		Witness Statement Ref. No:	257/1
NAME OF CHILD: Claire Roberts			
Name: Margaret Jennifer Roberts			
Title: Mrs			
Previous Statements, Depositions and Reports:			
[Identify by date and title all those made in relation to Claire's death]			
OFFICIAL USE:			
List of previous statements, depositions and reports:			
Ref:	Date:		

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

I. QUERIES ARISING OUT OF YOUR HUSBAND'S STATEMENT

Your husband made a written statement on 29th September 2005 (Ref: 096-001-004) in which he detailed the events surrounding Claire's admission to RBHSC on 21st October 1996, and her care and treatment there until her death on 23rd October 1996.

Please confirm whether you wish to adopt this statement of facts as your own. The queries set out in the section that follows will attempt to investigate in more detail some of the issues that arise from this statement.

If there is anything you would like to correct or amend from this statement, please set out the corrections or amendments you would like to make.

With reference to your Statement dated 29th September 2005 (Ref: 089-012-035), please provide clarification and/or further information in respect of the following:

I confirm that I wish to adopt this statement of facts as my own.

Claire's condition prior to her admission to RBHSC on 21st October 1996

- (1) "Claire attended school on Monday 21 October 1996 and her teacher reported that she had been sick in school before returning home at approximately 15.00. This sickness continued at home with Claire vomiting on two or three occasions. She also had one loose bowel movement at home but no continuous diarrhoea symptoms." (Ref: 096-001-004)
- (a) Please state the dates of any 'episodes', 'convulsions' and 'episodes' that Claire might have had prior to her admission to RBHSC on 21st October 1996.

 Claire had no convulsions or episodes prior to her admission on 21 October 1996.
 - (b) Please state whether Claire was being administered Ritalin any time between 8th October 1996 and her admission on 21st October 1996, and if so:

(i) What amount she was being given, when and how often

None

(ii) What, if any, Ritalin she had been given on the day of her admission

None

(iii) What, if any, other medication she had been given on the day of her admission

None

- (c) Please describe Claire's state of health over the weekend 18th 20th October 1996 including:
 - (i) Who she came into contact with, particularly anybody who was unwell and any symptoms they may have had

Claires state of health on the weekend of Friday 18 Saturday 19 and Sunday 20 October 1996 was normal.

She visited her Grandparents (Roberts) Auntie and three cousins - also her two brothers, her Dad and myself were there. We learned during the visit that her cousin, (12year old) had a tummy upset that week (midweek).

- (ii) Any symptoms Claire had of sickness (including fever and vomiting) or any change from her usual self
 None
- (d) Please describe Claire's state of health before she was admitted to RBHSC on Monday 21st October 1996 including:
- (i) What she did during the day Claire attended school as normal on Monday 21 October 1996.
- (ii) How and when you first learned that Claire had been sick that day The school bus attendant informed me and Claire's homework diary had a note from her teacher.
- (iii) Claire's symptoms at school, including whether she was vomiting at school I do not believe Claire vomited at school, her homework diary stated that she was pale and lethargic
- (iv) The time Claire returned home from school Claire returned home from school between 3:00 and 3:30pm
- (e) Please state when Claire had "one loose bowel movement at home." I cannot recall Claire having a loose bowel movement at home.

- (2) "Claire's GP Dr Savage (Castlereagh Medical Centre) was called for advice; she called to our home at approximately 18.00 to examine Claire. Dr Savage recommended that Claire be taken to Hospital." (Ref: 096-001-004)
 - (a) Please describe your conversation with Dr Savage, including what she said about why Claire should "be taken to Hospital."

Dr Savage (Claire's GP) recommended we take Claire to the hospital for a second opinon.

Admission to RBHSC

- (3) "Claire was admitted to the Belfast Royal Hospital on Monday 21 October 1996 at 19.00." (Ref: 096-001-004)
- (a) Please identify to whom you spoke at Accident and Emergency. I cannot recall.
 - (b) Please describe the history you gave to the doctor(s) and the nurse(s) in Accident and Emergency, including information regarding her past history of seizures, vomiting and/or diarrhoea.

I gave the doctor a brief history of Claire i.e. she had a learning difficulty, also had a history of infancy epilespy, was seizure free for over three years and off all medication. She had been vomiting from 4pm and hourly - no diarrhoea.

- (c) Please describe, so far as you can recall, what the doctor at Accident & Emergency said to you about Claire's condition and his/her initial diagnosis (diagnoses).
 - (d) Please describe what information was given to you about the reason for Claire's admission, including who spoke with you regarding this.

Claire would be admitted overnight for observtion. I cannot recall who I spoke to.

Admission to Allen Ward

- (4) "She was administered intravenous fluids on Allen Ward over the following hours and Doctors advised my Wife and I that she had a viral infection. We asked about other illnesses and were relieved that Doctors did not think Claire was in danger from meningitis." (Ref: 096-001-004)
- (a) Please identify to whom you spoke upon Claire's admission to Allen Ward. I cannot recall.
 - (b) Please describe the history you gave to the doctor(s) and the nurse(s) upon Claire's admission to Allen Ward including information regarding her past history of seizures, vomiting and/or any diarrhoea.

I gave a history at Accident & Emergency. I gave another history (ie) on Claire's general wellbeing, unsure were this took place.

- (c) In particular, please comment on whether you told the doctor any of the following regarding Claire's condition (Ref: 090-022-050):
 - (i) "Vomiting at 3.00pm and every hour since"

yes

(ii) "Slurred speech + drowsy"

yes

(iii) "Off form yesterday"

"off form yesterday" possibly refers to Claire's behaviour rather than sickness.

(iv) "Loose motions 3 days ago" "loose motion 3 days ago" - I only recall saying that Claire had smelly poos on the Friday.

(v) "Severe learning difficulties" yes

- (d) Please identify to whom you spoke with when your husband states that:
- (i) "Doctors advised my Wife and I that she had a viral infection" I cannot recall the Doctors name.
- (ii) "We asked about other illnesses"
 I cannot recall, it would have been the same doctor who mentioned viral infection.
- (iii) "Doctors did not think Claire was in danger from meningitis." I cannot recall, same doctor as above.
 - (e) Please identify to whom you spoke with when you state that:
 - (i) "Doctors advised my Wife and I that she had a viral infection."
 - (ii) "We asked about other illnesses."
- (iii) "Doctors did not think Claire was in danger from meningitis." I cannot recall, same doctor as (d) above.
 - (f) Please state which "other illnesses" you asked the medical staff about upon Claire's admission to Allen Ward.

The other illness I was concerned about was meningitis.

(g) Please state, so far as you are aware, whether any blood or urine samples were taken from Claire on the evening of 21st October 1996, and if so, how many times they were taken, when, by whom, and for what reason.

None.

(i) Please state if anyone advised you of Claire's sodium result of 132mmol/L from a blood sample that was taken on 21st October 1996 (Ref: 090-031-099). Sodium result of 132mmol/L was not mentioned.

- (5) "Claire appeared more settled after 21.00, was asleep so my wife and I left the hospital to prepare for Tuesday morning and our two sons schooling." (Ref: 096-001-004)
- (a) Please state the time at which you left the hospital on 21st October 1996. Approximately 22:00hrs.
- (b) Please explain what is meant by "Claire appeared more settled after 21.00" and in what respects.

Claire was admitted to Allen Ward and to me was in her nights sleep at approximately 21:00hrs.

- (c) Identify whom you informed that you were leaving the hospital and state:
- (i) Whether you told them when you intended to return. Nursing staff, I informed the nurse(s) that we would return early the next day.
- (ii) What (if anything) they told you about Claire's condition at that time. Nothing.
- (d) Please describe, so far as you can recall, your understanding of Claire's condition when you left the hospital that evening, based on your impression of her and the information given to you by the doctors / nurses up until that point.

 No concern was expressed to me, I believed Claire had a tummy bug and hopefully would be ok the

following day.

Morning of 22nd October 1996

- (6) "My wife and I arrived at the hospital on Tuesday morning and were pleased to be advised by nursing staff that Claire had been comfortable through the night. However Claire did not appear to be herself that morning" (Ref: 096-001-004)
- (a) Please state the time at which you arrived at the hospital on the morning of Tuesday 22nd October 1996.

We arrived at the hospital at 9:30am on Tuesday 22 October 1996.

- (b) Please identify which member(s) of nursing staff advised you that "Claire had been comfortable through the night". Please state when they told you this and please describe any other information that they gave you about Claire's condition. I recall speaking to a nurse who advised my husband and I that Claire had had a comfortable night. I cannot identify the nurse.
- (c) Please explain what is meant by "Claire did not appear to be herself that morning" Although Claire was awake that morning, she did appear vacant when looking at us, we did express our concerns to the nursing staff.
- (d) Please state if you were present during the 'ward round' on the morning of 22nd
 October 1996, and if so:
 Yes, I was present during the ward round.
 - (i) Please identify any doctors or nurses that you remember being present at this time

I only recall one doctor and one nurse.

- (ii) Please describe what happened during the ward round in relation to Claire, including what was discussed about her condition, care and treatment

 The ward round was casual and the discussion around Claire was general. I can recall internal fitting being mentioned.
 - (iii) In particular, please state if anything was discussed in regard to a request for further blood samples being taken for testing, including electrolyte testing, and when this would be done.

I cannot recall.

- (e) Please describe any information given to you during 22nd October 1996 about:
 - (i) The name of the consultant responsible for Claire between 21st and 23rd October 1996

No information on the consultant responsible for Claire.

- $\begin{tabular}{ll} \textbf{(ii)} & \textbf{A formal takeover of Claire's case by the neurology department} \\ \textbf{None} \\ \end{tabular}$
- (iii) The nature of treatment and its significant side effects None
- (iv) Claire's diagnosis

 I believe a tummy bug, (viral illness) was discussed and I also recall internal fitting being mentioned.
 - (v) Claire's prognosis

None

(f) Please state, so far as you can recall, whether Claire received any <u>oral</u> fluids whilst you were with her and if so describe, so far as you can, what those fluids were, the quantity, when Claire was given them and by whom.

I cannot recall Claire being given fluids orally.

Dr Andrew Sands

- (7) "[M]y wife and I expressed our concerns to Dr Sands about her lack of response." (Ref: 096-001-004)
 - (a) Please state when you first spoke with Dr Andrew Sands, and, in particular, please:
- (i) State for how long your conversation with Dr Sands at this time lasted. I now know that Dr Sands conducted the ward round at 11:00am. Approximately 5-10 minutes.
 - (ii) Describe the history that you gave to Dr Sands at that time of Claire's previous history of seizures and the treatment she had previously received for this

I would have stated that Claire had been off epilim and had been fit free for over three years.

(iii) Describe any other history you gave to Dr Sands at this time including information regarding vomiting and/or diarrhoea.

I assumed that Dr Sands would have read Claire's admission notes and that she was admitted with vomiting the previous evening. There was no discussion about diarrhoea.

(iv) Describe the specific concerns that you expressed to Dr Sands about Claire's "lack of response", when you expressed them to Dr Sands and his response to you.

I did express my concerns, as Claire was not her usual self, I was expecting Claire to be more active.

- (b) State when and where any subsequent conversations with Dr Sands took place, and please describe:
 - (i) What was discussed, if anything

None

- (ii) Any information he gave you about Claire, her condition or her treatment. I had no further conversations with Dr Sands.
 - (c) State if Dr Sands expressed at any time during your discussions with him:
- (i) His view of the seriousness or otherwise of Claire's condition Dr Sands did not inform me that Claire's condition was in any way serious.
- (ii) Any concerns about her condition.

 No concerns were expressed by Dr Sands on Claire's condition.
 - (d) Describe any possible diagnoses that Dr Sands discussed with you at that time, and any treatment or action he was going to take as a result. In particular, please state if any of the following were discussed with you:
 - (i) Non-fitting status (Ref: 090-022-053)

Not discussed.

(ii) Encephalitis (Ref: 090-022-053)

Not discussed.

(iii) Encephalopathy (Ref: 090-022-053)

Not discussed.

(iv) "No seizure activity observed" (Ref: 090-022-053) Not discussed.

(e) Please state if you expressed your concerns about Claire's "lack of response" to any other doctor, and if so, identify to whom you expressed your concerns, when you did so, what you expressed, and the nature of their response.

I cannot recall speaking to any other doctor about Claire's "lack of response"

Lunchtime of 22nd October 1996

- (8) "My wife and I stayed with Claire for the rest of that morning and when both grandparents arrived around 13.00 we went for lunch. We actually went into Belfast for some personal items for Claire, in the hope that her viral infection would pass and she would possibly be ready to leave hospital the next day." (Ref: 096-001-004)
 - (a) Please state whether you thought at that time that Claire had a viral infection and, if so, please explain why

My understanding at that time was that Claire had a 24 - 48 hour tummy bug.

(b) Please describe, so far as you can recall, your understanding of Claire's condition before you left the hospital at around 13.00 based on your impression of her and the information given to you by the doctors/nurses.

Claire's condition was that she was unwell, and not her usual self.

(c) Please state, so far as you are aware, whether any blood or urine samples were taken from Claire between your arrival at RBHSC on the morning of 22nd October 1996 and your leaving at 21.15, and if so, how many times samples were taken, when, by whom, and for what reason (if known).

I am not aware of blood/urine sample being taken on 22 October 1996.

(i) Please state whether Claire wore nappies following her admission on 21st October 1996.

Claire was in a night nappy only.

(ii) Please describe, so far you are able, the level of Claire's urine output during that period.

I am unable to describe the level of urine output, as I was more concerned about Claire's personal hygiene and comfort. She did not have a soiled nappy that day.

Afternoon of 22nd October 1996

- (9) "On returning to hospital at around 14.00 grandparents informed me that a Doctor had examined Claire. I left the hospital at 15:00 to collect our two sons from school with my wife remaining in hospital with Claire." (Ref: 096-001-004)
 - (a) Please describe, so far as you can recall, your understanding of Claire's condition when you returned to the hospital at around 14.00 based on your impression of her and the information given to you by the doctors/nurses.

On my return to the hospital at 14:00 I recall Claire as wakeful, though still pale and drowsy.

(b) Please identify, if you can, the doctor referred to by Claire's grandparents as having examined her.

I did not meet a doctor at 14:00 therefore I am unable to identify the doctor.

Dr David Webb

- (10) "I returned to hospital at approximately 18.30 with our two sons and my wife informed me that Doctor Webb had examined Claire at 16.00 and 17.00 with a different type of medication being administered. I assumed that his medication was counteracting any viral infection Claire had and was having a sedation effect. Like all children Claire over the years had had several childhood illness from measles to common cold which would have made her unwell for a few days before she would bounce back into action." (Ref: 096-001-004)
- (a) Please state when you first spoke with Dr Webb I first spoke to Dr Webb at approximately 17:00hrs on 22 October 1996.
 - (b) Please describe the history that you gave to Dr Webb of Claire's previous history of seizures and the treatment she had previously received for this.

I explained to Dr Webb that Claire did not have seizures for over three years and was off all medication (Epilim)

(c) Dr Webb notes at Ref: 090-022-053 that Claire had "known learning difficulties." Please state if you and Dr Webb discussed this.

There was no in depth conversation or discussion about Claire's learning difficulties.

(d) Dr Webb also notes at Ref: 090-022-055 that Claire had "loose motions on Sunday and vomiting Monday." Please state if you and Dr Webb at any time discussed this.

Not in any detail. Claire had a smelly poo (as I described) on Friday and arrived home from school on Monday pale and legthargic and then vomited.

(e) Please describe any other history you gave to Dr Webb at this time including information regarding vomiting and/or diarrhoea.

We did not discuss diarrhoea, I only recall informing Dr Webb about Claire's vomiting from her arrival home from school.

(f) Please describe any concerns you expressed to Dr Webb about Claire, including what concerns you had, when you expressed them to Dr Webb, and the nature of his response to your concerns.

No concern about Claire's condition. I mentioned that Claire had a strong seizure at 3:25pm, but thought that she was coming out of "internal fitting" that had been described to me earlier.

(g) Please state if you expressed your concerns about Claire to any other personnel, and if so, identify to whom you expressed your concerns, when you did so, what you expressed, and the nature of their response.

I did not express any concerns as I thought Claire had a tummy bug and would recover within 24-48 hours.

- (h) Please state If Dr Webb expressed at any time during your discussions with him:
- (i) His view of the seriousness or otherwise of Claire's condition No expression or impression was expressed during my discussion with Dr Webb.

(ii) Any concerns about her condition.

Nothing.

- (i) Please describe any possible diagnoses that Dr Webb discussed with you at that time, and any treatment or action he was going to take as a result. In particular, please state if any of the following were discussed with you:
 - (i) "Acute encephalopathy" (Ref: 090-022-054)

Not discussed.

(ii) That Claire had "some focal seizures on Monday with right sided stiffening" (Ref: 090-022-055)

No

(iii) "Meningoencephalitis" (Ref: 090-022-055)

No

(iv) "Enterovirus" (Ref: 090-022-055)

No

(v) Non-convulsive status epilepticus

No

(vi) The medication that Claire was being administered

No

- (j) Please state for how long your conversation with Dr Webb lasted. My conversation with Dr Webb lasted 5 10 minutes and was in no great detail.
 - (k) If you spoke further with Dr David Webb at any <u>other</u> point prior to 03:45 the following morning, and if so, state when and where this took place, and describe what was discussed.

I only recall speaking to Dr Webb on one occasion.

(l) Please describe the basis for the assumption that the "medication ... was having a sedation effect"

I cannot recall

Evening of 22nd October 1996

- (11) "Over the following hours to 21: 15 Claire was reviewed by the ward nurse in a way that appeared as general observation and certainly without alarm or concern." (Ref: 096-001-004)
 - (a) Please state whether you asked any doctor or nurse at any time about Claire's

condition (other than Dr Sands or Dr Webb as detailed above), and, if so, please:

(i) Identify whom you asked

I did not ask a doctor or a nurse about Claire's condition.

- (ii) State when and where you asked
- (iii) Describe what you were told in response.
- (b) Please explain if you were informed at any time that:
 - (i) Non-fitting status epilepticus was a working diagnosis for Claire
 - (ii) Encephalitis was a working diagnosis for Claire
 - (iii) Encephalopathy was a working diagnosis for Claire
- (iv) Claire was receiving anti-convulsant medication Yes, as I was aware that Claire had had a strong seizure at 3:25pm.
- (v) Claire was receiving more than one type of anti-convulsant medication I only recall Epilim.
 - (vi) It was believed that Claire may have a neurological illness
- (vii) Claire's neurological signs were being observed on an hourly basis I was not informed of hourly observations.
- (viii) Claire was being assigned a Glasgow Coma Scale score hourly and that this dropped to 6 at 16.00 and 21.00 (Ref: 090-039-037).

 I was not informed.

If so, please identify who told you about it, when and where this occurred, what was discussed, and your reaction to the discussion. If not, please explain how you would have reacted had you known.

If I had been informed of a GCS I would have asked what this meant, and on learning this it would have raised questions.

- (c) Please identify the ward nurse(s) who reviewed Claire up to 21.15. I cannot recall.
 - (d) Please describe any discussions you had with the ward nurse(s) regarding Claire's condition, treatment and/or medication, including when and with whom you had any discussions and the subject of those discussions.

I only had general conversations with a nurse - nothing medical.

(e) Please describe, to the best of your recollection, the level of nursing care Claire

received between your arrival at 18.30 and your departure at 21.15 including:

(i) how often Claire was checked, and

I cannot recall

(ii) How concerned the nursing staff were for her condition. No concerns were expressed by nursing staff.

- (12) "We left the hospital at 21:15 with as we thought Claire settled and asleep and a reassurance from nursing staff that Claire was comfortable. We informed the nursing staff that we would return to the hospital the following morning. Throughout Tuesday 22 October no Doctor, nurse or any medical staff indicated to my wife or I that Claire was in a serious condition or in any danger." (Ref: 096-001-004)
 - (a) Please describe, so far as you can recall, your understanding of Claire's condition when you left to the hospital at 21.15 based on your impression of her and the information given to you by the doctors / nurses.

I left the hospital at 21:15. I recall going to the nurses station to say that Claire was settled and asleep for the night, that we would be returning the next morning. My only concern was that the bed sides were secure, in case Claire would waken and get out of bed. The staff replied "ok" and "see you in the morning". My cousin, (a nurse from Scotland, rang Allen Ward as we were leaving, the nurse passed the phone to me and I spoke to my cousin, saying that Claire was settled for the night and that we were leaving the hospital with Claire's two brothers.

- (b) Please describe the "reassurance from nursing staff that Claire was comfortable", including:
- (i) The identity of the "nursing staff" I cannot identify any nursing staff.
- (ii) The nature of the "reassurance" you received
 The reassurance that I received was no more than staff saying "ok, see you in the morning, goodnight"
- (iii) Whether any medical staff were involved in the reassurance you received Only the nursing staff.
- (c) Please identify "the nursing staff" whom you informed that you "would return to the hospital the following morning".

 I cannot identify any nursing staff.
 - (d) Please describe the response by nursing staff to your decision to leave for the night.

The response from nursing staff on our decision to leave for the night was fine and casual.

Early morning of 23rd October 1996

(13) "I received a call from the hospital at 3:45 Wednesday 23 October to say that Claire was having breathing difficulties and that my wife and I should make our way to the Hospital

as soon as possible. On arrival Dr Steen and Dr Webb informed us that there was a build up of fluid around Claire's brain and pressure was being applied to her brain stem. Claire was being sent for a CT scan to confirm this." (Ref: 096-001-004)

(a) Please identify who at the hospital called you at 03.45 on 23rd October 1996.

My husband informed me that Dr Bartholome had called.

(b) Please describe, so far as you can recall, if they said anything other than that "Claire was having breathing difficulties".

I cannot recall.

- (c) Please state what time:
 - You arrived at RBHSC.

I arrived at the hospital at approximately 4:30am

(ii) At what time Dr Steen and Dr Webb spoke to you.

On arrival - I am unsure of the time.

(d) Please describe, so far as you can recall, what happened upon your arrival at RBHSC on 23rd October 1996.

I cannot remember.

(e) Please state if you personally had any contact prior to 03.45 on 23rd October 1996 with Dr Heather Steen in regard to Claire's care.
 I had no contact with Dr Steen prior to 03:45am on 23 October 1996.

(f) In particular, please state if, so far as you are aware, Dr Steen attended and examined Claire at any time prior to 03.45 on 23rd October 1996.

I am not aware that Dr Steen attended or examined Claire prior to 03:45 on 23 October 1996.

- (g) Please identify which of Dr Steen and Dr Webb informed you that:
- (i) "There was a build up of fluid around Claire's brain" I cannot recall.
- (ii) "Pressure was being applied to her brain stem" I cannot recall.
- (iii) "Claire was being sent for a CT scan to confirm this." I cannot recall.
 - (h) Please describe whether Dr Steen or Dr Webb explained why or how "there was a build up of fluid around Claire's brain" and/or "pressure was being applied to her brain stem."

I recall being informed about a fluid built up but not the reasons for it.

(i) Please describe any other discussions that Dr Steen and Dr Webb had with you at that time.

I cannot recall.

- (14) "Dr Steen and Dr Webb later advised us that the outcome of the CT scan confirmed severe fluid build up, that Claire was brain dead and that nothing could be done to save her. At 18:45 a decision was taken by my wife and I to discontinue Claire's life support." (Ref: 096-001-004)
- (a) Please state when "Dr Steen and Dr Webb later advised" you. I do not recall the time, but would have been after the CT scan.
 - (b) Please identify which of Dr Steen and Dr Webb advised you that:
- (i) "the outcome of the CT scan confirmed severe fluid build up" Dr Steen advised.
- (ii) "that Claire was brain dead" Dr Steen advised.
- (iii) "that nothing could be done to save her". Dr Steen advised.
- (c) Please describe any other discussions that Dr Steen and Dr Webb had with you at that time.
 - (d) Please describe the conduct and/or behaviour of Dr Steen and Dr Webb during your meetings with them after your arrival at RBHSC on the morning of 23rd

I can only recall Dr Steen and Dr Webb saying to my husband and I that Claire was brain dead and nothing more could be done for her. This took place in a counselling room near PICU.

- (e) Please state if you were told at any time:
 - (i) During Claire's admission to RBHSC in October 1996
 - (ii) **Prior to 2004**

October 1996.

of Claire's serum sodium levels or her having hyponatraemia or this likely being caused by SIADH.

Serum sodium and hyponatraemia was never mentioned to me during Claire's admission to RBHSC in October 1996.

I was not told of serum sodium and hyponatraemia prior to 2004.

Involvement of the Coroner

(15) "Why was an inquest not held into Claire's death considering it was sudden, unexpected and without a clear diagnosis? Why did Dr Steen state to me on Wednesday 23 October 1996 at approximately 19:00 that there would be 'no need' for an inquest?" (Ref:

096-001-005)

(a) Please state whether the possibility of a Coroner's Inquest into Claire's death was discussed with you by any doctor in 1996. If so, please identify the person who discussed it with you and describe so far as you can recall what was discussed this, when and where.

I cannot recall

(b) If not, please explain whether you would have wanted such an Inquest if it had been suggested to you.

If an Inquest had been suggested, I would have asked why that was required.

Post-mortem examination

- (16) "Dr Steen highlighted that a post mortem may give answers to Claire's death and help prevent similar tragedies in the future. Was a report issued and did it define hyponatraemia? Why does the post mortem report not mention hyponatraemia?" (Ref: 096-001-005)
 - (a) Please describe what Dr Steen discussed regarding the fact that a post-mortem:
 - (i) "may give answers to Claire's death"

Dr Steen explained that a post-mortem may identify the virus which caused Claire's brain to swell.

(ii) "help prevent similar tragedies in the future"

Dr Steen explained that doctors would learn from this tragedy and could possibly help other children in the future.

(b) Please state when Dr Steen discussed a post mortem examination with you, and where this took place.

I recall this discussion taking place in a room near PICU.

(c) Please identify any other doctors who discussed the possibility of a post-mortem autopsy with you, and where and when this took place.

There were no other discussions with any doctor.

(d) Please describe, so far as you can recall, what was discussed, the options you were offered, and the results of the discussions.

Dr Steen advised us that there would not be an inquest and that a limited post-mortem would be required.

- (e) In particular, please describe any discussions regarding:
 - (i) Whether there should/would be a full or limited post-mortem

There was no discussion regarding a full or limited post-mortem.

(ii) The limiting of the post-mortem examination to a brain-only autopsy.

This was advised by Dr Steen.

(f) Please state whether the brain-only aspect of the autopsy was recommended to you in any way, and if so, describe how it was recommended and explain why you agreed to this.

The brain-only aspect of the autopsy was recommended to us by Dr Steen. We agreed to this as we wanted to identify the virus responsible for Claire's brain swelling.

(g) Please state whether you requested that the post-mortem examination be limited to 'brain-only' and if so, please explain why you decided to do so.

I did not request a post-mortem examination to be limited to 'brain-only'. This decision was made by Dr Steen.

Following Claire's death

- (17) "Claire's diagnosis on admission to hospital, during her treatment on Allen ward, at ICU and at subsequent meeting in 1996/1997 at the Belfast Royal Hospital was a viral infection. The post mortem report (condensed and full versions) also refers to a viral infection. Subsequent meetings with Dr Steen at the Belfast Royal Hospital continued to state a viral infection. At no time was Hyponatraemia or falling sodium levels defined as a cause for the fluid build up. At a meeting on 7 December 2004 with medical staff from the Belfast Royal Hospital Professor Young stated that hyponatraemia (falling sodium) may have contributed to swelling of Claire's brain and therefore ultimately to her death." (Ref: 096-001-005)
 - (a) Please identify who told you, and any explanations they gave, that Claire's diagnosis was a viral infection:
 - (i) "on admission to hospital"

Doctor on Allen Ward

(ii) "during her treatment on Allen ward

Doctor on Allen Ward

(iii) "at ICU"

Dr Steen and Dr Webb explained to us that the virus from Claire's stomach had gone to her brain

(iv) "at subsequent meeting in 1996/1997"

My husband and I visited Allen Ward in November 1996.

(b) Please describe, so far as you can recall, any meetings that took place between you

and RBHSC staff in 1996 and 1997 following Claire's death, including the "subsequent meeting in 1996/1997", and:

(i) The identities of those present at the meeting(s)

I recall Dr Steen being present at a meeting in March 1997.

(ii) When the meeting(s) took place

March 1997

(iii) What was discussed at the meeting(s).

The post-mortem results were discussed, and Dr Steen explained that a viral infection had been identified at post-mortem.

If you have any correspondence from these meetings, please provide a copy to the Inquiry.

(c) Please describe, so far as you can recall, what was discussed at the "subsequent meetings with Dr Steen at the Belfast Royal Hospital", including the identities of those present at the meeting, and when the meeting took place.

We had no further discussions with Dr Steen following the meeting in March 1997.

(d) Please identify who was present at "the meeting on 7 December 2004 of medical staff from the Belfast Royal Hospital" and describe, so far as you can recall, what was discussed.

Dr Rooney, Dr Steen, Dr Sands, Professor Young and an Administrator, who took notes at the meeting on 7 December 2004.

We discussed Claire's diagnosis, care management, if hyponatraemia played any part in Claire's condition, what Claire's sodium levels were, when blood tests were carried out and what Claire's fluid management was in 1996.

Subsequent meetings with RBHSC doctors

(18) Please describe any communication you had with the hospital between Claire's death and the UTV Insight programme on 21st October 2004.

Visit to the hospital on 11 November 1996.

Letter from Dr Steen dated 18 November 1996.

Meeting with Dr Steen and other Doctor(s) 3 March 1997, to discuss the post mortem results.

Letter from Dr Webb dated 21 March 1997.

- (19) Please describe your actions in the immediate months following the UTV Insight programme on 21st October 2004, including:
 - (a) Your initial reactions to the programme

When I watched the programme I was shocked at the similarities between that of Lucy Crawford and Claire. The programme highlighted issues around fluid management and I felt my husband and I had to contact the hospital again to raise our concerns.

(b) Whom you contacted at RBHSC/RVH after seeing the programme, when you did so, the purpose of your contact, and what was said

My husband contacted the RBHSC the day after the programme was broadcast.

(c) The actions that RBHSC took to meet you and your wife following your contact

The RBHSC, Dr Rooney arranged a meeting for my husband and I to attend on 25 October 2004. Dr Rooney organised a further meeing with the doctors involved in Claire's treatment for 7 December 2004.

(20) Please describe any communication you had with the RBHSC following Claire's inquest.

None.

- (21) Please state if you were asked by RBHSC or the Trust to be involved in any way with a discussion / review / audit about what happened to Claire, your experience, and any lessons which could be learned following Claire's death.
 - (a) If so, please explain your involvement (if any), and who asked you to be involved and when.

I was not asked to be involved in any further discussions.

(b) If you were not asked, please state whether you would have expected to have been included.

I assumed that the RBHSC or the Trust would carry out internal hospital reviews.

Additional Comments

(22) Please provide any further points and comments that you wish to make, together with any documents

Blobonts
9 August 2012