27.7	pg	27-33
LEUCOCYTES	5.70	THOUSANDS/UL	4-11
PLATELETS	477	THOUS./UL	150-500

[Handwritten signature]



Date of Report	8/9	Report signed by	<i>[Signature]</i>	JB-09499	WMA 317
HAEMATOLOGY					

9150

CH 328770

Page: 113

HAEMATOLOGY			
LAB. No. 019585	R.V.H. C.S.H. R.B.H.S.C. R.M.H. Please Indicate	Haypark Throne Dental Other ...	MR. MRS MIS
Department of Haematology R.V.H. Belfast BT12 6BA		[REDACTED] 15/01/87 NUMBER	
		BIRTH	

Haemoglobin	10.6 g/dl	(12 — 18)
Erythrocytes	4.13 millions/ul	(4.0 — 6.5)
P.C.V.	0.32	(0.36 — 0.54)
M.C.V.	fl	(84 — 99)
M.C.H.C.	g/dl	(30 — 35)
M.C.H.	pg	(27 — 32)
E.S.R.	mm/h	
Reticulocytes	%	
Platelets	/ul	
Leucocytes	13.0 thousands /ul	(4 — 11)
Differential Count		
Neutrophils	%	/ul
Eosinophils	%	/ul
Basophils	%	/ul
Lymphocytes	%	/ul
Monocytes	%	/ul
Abnormal Cells	%	/ul

Date Specimen Received	Remarks:— FBP PL

JB-C9499	WMA 317
----------	---------

Date of Report

8/9

Report signed by

HAEMATOLOGY

CR - PSNI

096-025-318

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

↑ ↑ ↑ ↑ ↑ ↑ ↑

bottom upwards

SURNAME	ROBERTS
FORENAME(S)	CLAIRE
CASENOTE	CH 328770
D.O.B./SEX	10-JAN-87 FEMALE
DATE TYPED	23-OCT-96 MG

096-025-319

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

FOR THE USE OF THE RADIOLOGIST
 ONLY - DO NOT WRITE IN THESE SPACES
 THE RADIOLOGIST'S REPORT SHOULD BE WRITTEN IN THESE SPACES
 THE RADIOLOGIST'S SIGNATURE SHOULD BE WRITTEN IN THESE SPACES
 THE RADIOLOGIST'S DATE SHOULD BE WRITTEN IN THESE SPACES

DR MI MCMILLAN
 DR HL SLECH

DR MI MCMILLAN
 DR HL SLECH
 CASENOTE CH 328770

Intensive Care Unit
 DR P. CREAN
 DR MI MCMILLAN

SURNAME ROBERTS
 FORENAME(S) CLAIRE
 CASENOTE CH 328770
 D.O.B./SEX 10-JAN-87 FEMALE
 DATE TYPED 23-OCT-96 SC

CHEST 23-OCT-96 07:15
 Diagnostic Code 60.212

(2 and 3) There is patchy consolidation in the mid and upper zones on both sides, slightly more extensive in examination 2. An ETT is in position with the tip at the thoracic inlet and in film 3 an IV line is present with the tip in the SVC.

CR - PSNI

P. S. ROBERTS RADIOLOGIST
 23-OCT-96
 CHEST

096-025-320

R.V.H. NEURO RADIOLOGY DEPT

STANDARDIZED AND TO THE 2700
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CH 328770

Page: 116

STANDARDIZED AND TO THE 2700
STANDARDIZED AND TO THE 2700

R.B.H.S.C.

HOSPITAL NO. : CH328770
D.O.B./SEX : 10-Jan-87 / FEMALE
DATE OF REPORT: 10-Sep-87

C.A.T. SCAN OF SKULL 09-Sep-87

Diagnostic Code 10.000

The ventricular system is normal in size, shape and position. No focal lesion is seen.

NN

EmH

COST OF EXAMINATION(S) £103.00

SURNAME

CHANCE ROBERTS

Date 24-6-88

Age

Test by

R. Langman

Right

Compensated Compliance

Basic Line

Box

Pressure da Pa

Pressure da Pa

NUMBER

0

F BIRTH

ORT

ORT

PORT

RT

Date of Recording

14.9.37

CR - PSNI

096-025-322

Interacoustics

Name: Claire Roberts

Address: _____

Notes: _____

Date: 7/12/87

Age: _____

Test by: E. H. G.

13

14

E

Left

Reflex

Compensated Compliance

Base Line ml

2.5

2

1.5

1

0.5

0

Pressure da Pa

-300 -200 -100 0 100 +200

Right

Reflex

Compensated Compliance

Pressure da Pa

-300 -200 -100 0 100 +200

Date: 14.9.87

E. H. G. REPORT

CR - PSNI

096-025-323

1985

Name	Claire Roberts	
Address		
Notes	Date	8:11:88
	Age	1 yr.
	Test by	AMCN
Balance		
	Best	25

Right
Compensated Compliance

100-100000

25 mi
Lm

Compensated Compliance

1911

15

Right
Compensated Compliance

100-100000

25 mi
Lm

Compensated Compliance

1911

15

TE OF BIRTH

months).
Patients
ve,
matter
effect

REPORT

14.9.37

Report signed by

096-025-324

(Consent forms to be affixed to back of sheet)		D.O.B.
		AFFIX PATIENT'S IDENTIFICATION LABEL HERE
14		
13		

E. E. G. DEPT.		AFFIX LABEL HERE OR ENTER:—		
Royal Victoria Hospital, Belfast, 12	Form No. M232 RS268	MR. MRS. MISS	FULL NAME Claire Roberts	HOSPITAL NUMBER 328770
E.E.G. No. 6803		CONSULTANT		WARD/CLINIC
REPORT				DATE OF BIRTH

Remarks

The patient was — alert, drowsy, semi-conscious, unconscious, unco-operative.

Conclusion: The record is outside normal limits for age (8 mths). No well-defined components of sleep were seen during the patients somnolent periods, and one poorly formed episode of spike-wave, complexes was associated with a left-sided body jerk. The latter is of doubtful significance, due to associated movement, artefact and the likelihood of 'K' complexes arising during this period of sleep/drowsiness. Further EEG investigation may be useful.

120

WMQ 320

Date of Recording 10.9.87	Report signed by	E. E. G. REPORT
Date of Recording 10.9.87	Report signed by	E. E. G. REPORT
Date of Recording 14.9.87	Report signed by	E. E. G. REPORT
Date of Recording 14.9.87	Report signed by	E. E. G. REPORT

133

E. E. G. DEPT.		AFFIX LABEL HERE OR ENTER:—		
Royal Victoria Hospital, Belfast, 12	Form No. M232 RS268	MR. MRS. MISS	FULL NAME Claire Roberts	HOSPITAL NUMBER 328770
E.E.G. No. 6509		CONSULTANT Dr Hicks		WARD/CLINIC Allen
REPORT				DATE OF BIRTH 10.1.87

Remarks

The patient was — alert, drowsy, semi-conscious, unconscious, unco-operative.

The baby drifted between drowsiness and sleep for most of the recording. During the more alert periods a rhythmic pattern of mixed frequencies at 3-7Hz of amplitude 30-70uv was recorded fairly symmetrically. When the patient was drowsy the voltage of the dominant activity increased to 50-250uv, the pattern showed hypersynchronous qualities. Slightly deeper sleep was achieved and the background frequencies gave way to arrhythmic waves at 3-6Hz. At this stage the patient had a left-sided body jerk, this was accompanied by a high voltage burst of indefinite spikes and slow waves. Further, less well developed complexes occurred without clinical signs. No consistent focus noted.

WMQ 320

Date of Recording 10.9.87	Report signed by	E. E. G. REPORT
Date of Recording 14.9.87	Report signed by	E. E. G. REPORT
Date of Recording 14.9.87	Report signed by 134	E. E. G. REPORT

CR - PSNI

096-025-326

E. E. G. DEPT.

AFFIX LABEL HERE OR ENTER:—

Royal Victoria Hospital,
Belfast, 12

Form No. M232
RS268

MR.
MRS.
MISS

FULL NAME
Claire Roberts

HOSPITAL NUMBER
328770

E.E.G. No. 6303A

CONSULTANT

WARD/CLINIC

DATE OF BIRTH

REPORT

Claire Robert

10.1.87

Remarks

The patient was — alert, drowsy, semi-conscious, unconscious, unco-operative. ** Sleeping.*

Conclusion:- the record is outside normal limits for age (8 mths) and level of consciousness, due to the questionable morphology of a few components of the sleep pattern.

Conclusion

WMQ 320

Date of Recording
14.9.87

Report signed by

E. E. G. REPORT

Date of Recording

14.9.87

Report signed by

135

E. E. G. REPORT

CR - PSNI

096-025-327

E. E. G. DEPT.		AFFIX LABEL HERE OR ENTER:—		
Royal Victoria Hospital, Belfast, 12	Form No. M232 RS268	MR. MRS. MISS	FULL NAME Claire Roberts	HOSPITAL NUMBER 328770
E.E.G. No. 6303A		CONSULTANT <i>Dr. H. K. S.</i>		DATE OF BIRTH 10.1.87
REPORT		WARD/CLINIC <i>Allen Ward</i>		

Remarks

The patient was — alert, drowsy, semi-conscious, unconscious, unco-operative. *sleeping.*

At the outset of the recording the baby was drowsy and very rhythmic, high voltage activity at 4-6Hz was recorded symmetrically. When the child was sleeping lightly the dominant rhythm dropped in voltage and became less well organised. Bursts of irregular, slow components at 2-3Hz stood out from the background pattern with voltages up to 250uv and forming phase reversals in the region of the vertex; they arose spontaneously and following sound stimulus in the manner of 'K' complexes. A few irregular runs of fast components at 14-18Hz were noted in the central regions and once they occurred in a very brief generalised episode with marked attenuation of voltage. No consistent localising signs or epileptiform discharges noted.

WMQ 320

Date of Recording

14.9.37

Report signed by

136

E. E. G. REPORT

CR - PSNI

096-025-328

CHILDREN'S HOSPITAL
Allen ward

FALLS ROAD
BELFAST

Surname ROBERTS
Forename CLAIRE
Age/DOB 35W 10/01/87 Sex F
Hosp. No. 328770
Specimen CSF

CEREBRO-SPINAL FLUID. CULTURE. NO GROWTH IN 48 HOURS

Date of specimen 12/09/87

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Page 1 of 1

CR - PSNI

096-025-329

CHILDREN'S HOSPITAL
Allen Ward

FALLS ROAD
BELFAST

Surname ROBERTS

Forename CLAIRE

Age/DOB 08M

Sex F

Hosp.No. C328770

Specimen SWAB

SPOTS OF RASH

CULTURE.....

NO SIGNIFICANT GROWTH

Date of specimen 12/09/87

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Page 1 of 1

CR - PSNI

096-025-330

CHILDREN'S HOSPITAL
Allen Ward

FALLS ROAD
BELFAST

Surname ROBERTS
Forename CLAIRE
Age/DOB 35W 10/01/87 Sex F
Hosp. No. 328770
Specimen CSF

CEREBRO-SPINAL FLUID. CULTURE. NO GROWTH IN 48 HOURS

126

Date of Specimen 12/09/87

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Page 1 of 1

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096-025-331

CHILDREN'S HOSPITAL
Ward

WALLS ROAD
BIRMINGHAM

Surname ROBERTS
Forename CLAIRE
Age/DOB 35W 10/01/87 Sex F
Hosp. No. 328770
Specimen CSF

CEREBRO-SPINAL FLUID ANALYSIS.

Appearance.....	Faintly bloodstained
Supernatant.....	
Protein (g/l).....	0.42
	(Normal range. 0.15-0.45)
Globulin.....	+
Erythrocytes (cells/ul)...	1140
Leucocytes (cells/ul)...	<1
Cytology.....	

12X

PL

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Date of Specimen 12/09/87.

Page 1 of 1

CR - PSNI

096-025-332

REF: 1070

CHILDREN'S HOSPITAL
1000 Broadway
BOSTON, MA 02115

Surname ROBERTS
Forename CLAIRE
Age/DOB 35W 10/01/87 Sex F
Hosp. No. 328770
Specimen CSF

CEREBRO-SPINAL FLUID ANALYSIS.

Appearance..... Bloodstained
Supernatant.....
Protein (g/l)..... 1.7
(Normal range, 0.15-0.45)
Globulin..... Nil
Erythrocytes (cells/ul)... 8400
Leucocytes (cells/ul)... <1
Cytology.....

128

PL

CR - PSNI

Date of Specimen 12/09/87

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Page 1 of 1

006-025-333

[illegible]

Number

328-0

Name of Patient

Claire Roberts

REGULAR PRESCRIPTIONS — DRUG RECORDING SHEET

	6 a.m.	8.30 a.m.	12 noon	12.30 p.m.	5.30 p.m.	6 p.m.	9.30 p.m.	12 mn.	Other Times
1		H 10			H 10				
2		H 10			H 10				
3		H 10			H 10				
4		H 10			H 10				
5		H 10			H 10				
6		H 10			H 10				
7		H 10			H 10				
8		H 10			H 10				
9		H 10			H 10				
10		H 10			H 10				
11		H 10			H 10				
12		H 10			H 10				
13		H 10			H 10				
14		H 10			H 10				
15		H 10			H 10				
16		H 10			H 10				
17		H 10			H 10				
18		H 10			H 10				
19		H 10			H 10				
20		H 10			H 10				
21		H 10			H 10				
22		H 10			H 10				
23		H 10			H 10				
24		H 10			H 10				
25		H 10			H 10				
26		H 10			H 10				
27		H 10			H 10				
28		H 10			H 10				
29		H 10			H 10				
30		H 10			H 10				

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	Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration										Method and other Instructions	SIGNATURE	Discontinued	
				AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12	Other Times	Date			Init	
G	19/8/82	~~CARBAMAZEPINE~~	~~1.75mg~~														
H	7/9/82	CARBAMAZEPINE	35mg											0	Ph		
I	12/9/82	Sodium Valproate	100mg											0	Ph		
J	15/8/82	Carbamazepine	35mg											0	Ph		
K																	
L																	
M																	
N																	
O																	
P																	
Q																	
R																	
S																	
T																	
U																	

REGULAR PRESCRIPTIONS

DRUG SENSITIVITY

	Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration										Method and other Instructions	SIGNATURE	Discontinued	
				AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12	Other Times	Date			Initials	
V																	
W																	
X																	
Y																	
Z																	

DIET

TAKE HOME DRUGS INDICATE BY LETTER

Date	Details	Initials

Ward	Name of Patient	Age	Hospital Number	Consultant
Allen	Claire Roberts	144	328770	Dr. Hicks

20
20

Fluid Balance and I.V. Prescription Sheet.

Weight.....24.1.....Kg

Hosp. No.

328770

Robert

CR - PSNI

134 Name..... Date...../...../..... Hosp. No..... Wt. 24 Kgs. 10 40 16 20 4 4

INTRAVENOUS FLUID PRESCRIPTION CHART

	AMOUNT (mls)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	RATE mls/hr	TIME		Prescribed by	ERECTED BY
					Start	Finish		
1	500 ml	0.18% NaCl 4% Dextrose	/	64 ml/hr			Popell	
2								
3								
4								
5								
6								

PARENTERAL NUTRITION PRESCRIPTION CHART

TOTAL VOL. Per.....Hrs. mls. mls/kg		TOTAL ENERGY kcal kcal/kg	
PROTEIN Vol. Cals.		DEXTROSE Conc. Vol. Cals.	
		FAT Conc. Vol. Cals.	

Amino Acids (grams)	Nitrogen (grams)	Nitrogen/Cal Ratio	CHO (grams)	Other Additives
Fat (grams)	NaCl mmols	Na Lactate mmols	K+ mmols	
Cl- mmols	Ca++ mmols	Mg++ mmols	PO ₄ = mmols	
Addamel (mls)	Solvito (mls) 147	Vitlipid (mls)	Critical Ag. Conc.	

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
Fluid Balance and I.V. Prescription Sheet

Date 22/10/96
Weight 24.1 Kg

Name
Clarke
Roberts

D.O.B.
10/1/87

Hosp. No.
328770

IV Site

TIME (hr)	INTAKE						OUTPUT			
	INTRAVENOUS				ORAL		Urine	Aspirate or Vomit	Stool	Comment
	1 Level	Amount	2 Level	Amount	Fluid	Amount				
08.00	No 1	68								8 fluid
09.00		110								8 fluid
10.00		179			cup of water					8 fluid
11.00		259					P.U. large - diarr			15 spence (ok)
12.00		308								8 fluid
13.00		350								8 fluid
14.00										
15.00		527								V.Pell
16.00		562								V.K.Taylor
17.00		616		0.8						V.Pell
18.00		677		2.7						V.Pell
19.00		769		5.5			P.U.			V.Pell
20.00		806		6.7						V.Pell
21.00		868		8.7	IV Acyclovir		P.U.			V.MCCo
22.00		943		10.9	60					① V.MCCo
23.00		1014		13.9	PHENYTOIN					② red
24.00		1037		16.8	110		small	mouth		① Rmphy
01.00		1037		19.3	170		small	mouth		② Rmphy
02.00		1070		21.5						③ V.MCCo
03.00										④ V.MCCo
04.00										⑤ V.MCCo
05.00										⑥ V.MCCo
06.00										⑦ V.MCCo
07.00										⑧ V.MCCo

Total Intake	Total Output		No. of Vomits		No. of Stools	
Intravenous.....ml	Urine	Aspir ⁿ				
Oral.....ml	ml	ml				
24 - Hour INTAKE	24 - Hour OUTPUT					
.....ml	148					ml

Name..... Date...../...../..... Hosp. No..... Wt.....Kgs.

INTRAVENOUS FLUID PRESCRIPTION CHART

	AMOUNT (mls)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	RATE mls/hr	TIME		Prescribed by	ERECTED BY
					Start	Finish		
1	500mls	No 8 Solu		64 mls/hr			<i>[Signature]</i>	
2	Solu.	N. SQUINE	+ 60mg MIDAZOLAM. ~~100mg~~	2mls/hr	0800	2400	<i>[Signature]</i>	<i>[Signature]</i>
3	500 mls	No 18 ~~100mls~~	20 mmol/Kcl.	60mls. ~~100mls~~			<i>[Signature]</i>	<i>[Signature]</i>
4								
5								
6								

PARENTERAL NUTRITION PRESCRIPTION CHART

TOTAL VOL. Per.....Hrs. mls. mls/kg		TOTAL ENERGY kcal kcal/kg	
ROTEIN Vol. Cals.		DEXTROSE Vol. Cals.	
FAT Vol. Cals.		FAT Vol. Cals.	

Amino Acids (grams)	Nitrogen (grams)	Nitrogen/Cal Ratio	CHO (grams)	Other Additives
Fat (grams)	NaCl mmols	Na Lactate mmols	K+ mmols	
Cl- mmols	Ca++ mmols	Mg++ mmols	PO ₄ = mmols	
Addamel (mls)	Solvito (mls)	Vitlipid (mls)	Critical Ag. Conc. 149	

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

DATE/TIME	EVALUATION	SIGNATURE	ADDITIONAL INFORMATION	SIGNATURE
9 ³⁰ pm	11.5W at 6.5ml/kg/hr. Cannulae needed at 10 ⁰⁰ afternoon	P. Miller		
	First dose of 1V Ayclopin erected by doctor and run over one hour.		tube inserted	
	Hypnoval infusion increased by 0.1ml every 5 minutes until running at 3mls/hr as prescribed by doctor - completed at 10.40 pm.		(R) hand	
11 pm	1V phenytoin erected by doctor and run over one hour - cardiac monitor in situ throughout infusion		Bloods - U+E	
	Due to U+E results No 18 solution with 20 mmols KCL erected as ordered by Registrar. To have fluid restriction of 4mls/hr.		phenytoin level.	McCauley
	Hourly CNS observations recorded - temperature elevated at 10 pm - paracetamol given (at 8.30 pm) by day staff			S/N.
	Other observations within normal limits.		Glaucoma scale 6.	McCauley
23/10/96 - 2am.	Slight tremor of right hand noted lasting few seconds. Breathing became laboured and grunting - respiratory rate 20 per minute			
	O ₂ saturations 97% - clauve stopped breathing			
PATIENT'S NAME	Blaine Roberts			

REG. No. 3 287770

096-025-343

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096-025-344

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

DATE/TIME	EVALUATION	SIGNATURE	ADDITIONAL INFORMATION	SIGNATURE
21/10/96 10pm	9 year old girl with H/O mental handicap and severe learning difficulties. Admitted via casualty with H/O vomiting this afternoon, slurred speech, drowsiness, pallor. ? seizure.		FBPV U+E ✓	SNQM Randal
	O/A to ward, child pale and lethargic. Apyrexia, observations within normal limits. Bloods taken, IV fluids S/N saline commenced at 6mls/hr. Two small bile-stained vomits following admission to ward.		Bx cultures ✓	
21	SLB Dr. and Registrar - to be reviewed following blood results and election of IV fluids.		Urine direct R? OTS R	
22/10/96 7am	Slept well. Much more alert and brighter this morning. One further bile-stained vomit. IV fluids continued as listed. No oral fluids taken. Apyrexia, observations satisfactory.	SNQM Randal		
8am-2pm	Slept for periods during early morning - bright when awake, no accommodation but arms active. Late morning coarse, became lethargic & "vacant". Parents concerned as Claire is usually very active. Spooning or Sando - braxos epileptiform - non fitting			
	Claire Roberts			

CR - PSNI

096-025-345

228770

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

DATE/TIME	EVALUATION	SIGNATURE	ADDITIONAL INFORMATION	SIGNATURE
22.10.96	Re-examined by Dr. P. R. G. + continued on CNS over 4000.			
2.20pm	PEARL BR 120/70 P 88 R 28 T 37.1°C			
2pm	Do not see by Dr. Webb + ? CI scan in progress. Sore by Dr. Webb - to have W phenytoin, 300mg			
2.30pm	Parents not in attendance.			
	Continued on very CNS over GCS 6-7: Stat dose EUPhenytoin at 2.45pm - to have B.D. 500mg Webb still status epilepticus given Stat F.V. Phenytoin at 3.25pm continuous infusion running at 2ml/hr of Phenytoin - to be 4 by 1ml/5mins until up to 3ml/hr. Dr. Webb up. Given stat dose epilepsy at 3.15pm. Very unresponsive - only to pain. Remains pale. Occasional episodes of beats clenching commenced on F.V. Phenytoin and F.V. acyclovir. 1st dose acyclovir given at 9.30pm. Parents in attendance		Die Phenytoin levels at 8pm. TD 23.4.	

PATIENT'S NAME

REG. No.

ROYAL LELFEST HOSPITAL FOR SICK CHILDREN

CH 329770
MISS CLAIRE ROBERTS

19/01/87
Female
375.944
44582
COVER TAYL

SEX: F

AGE 9¹⁰/12 D.O.B. 10/1/87

CONSULTANT Dr Steen

NAME KNOWN BY Claire

NEXT OF KIN (Relationship) Mother + father

NAME Alan + Jennifer Roberts

ADDRESS AS ABOVE

TEL NO. Day [REDACTED]

Night [REDACTED]

WHO ACCOMPANIED PATIENT Parents

WHO MAY CONSENT TO TREATMENT parents

SCHOOL/PLAYGROUP/NURSERY Toebank Special School
(Dundonald)

REASON FOR ADMISSION ? Seizure, vomiting

PARENTS/PERCEPTION OF ADMISSION Aware + Understand

DATE AND TIME OF ADMISSION 10/01/87 9.45pm

PREVIOUS ILLNESSES/HOSPITAL ADMISSIONS/CONTACT WITH INFECTIOUS DISEASES

PREVIOUS ILLNESSES Mental Handicap
Severe learning difficulties

Epilepsy (No seizures for past 3 years)

HOSPITAL ADMISSIONS

No hospital admission for approx 8 yrs
Admissions as baby + toddler with seizures

RECENT CONTACT WITH INFECTIOUS DISEASES

None known

IMMUNISATIONS RECEIVED

all to date

CURRENT MEDICATION

None

KNOWN ALLERGIES

None known

DENTURES (include crowns, plates) loose teeth

OTHER PROSTHESIS

DISCHARGE DETAILS
Dr McMillan, Campbell H/C

GP LETTER

YES/NO

O.P. APPOINTMENT

YES/NO

MEDICATION

YES/NO

COMMUNITY REFERRAL

HEALTH VISITOR

DISTRICT NURSE

SOCIAL WORKER

OTHERS

COMMUNICATING AND SPECIAL NEEDS	Severe hearing difficulty - does not attend special school. Able to speak, hear and see. Has some understanding and can answer some questions.	VITAL SIGN: T. 37.3°C P. 120 R. 24 B.P. 116/66 HT. 24.110 URINALYSIS CONDITION OF SKIN HAIR AND TEETH Skin, hair, teeth appear clean + intact
MAINTAINING A SAFE ENVIRONMENT	Parents maintain constant supervision. Sleeps with cot sides on bed.	
BREATHING AND CIRCULATION	Normally no problems.	
CONTROLLING BODY TEMPERATURE	Normally Apyretic.	
EATING AND DRINKING	Normal diet and fluids. Drinks from cup. Can feed herself with supervision. Vomiting today.	Drowsy + lethargic on admission. Ensure airway and circuit. Nurse beside O ₂ + suction. Nurse in bed with cot sides. Observations satisfactory on admission - check P + R + Sps 4 hourly. Apyretic. Check temp 4 hourly. Observe vomiting. Offer clear fluids as tolerated. Ensure safe administration of N fluids. Ensure skin is kept clean + dry. Change nappy per 4. Ensure supervision at all times. Moving all limbs. Provide warm, quiet, dark room conducive to sleep.
ELIMINATING	Wears a nappy at ~~nighttime~~ only.	
POSTURE AND MOVEMENT	Walks, runs, walks up and down stairs. Favours left side of body.	
REST AND SLEEP	Good sleeper. Sleeps all night. Bed approx 8-9pm → morning.	
PERSONAL HYGIENE	Mother attends to daily hygiene and dressing needs. Claire is unable to dress herself.	Ensure daily bath, hair care, oral hygiene and daily change of clothes. Involve school teacher + play therapist to provide activities suitable to age + development. Maintain dignity + privacy.
PLAY AND EDUCATION	Special needs. attends Special School.	
EXPRESSING SEXUALITY	As per 9'10" old girl.	
MEETING SPIRITUAL NEEDS	As per parents wishes.	
SOCIAL HISTORY	Lives at home with both parents + Brothers aged 11yrs + 13yrs.	SIGNATURE OF ACCOUNTABLE NURSE SN G. E. L. Dine M. R. D. 9:45 pm 21/10/96 DATE AND TIME

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RECORD OF ATTACKS OBSERVED

NAME: Clair Roberts U.N. _____ AGE: _____ WARD: CU

DATE	TIME	EXACT DESCRIPTION OF ATTACK	DURATION	STATE AFTERWARDS	INITIALS
22/10	3:10	Lasted frequently Strong Seizer at	5min	Sleepy	MUR
	3:25				
	4:30	teeth tightened slightly	few	asleep	
	15	teeth clenched + groaned	secs		
	7 p		1min	asleep	
	9pm	Episode of screaming and drawing up of arms. pulse rate ↑ 165 bpm. pupils large but reacting to light. Dr informed.	30secs	asleep	UNGA

NURSING CARE PLAN

DATE	PROBLEM	GOALS	NURSING ACTIONS	REVIEW DATE/SIG	DATE ACH
2/10/96 ①	Maintaining A Safe Environment Claire has a potential problem of further seizures.	Claire's safety will be maintained, during a convulsion and the characteristics of the convulsion will be recorded.	1. Nurse beside oxygen and suction. 2. If convulsion occurs do not restrain the child. 3. Remove harmful objects out of the vicinity during convulsions. 4. When convulsion subsides record temperature. <i>pulse + respirations</i> 5. Inform doctor of length and type of seizure. 6. Record type of seizure and duration. 7. Administer medication as prescribed by doctor, observing for desired effects / side effects. 8. Assist doctor with necessary investigations. 9. Report abnormalities to doctor/nurse in charge.	2/10/96 R/V Dailly SNGM Renda	
-					
01					
08					
PATIENT'S NAME..... Claire Roberts					

PATIENT'S NAME.....Claire Roberts.....

HOSE 228710

HOSPITAL NO:.....

NURSING CARE PLAN

[illegible]

PATIENT'S NAME

HOS.

HOSPITAL NO.

R.B.H.S.C. 17.

PNP94J184 WNC769

DIAGNOSIS OF BRAIN DEATH

PATIENT'S NAME Clare Roberts AGE 9 UNIT NO: 328770DOCTOR 1 Dr. D. Webb DOCTOR 2 Heather J. SteenDIAGNOSIS Cerebral Oedema.
(Condition leading to brainstem death)

	1st Test Date: 23-10-96 Time 0600 Dr 1 Dr 2		2nd Test Date: 23-10-96 Time: 18-25 Dr 1 Dr 2	
1. DRUGS/HYPOTHERMIA				
a. Have any muscle relaxants been given during the preceeding 12 hrs?	No	No	No	No.
b. Could any significant neuromuscular blockade remain?	No.	No	No.	No
c. Could other drugs affecting ventilation or level of consciousness been responsible for the patient's condition?	No.	No	No	No.
d. Is the rectal temperature below 35°C?	No.	No	No	No.
e. Is the blood pressure adequate and stable?	No	Yes	Yes	Yes.
f. Could patient's condition be due to a metabolic/endocrine disorder?	No.	No	No	No.
2. BRAINSTEM REFLEXES				
a. Do the pupils react to light?	No	No	No	No.
b. Is conjugate deviation of the eyes induced by instilling ice cold water on each eye (Caloric test)?	No	No.	No	No.
c. Is any eye movement present when head rotated (Doll's eye reflex)?	No	No.	No	No.
d. Does any response occur when each cornea in turn is touched?	No	No	No	No.
e. Is there any response to painful stimuli in the area supplied by the cranial nerves?	No	No	No	No.
f. Is there a gag reflex or reflex response following bronchial stimulation by a suction catheter passed down the trachea?	No	No	No	No.
3. APNOEA TEST				
a. Is there any evidence of spontaneous respiration?	No	No	No	No
b. Did PaCO ₂ rise above 50 mmHG during apnoea test?	Yes	Yes	Yes	Yes
c. Was there any evidence of spontaneous respiration during apnoeic period?	No	No	No	No

1st testing

2nd testing

SIGNED: Doctor 1 Dr. D. WebbDoctor 2 Heather J. SteenHeather J. SteenHas organ donation been considered? YesIs this a Coroner's case? No

GUIDELINES FOR MULTIPLE ORGAN RETRIEVAL

1. Blood should be sent to the Virology Laboratory RVH, for Hepatitis B, HIV and CMV antibody titres. If not already available the patient's blood group must be ascertained.
2. Perform first set of brain stem tests. After this speak to parents about the concept of organ donation. Give them approximate timing of second set of brain stem tests.
3. Inform UK Transplant Service (UKTS) in Bristol [REDACTED] about the potential organ donor. Information required - age, height, weight, abdominal girth, FBP, LFTs, U&E and creatinine.
4. If a kidney only donation is anticipated, page the on call Consultant Nephrologist, Belfast City Hospital [REDACTED] Have information regarding the use of inotropes, antibiotics and other drugs, blood gas analysis, blood pressure and urinary output.
5. Perform second set of brain stem tests. Ensure brain stem death form is completed.
6. Inform parents that a diagnosis of brain stem death has been made. Request consent for organ retrieval and specify which organs. ~~consent form should be signed by a parent plus two witnesses.~~
WRITE IN CHART THAT CONSENT HAS BEEN OBTAINED.
7. If relevant, phone the Coroner [REDACTED] to report the death and request his permission for organ retrieval. Phone UKTS and/or Renal Unit, BCH to confirm that organs have been made available for retrieval.
In the case of multiple organ retrieval UKTS should be given about four hours (depending on the time of day) by which time confirmation for organ retrieval should have been received. If no assurance for retrieval has been given by this time then the Renal Unit should be informed and a kidney only retrieval organised.
8. Communicate with the Operating Theatre Sister and give details of the scope of surgery and the estimated starting time. Please keep Theatre involved of any change in plans.
9. Should retrieval be repeatedly postponed the guiding principle should be that any retrieval be completed before the morning following the diagnosis of brain stem death. This allows a post mortem or funeral arrangements to proceed without any delay attributed to organ retrieval.

ALFALFAST HOSPITAL FOR SICK CHILDREN

CONSENT BY PARENT OR GUARDIAN

MARGARET JENNIFER ROBERTS of [REDACTED]
do hereby consent to the submission of CLARE MGT ROBERTS to the operation
CT SCAN, the nature and effect of which have been explained to me
by Mr. R. MACKIE

I also consent to such further or alternative operative measures as may be found necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.
Assurance has been given to me that the operation will be performed by a particular surgeon.

8-9-87

(Signed)

[Signature]

I certify that I have explained the nature and effect of this operation to the child's parent/guardian.

8-9-87

(Signed)

[Signature]

CONSENT BY PARENT OR GUARDIAN

_____ of _____
do hereby consent to the submission of _____ to the operation
_____, the nature and effect of which have been explained to me
by _____/Mr. _____

I also consent to such further or alternative operative measures as may be found necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.
Assurance has been given to me that the operation will be performed by a particular surgeon.

(Signed)

I certify that I have explained the nature and effect of this operation to the child's parent/guardian.

(Signed)

CONSENT BY PARENT OR GUARDIAN

_____ of _____
do hereby consent to the submission of _____ to the operation
_____, the nature and effect of which have been explained to me
by _____/Mr. _____

I also consent to such further or alternative operative measures as may be found necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.
Assurance has been given to me that the operation will be performed by a particular surgeon.

(Signed)

I certify that I have explained the nature and effect of this operation to the child's parent/guardian.

(Signed)

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