THE GILES DOCUMENT LABORATORY

Report of Dr Audrey Giles

In the matter of: Medical Notes

Instructions from: The Inquiry into Hyponatraemia Related Deaths *(Ref: AD-0617-13)*

Lab Ref: TC03913 **Date:** 13th September 2013

The Giles Document Laboratory Limited
[redacted]
T [redacted] F [redacted] DX [redacted] E agile[redacted] I www.gdll.co.uk
Registered in England No 04619071

INSTRUCTIONS

My instructions have been received from The Enquiry into Hyponatraemia Related Deaths.

I have been asked to examine Notes and Records relating to Claire Roberts. In particular, I have been asked to carry out what examinations are possible with a view to determining the timing of the entries *"/encephalitis/encephalopathy"* and "*4pm*" made in the Clinical Notes.

SUMMARY OF FINDINGS

1. I found no evidence of impressions of either of the entries *"/encephalitis/encephalopathy"* or "*4pm*" on any of the other cards bearing Medical Notes, the Prescription Cards, or the Folder. However, this seems to be in keeping with manner in which the Medical Notes appear to have been written.

2. There is positive, albeit weak, evidence to support the view that the questioned entry *"/encephalitis/encephalopathy"* was written using a pen different from that used by Dr Sands to make an entry timed at 5.15 pm on a Prescription Card. However, the Raman spectrum obtained from the questioned entry *"/encephalitis/encephalopathy"* is similar to that which can be obtained from an analysis of commonly available BIC ballpoint pens.

3. My findings are essentially inconclusive. I am unable to determine when the questioned entry *"/encephalitis/encephalopathy"* in the Medical Notes was made by Dr Sands, or the entry "*4pm*" was made by Dr Webb, either in absolute terms or in relation to other entries made by him on these documents.

QUALIFICATIONS, BACKGROUND AND EXPERIENCE

I am a Bachelor of Science and a Doctor of Philosophy. I was formerly the Head of the Questioned Documents Section of the Metropolitan Police Forensic Science Laboratory (Scotland Yard). With over thirty-six years' experience in all areas of the scientific examination of documents and handwriting, I now lead the scientific work of The Giles Document Laboratory.

Training and background

I trained in all aspects of Forensic Document Examination in the Questioned Documents Section of the Metropolitan Police Forensic Science Laboratory (MPFSL) in London, where I worked for thirteen years. In 1986 I was appointed Head of that Section supervising the work of twelve experienced scientists. In addition to carrying out my own casework, my responsibilities at that Laboratory included direction of research, Quality Assurance and the Training of Questioned Document Examiners. From 2002 – 2009 I was registered with the Council for the Registration of Forensic Practitioners and was a Speciality Assessor of candidates for registration.

The Giles Document Laboratory

In 1989 I left the MPFSL to set up my own independent Laboratory. The Giles Document Laboratory is equipped to the highest standards for Forensic Document Examination. The Laboratory has made specific investment to ensure that the most up-to-date equipment is available for all necessary examinations, including the latest in Video Spectral Comparators and Raman Spectrometry for ink examinations, electrostatic detection equipment (ESDA) for detecting impressions, etc. I have worked closely with manufacturers in the development of new equipment, software and techniques. The Laboratory also uses image capture software to provide demonstration material for reports and Courts. The Giles Document Laboratory is accredited to the internationally recognised Quality Standard, BS EN ISO 9001 : 2008.

Standing in the profession

I am an active member of the leading learned organisations in the field:

- The Forensic Science Society
- The American Society of Questioned Document Examiners
- The Gesellschaft für Forensische Schriftuntersuchung

I have attended meetings in the United Kingdom, Europe, the United States and South America, contributing papers on original research carried out at the Giles Document Laboratory. I chaired the Forensic Science Society Questioned Document Group Meetings in 1987, 1991 and 1998. In 1999 I was appointed Chair for the Questioned Documents discipline at the 15th Triennial Meeting of the International Association of Forensic Sciences in Los Angeles, USA.

I have contributed to scientific journals and forensic science text books and am a member of the Editorial Board of the Journal of the American Society of Questioned Document Examiners. I have been appointed as an external examiner by the University of Strathclyde and have appeared as a consultant expert on television and radio a number of times.

In 1992 I gave evidence to the House of Lords Select Committee on Science and Technology (Sub-committee on Forensic Science), and in 1994 participated in the development of National Vocational Qualifications in Questioned Document Examination and in the Working Group for the Registration Council for Forensic Practitioners (CRFP).

Casework and Court Attendance

I have provided independent expert advice to Claimants, Defendants and Prosecutors in thousands of cases, both in the United Kingdom and overseas.

- Disputed handwriting and signatures
- Inks
- Alterations to documents
- Latent impressions
- Photocopies
- Faxes
- Typewriting
- Products of modern office technology

I advise a wide range of clients:

- Banks
- Building Societies
- Financial Institutions
- Solicitors
- Companies
- Government Agencies
- Police
- Crown Prosecution Service

My experience is extensive in presenting expert evidence in British and international courts of law (including the International Court in The Hague) as well as Arbitration and Employment Tribunals. As an expert who deals with both civil and criminal cases, I have given evidence in the High Court, the Court of Appeal, the County Court, the Crown Court and Magistrates Courts. I have been trained in the role of Single Joint Expert and routinely act in this capacity.

DOCUMENTS EXAMINED

(Copies of the parts of these documents relevant to my examinations are attached to this report)

N°	*Description*	*Date*
[1]	Prescription Card	22 October 1996
[2]	Prescription Card – Re-written 9.30 pm	22 October 1996
[3.1 – 3.6]	Medical Notes	21 – 22 October 1996
[4]	Cardboard Folder	04 September 1987

THE DATING OF DOCUMENTS

The dating of documents is a difficult forensic science problem. There are no reliable techniques available which allow the absolute dating of ink on paper. Occasionally documents can be dated by association with other documents of known age by a study of latent marks and impressions which are not visible to the unaided eye.

Impressions of handwriting may be left on a document as a result of writing on another document which at the time of writing was overlying the first one. These impressions are rarely visible to the naked eye and need to be detected using specialised equipment and techniques.

I therefore examined the Prescription Cards [1 and 2], the Medical Notes [3.1 & 3.2 and 3.5 & 3.6], as well as the Notes [3.4] bearing the questioned entries, using the techniques of obliquely directed light and Electrostatic Detection (ESDA).

In addition, I used obliquely directed light to examine the Cardboard Folder [4] which is a document not amenable to examination using the ESDA technique.

Results

The results of my examinations are set out in the following table.

Table – *Examination of impressions*

Document	***Impressions found***
[1]	Impressions of encircled figures and *"spm"* from unknown sources
[2]	No significant impressions
[3.1]	*"ALLEN"* and *"Epilepsy severe"* – all from unknown sources
[3.2]	[redacted] *Removal of two staples Monday 28 October"* from unknown source
[3.4]	No significant impressions
[3.5]	No significant impressions
[3.6]	*"Claire Roberts"* and some faint fragmentary impressions all from unknown sources
[4]	Some isolated figures from unknown sources

There are few impressions on the Medical Notes [3]. Those impressions which I did find appear to have originated from other documents which I have not seen. Accordingly, there is no evidence that the Medical Notes [3] were made whilst the individual cards [3.1 & 3.2], [3.3 & 3.4] and [3.5 & 3.6] were lying one on top of another.

I found no evidence of impressions of the entries *"/encephalitis/encephalopathy"* or *"4pm"*, both of which appear on the Medical Notes [3.4], on any of the other documents.

EXAMINATION OF INKS AND PEN LINES

I examined the entry made by Dr Sands on the Prescription Card timed at 5.15pm [1] and the questioned entry *"/encephalitis/encephalopathy"* on the Medical Notes [3.4] using a Video Spectral Comparator. This instrument allows the ink of the writings to be viewed in infra-red light and also under conditions which cause fluorescence at different wavelengths. Using these techniques it is possible to examine features of the writings not visible to the unaided eye and to distinguish between inks which appear to be similar. I also examined these handwritten entries using a Raman Spectral Comparator which can be used to further distinguish between inks which appear similar.

I further examined the detail of these writings using low power stereomicroscopy.

Results

The entry made by Dr Sands on the Prescription Card [1] and the questioned entry *"/encephalitis/ encephalopathy"* are made in black ballpoint pen ink.

The ink of the questioned entry *"/encephalitis/encephalopathy"* [3.4] appears somewhat different from that of the writing on the Prescription Card [1] when viewed using the Video Spectral Comparator, and there are also differences in the Raman spectra obtained from these inks. The apparent differences in these inks are not easy to interpret and may have arisen, not as a result of different composition of ink being used, but because of the relative amount of dye in the ink being delivered from the pen to the paper in these writings. When viewed using low power microscopy the writings of the questioned entry *"encephalitis/encephalopathy"* do appear to contain somewhat less dye than the entries on the Prescription Card [1].

I have also noted that the Raman spectrum obtained for the questioned entry *"/encephalitis/ encephalopathy"* is similar to that of BIC ballpoint pen inks from my laboratory collection. The components of the Raman spectra obtained for the ink used for other writing made by Dr Sands on the Prescription Card [1] may be from this brand of ink but are less easily identifiable.

CONCLUSIONS

I have considered the following propositions with regard to each of the entries *"/encephalitis/ encephalopathy"* and "*4pm*" on the Medical Notes [3.4]:

1. That the entry was made at a similar time to the other medical notes on this page.

2. That the entry was made at a significantly later time.

In this Laboratory, in keeping with the practice of Forensic Science Laboratories around the world, conclusions are expressed on a qualitative scale describing the strength of the evidence. The main points on the scale are:

Positive		*Negative*
Conclusive evidence		Weak evidence
Very strong evidence	Inconclusive	Strong evidence
Strong evidence	evidence	Very strong evidence
Weak evidence		Conclusive evidence

The results of my examination of impressions on the documents provided for examination [1 – 4] is consistent with the Medical Notes having been made with each card placed separately on the writing surface, rather than with the cards placed one on top of another in a pile. Therefore, although there is no evidence of impressions of either of the questioned entries *"/encephalitis/encephalopathy"* and *"4pm"* [3.4] on any of the other cards bearing Medical Notes [3.1 & 3.2 and 3.5 & 3.6], the Prescription Cards [1 and 2] or the Folder [4], this would be in keeping with manner in which the other Medical Notes appear to have been written.

There is positive, albeit weak, evidence to support the view that the questioned entry *"/encephalitis/encephalopathy"* [3.4] was written using a pen different from that used for writings made by Dr Sands on the Prescription Card [1] . However, I have noted the Raman spectra obtained from the questioned entry *"/encephalitis/encephalopathy"* [3.4] is similar to that which can be obtained from an analysis of BIC ballpoint pens. Such ink is very common and several pens each containing ink of similar chemical composition, although differing in the amount of usage, may have been available during the period when the relevant Medical Notes were made by Dr Sands.

My findings are essentially inconclusive. I am unable to determine when the questioned entry *"/encephalitis/encephalopathy"* in the Medical Notes was made by Dr Sands, or the entry "*4pm*" was made by Dr Webb, either in absolute terms or in relation to other entries made by him on these documents.

DECLARATION

1. I understand that my overriding duty in written reports and giving oral evidence is to the Inquiry. I believe that I have complied with that duty.
2. I am aware of the requirements of Part 35 of the Civil Procedure Rules and Practice Direction, and the Protocol for Instruction of Experts to give Evidence in Civil Claims.
3. The report reflects my views as an independent expert.
4. I believe my report to be accurate and to cover the issues which I have been asked to address.
5. Where relevant I have included in my report any information of which I have knowledge, or of which I have been made aware, that might adversely affect the validity of my conclusions.
6. Where relevant I have indicated in my report any sources of information upon which I have relied.
7. I will notify those instructing me immediately, and confirm in writing, if for any reason my existing report requires any correction or qualification.
8. I understand that my report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under oath.
9. I understand that any cross-examination on my report may be assisted by an expert.
10. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
11. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signed: 

Date: 13th September 2013

DOCUMENTS EXAMINED

TC03913 [1]

ERN HEALTH & SOCIAL SERVICES BOARD
AL BELFAST HOSPITAL FOR SICK CHILDREN
ESCRIPTION SHEET

PARENTERAL DRUGS

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
[illegible]	PHENYTOIN	60mg		✓					✓			IV	[signature]		
[illegible]	MIDAZOLAM	2mcg/kg/minute (= [illegible])										via infusion	[signature]		
[illegible]	CEFOTAXIME	600mg		✓		✓	✓		✓			IV	[signature]		
[illegible]	ACYCLOVIR	240mg		✓		✓			✓			IV	[signature]		
[illegible]	[illegible]	5mg		✓		✓	✓		✓			IV	[signature]		
~~[illegible]~~	~~Sodium Valproate~~	~~2[illegible]mg/[illegible] [illegible] 12 hours~~										IV	[signature]	22/10	[initials]

DRUGS-ONCE ONLY PRESCRIPTIONS

Date Given	DRUG (Block letters please)	DOSE	Time of Admin.	Method of Admin.	SIGNATURE	Given by Initials
[illegible]	DIAZEPAM 5	8mg	12-15	PR	[signature]	[initials]
[illegible]	PHENYTOIN	[illegible] mg	[illegible].45pm	IV	[signature]	[initials]
[illegible]	MIDAZOLAM	100mg	3.25pm	IV	[signature]	
[illegible].96	SODIUM VALPROATE	400mg	5.15pm	IV	[signature]	[initials]

95E090 WNC767

REGULAR PRESCRIPTIONS

TC03913 [1]

Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration: AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12	Other Times	Method and other Instructions	SIGNATURE	Discontinued: Date	Initial
21/10	PARACETAMOL	240mg			4-6H							O/R			

REGULAR PRESCRIPTIONS

DRUG SENSITIVIT

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

DIET

Date	Details	Initials

TAKE HOME DRUGS
INDICATE BY LETTER

Ward	Name of Patient	Age	Hospital Number	Consultant
EN	CLAIRE ROBERTS	9/10/12	328770	DR Steen

ERN HEALTH & SOCIAL SERVICES BOARD
L BELFAST HOSPITAL FOR SICK CHILDREN
ESCRIPTION SHEET

PARENTERAL DRUGS

Re-written 930 pm - 22/10/96.

REGULAR PRESCRIPTIONS

DRUG SENSITIVITY

Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12	Other Times	Method and other Instructions	SIGNATURE	Discontinued Date	Initials
22/10	PHENYTOIN	60mg		✓					✓			IVI	[signature]		
22/10	MIDAZOLAM	2ml p/kg [illegible] to 3ml/hr every 5min										IVI	[signature]		
22/10	CEFOTAXIME	600mg		✓		✓	✓		✓			IV	[signature]		
22/10	ACYCLOVIR	240mg		✓		✓			✓			IVI	[signature]		
22/10	HEPSAL	5mls		✓		✓		✓	✓			IV	[signature]		

DRUGS-ONCE ONLY PRESCRIPTIONS

Date Given	DRUG (Block letters please)	DOSE	Time of Admin.	Method of Admin.	SIGNATURE	Given by Initials

95E090 WNC767

95E

REGULAR PRESCRIPTIONS

TC03913 [2]

Date Comm.	DRUG (Block letters please)	DOSE	Time of Administration: AM 6	AM 8.30	MD 12	PM 12.30	PM 5.30	PM 6	PM 9.30	MN 12	Other Times	Method and other Instructions	SIGNATURE	Discontinued: Date
22/10	PARACETAMOL	2 tabs				4-hourly PRN						O/PR		

REGULAR PRESCRIPTIONS

DRUG SENSITIVIT

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

DIET

ate	Details	Initials

TAKE HOME DRUGS
INDICATE BY LETTER

ard	Name of Patient	Age	Hospital Number	Consultant
EM	CLARE ROBERTS	9/10/12	328750	Dr Steen

CH.96AEC213536
CLAIRE ROBERTS
DOB 10-JAN-87
DATE
TIME
AE DEPT: RBHSC

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/10/96 8pm.	9 year old admitted via A+E
PC	Vomiting at 3pm and every hour since.
	Slurred speech + Drowsy
	Off form yesterday, Loose motions 3 days ago.
HPC	Severe learning difficulties
	Seizures 6mo – 1yr – Controlled by Na Valproate
	Age 4 – x1 seizure.
	Anticonvulsant gradually weaned until Epilim stopped.
H+S	Speech – [illegible] speech in sentences, meaningful.
	Hearing ✓
V	vision ✓
FM	scribbling – feed herself c̄ supervision.
	Cannot dress herself
Gross M	Walk, Run, UP + Down Stairs, Favours left side of body
	– Torbank Special school. Dundonald
	– Dr. Gaston [illegible], previously Dr Mayo
	Recently tried Ritalin – Dry mouth, then became agitated, Dry mouth
DH	nil FH 
All	nil

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
9/e	37° Cvs: I+II 80/min. RS: clear. Abd: soft. NBS. Vendor No mass. CNS: Fundii normal, Discs NOT blunned. PERLA. CNs VII – IX – X – MOS: Sit-up + Stairs / ataxia, ? Ataxic Power not assessed Tone: upper limb Cogwheel Rigidity ↑ Tone lower limb ↑ Tone ↑ Tone R L Reflexes BJ ++ + TJ ++ + SPJ ++ + KJ ++ ++ AJ + + P ↓ ↓ clons+ clons+ Sens – not responding to parents voice / intermittently responding to deep pain. responding

elaine 8cbf.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
AA.	Viral illness
	2° ~~Encephalitis~~
IW.	FBC –
	UEE –
	BCx –
	Viral titres, ± LP. – afebrile.
Mx.	IV fluids,
	↓ dysp/dm. ↓. ? Seizure. Activity.
	Re-assess after fluids. /30/10
2mw	Slightly more responsive – No change.
	Observe + reassess dm. /30/10
	Na 132. ↓ Hb 10.4
	Ic⁺ 3.8. PCV .31
	U 4.5 WCC 16.5 ↑
	Gluc. 6.6. plats. 422.000
	Cr 36.
	Cl. 96.
	Nofever CSM0
22/10/96	WK DR Sonas
	Admitted ? Viral illness.
	Usually very active, has not spoken to parents & per normal.
	Wretching. No vomiting.
	Vagueness/Velar (apparent to parents)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	No seizure activity observed.
	Attends Dr Gaston (UHD)
	6 mth old seizures and Ix for this - NAD.
	U+E - Na+ 132. FBC - WCC ↑16.4. Gluc 6.6.
	O/E Apyrexic. On IV fluids.
	Pale colour. Little response compared to normal.
	CNS. Pupils sluggish to light. Ears
	Difficult to see fundi. Throat difficult to
	Ellis. long tract signs. Full see
	Imp. Non fitting status / encephalitis / [illegible]
	Plan. Rectal DIAZEPAM
	Dr Webb
	D/W Dr. Gaston re PMHx
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 appeared to improve following rectal diazepam 5mg at 12-30pm
	O/E Afebrile, No meningism. Pale
	Rousable - Eye opening to voice, Non verbal, withdraws
	from painful stimuli. Reduced movements Rt side?
	Antigravity all 4 limbs.
	Mildly increased tone both arms
	Reflexes symmetrically brisk.

WNC 762

TC03913 [3.5]

CH 328770
MISS CLAIRE ROBERTS
[redacted]
10/01/87
Female
[redacted]
EHSSB
WD/OP
CONSULTANT

DATE	CLINICAL HISTORY, EX
22.10.96	- Clonus - sustained both ankles
	toes ↑↑.
	• Sits up - eyes open - looks vacantly.
	Not obeying commands.
	- Pupils - 5mm
	Optic discs pale. No papilloedema.
	Facial palsies + conjugate movements appear (N).
	Imp - I don't have a clear picture of previous + yesterday's episodes.
	The motor findings today are probably long standing but this needs to be
	checked with notes. The picture is of acute encephalopathy
	most probably post-ictal in nature. I note is ...
	Suggest i) starting IV phenytoin 18 mg/kg stat followed by
	2.5 mg/kg 12 hrly. Check levels 6 hrs after loading
	dose
	ii) Hourly neuro obs
	iii) CT ... of ...
	[signature]
22/10/96	
9.30 pm	24 kg Phenytoin 18 mg/kg - loading dose = 18 × 24
	= 632 mg
	24 kg Phenytoin 2.5 mg kg 12 hrly = 60 mg 12 HRLY either IV
	or orally.
	Check levels at 9pm.
	[signature]

WNC 782

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/10/96	S/B. Dr Well
	Still in status
	1. MIDAZALAM 0.5 mg/kg STAT DOSE = 0.5 × 24
	= 12 mg IV Stat
	2. MIDAZALAM 2 mcg/kg/min = 2 × 24 mcg/min
	= 48 mcg/min
	= 48 × 60 mcg/Hr
	= 2880 mcg/Hr
	= 2.88 mg/HR. INFUSION
	= 69 mg/24 HRS.
22.10.96	
17.50	- Claire has had a loading dose of phenytoin + a bolus of midazolam. She continues to be largely unresponsive. She responds by flexing her (L) arm to deep supraorbital pain + does have facial grimace - but no localisation. She has intermittent mouthing + chewing movements.
	- Background from mum - contact with cousin in Dar who had a F.U.O. upset. Claire had been mardy on Sunday + vomiting Monday. She had some focal sz on Monday c no sudden [illegible].
	- Plan. 1) Cover c cefotaxime + acyclovir [illegible] - I don't think meningoencephalitis is likely.
	2) Check viral cultures ? enterovirus - Stool, urine, blood + T/S
	3) Add IV sod. valproate 20 mg/kg IV bolus followed by infusion of 10 mg/kg IV over 12 Hrs

[signature]

WNC 7

TC03913 [4]

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

Name Claire Roberts

Confidential

the

TAL No. REGISTRATION TC03913 [4]

Name and First Names (in block letters)
Roberts Claire

Date of Birth
10 1 87

Address (in block letters)
[redacted]

Sex
F

Telephone No. 797445

School

Religion-Inpatient and Spe
Outpatient only

anges of Address

mily Doctor
McMillan [redacted]

son to be notified in an Emergency:-
me Roberts S/A
dress
ephone No.

upation of Father

IMMUNISATION	DATE
B.C.G. — —	
Heaf — —	
Mantoux — —	
Small Pox — —	
Diphtheria — —	
Pertussis — —	
Poliomyelitis —	
Tetanus Toxoid (1) —	
(2) —	
(3) —	
Booster Dose —	
Tetanus (A.T.S.) —	

Affix Blood Group Reports in this space

of Admission	Date of Discharge	Diagnosis	Code
9/87	8/9/87	Seizures	780-

TC03913 [4]

BELFAST HOSPITAL FOR SICK CHILDREN

CONSENT BY PARENT OR GUARDIAN

MARGARET JENNIFER ROBERTS of [redacted]

onsent to the submission of CLAIRE MAY ROBERTS to the operation

CT SCAN, the nature and effect of which have been explained to me

r. R. MACKIE.

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

8-9-87. (Signed) Roberts

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

8-9-87. (Signed) Ronan A Mackie.

CONSENT BY PARENT OR GUARDIAN

of

nsent to the submission of to the operation

, the nature and effect of which have been explained to me

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

(Signed)

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

(Signed)

CONSENT BY PARENT OR GUARDIAN

of

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, the nature and effect of which have been explained to me

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(Signed)

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(Signed)