THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ASTHA VASUDEVA SONI

This is Exhibit AVS1 of the witness statement of Dr Astha Vasudeva Soni dated 12 June 2024

STATEMENT OF WITNESS

(Criminal Procedure Rules, r. 27.2;

Criminal Justice Act 1967, s. 9, Magistrates' Courts Act 1980, s.5B)

Statement of Dr A Soni

Age of witness (if over 18, enter "over 18) **Over 18**

Occupation: Registered Medical Practitioner

This statement (consisting of 6 pages) **is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.**

Signed: ... Personal Data .... **Date**: ....12/03/21....

1. I am a Registered Medical Practitioner, GMC number PD I was awarded my primary medical degree, MBBS in March 2003 from the Baba Farid University of Health Sciences, Faridkot, Punjab, India. I undertook my medical studies at the Government Medical College, Patiala, Punjab, India. I enrolled on the degree course in 1997 and completed it in 2002 with my degree being awarded in March 2003. I also undertook internship between January and December 2002 at the Rajindra Hospital, Patiala and then a House Officer placement for 6 months at the General Hospital, Chandigarh from 1 January 2003 to 30 June 2003. I obtained my membership from the Royal College of Paediatricians and Child Health (MRCPH) Part 1 January in 2006, I completed the written Part 2 in January 2007 and the clinical Part 2 examination in October 2008.

Current Post

2. Since March 2016 I have been employed at the Sheffield Children's Hospital as a Consultant General Paediatrician with a specialist interest in diabetes. I have previously set out details of my current post in my witness statements dated 20 May, 11 September and 26 October 2018.

I&S

3. I have been asked to provide a statement setting out my involvement in I&S 's care whilst he was at the Countess of Chester Hospital in

Signed .... Personal Data ..... Witnessed by PD AVNIR....SONI

November 2015. For the purposes of doing so, the Police have provided me with electronic access to copies of I&S s medical records, comprising handwritten clinical records of his admission and stay in NNU from I&S/11/15 to I&S/11/15.

4. I confirm that I have no independent recollection of my involvement in I&S I&S 's care in November 2015. I am therefore making this statement based on my usual practice and my review of the entries made in the medical records in order to do my best to reconstruct my involvement.

5. I&S was born on PD November 2015 at term +14 days gestation. He was admitted to the neonatal unit on 3/11/15 at 0520 after he had a dusky episode. I have filled in parts of the admission proforma to the neonatal unit. The information I recorded will be a combination of any history I have taken from his mother and information taken from his birth records and his mother's notes. A transcript and explanation of my documentation is set out below:

I have written mother's name I&S, DOB PD/11/88, her hospital number cc PD.
Obstetric history- Primip (meaning it was her first pregnancy). This pregnancy-IVF pregnancy, maternal group- O negative, no antibodies. She had anti D.
I have circled negative for HepB/HIV/Syphillis on antenatal infection screen and immune for rubella.
Risk factors for sepsis: I have circled option N (No) for each of invasive GBS (Group B streptococcus) in a previous baby, maternal GBS colonisation in current pregnancy, preterm birth after spontaneous labour< 37 weeks, preterm rupture of membranes>18 hours, intrapartum fever of >38 degrees or chorioamnionitis, maternal iv A/Bs for bacterial infection in labour or 24 hours after birth and infection screen in another baby of a multiple pregnancy.
I have circled Y (yes) for prelabour rupture of membranes and noted induced next to it as mother was electively induced for labour. Antenatal steroids given : No
I have written I&S s gestation T+14, weight 4.08kg. Mode of delivery: LSCS due to failed ventouse. I have circled yes to meconium at delivery and noted Thick meconium APGARS 9 at 1 min and 10 at 5 minutes. Good condition at birth
Medical communication with parents: Parents updated. Query cause of dusky episodes. Needs full septic screen.

6. I have made an entry in the notes on P/11/15 at 0630. I believe I was the registrar on-call that night and I was called to review I&S on the postnatal ward. My entry reads:
T+14

Signed PD ..... Witnessed by PD AVNIR SONI

Born by emergency section 24 hours ago. Thick mec (meconium). Failure to progress (Mother induced). No resus needed. Breast fed.
Had 1 dusky episode in the afternoon. Was thought to be due to wind. Tonight fed at 0430, mum put him down on the cot, found him blue+ dusky, eyes rolled up ?Floppy
Brought to resuscitaire, facial O2 given, vitals ok but he was quiet, didn't pick up straight away.
On arrival (means when I arrived at the scene),
Baby on resuscitaire
O2 facial mask –sats 97%, no ↑WOB
O/E Jaundiced, Pink well perfused
CVS 1-11-0, Chest equal AE B/L, Abd Soft non- tender, Femorals palpable B/l
Imp (impression)? Sepsis
P: Transfer to NNU for obs, for full septic screen. Signed Soni ST8
Cannula inserted L saphenous
FBC, CRP, cultures sent
LP attempted- dry tap. To be repeated am.
Called by Nurse Y I&S *shown colour change/blue/ no respiratory effort. Eyes staring. O2 given*
IPPV commenced, picked up in 30-40secs. Colour back to pink/ quiet but obs stable
Imp? Seizure activity
Plan: Commence CFM, Think about phenobarbitone if repeated episodes. Signed Soni ST8

7. In summary, when I first saw I&S he had been born more than 24 hours ago and I admitted him to the NNU after he had a dusky episode on the postnatal ward. The Nurse reported that he had shown colour change and no respiratory effort and his eyes were staring. He was given oxygen and IPPV (intermittent positive pressure ventilation) and picked up in 30-40 seconds and his colour returned but he remained quiet. The initial impression was that I&S is likely to have sepsis. I inserted a cannula and took blood samples for a full septic screen but was unable to obtain a sample of cerebrospinal fluid via a lumbar puncture which was dry. I asked that the lumbar puncture was repeated in the morning. I recorded my impression that I&S may also be having seizures. This was because of the report of being floppy, eyes rolling and staring. I started him on CFM (cerebral functional monitoring) to monitor any seizure activity and planned to start anti-seizure medication (phenobarbitone) if he had repeated episodes.

8. I believe I was working the next night shift as my next entry is on 3/11/15 at 2208 and reads as follows:

Signed PD ..... Witnessed by PD ANWAR SONI

Dr. Soni Night review
Problems;? Sepsis, Seizure? Cause, hypoglycaemia
V-SVIA
Fluids: on 4 mls/kg/hr of 15% dextrose via long line R hand.
GIR 10mg/kg/min
Some concerns regarding vessel being radial artery but artery palpable. No blanching of hand. Line flushing.
GIR has been upto 12.5mg/kg/min. Urine output not accurate
Sepsis: on Ben pen, Gent, acyclovir
CSF microbiology sample- not able to access?lost
No further seizure activity since this evening on phenobarbitone
Parents present- very upset
Issues- deliberate mistakes have been made.

1. *CSF sample lost*
2. *Using line which is potentially dangerous*
3. *Demanding to talk to a consultant*
4. *Want to transfer* I&S *to another place*

I apologised and said I&S *is getting appropriate care. We are treating him for all possible causes for seizure/sepsis. Don't know why he is doing this. Possible sepsis.*
CSF sample won't change what we do tonight but help with the diagnosis of meningitis +/- herpes encephalitis as well as (help us) decide on duration of medicine (abx/antivirals)
Long line seems like venous line as I can palpate the artery and no blanching.
Low sugars can be due to ↑metabolic requirements secondary to seizure or could be due to hormonal imbalance. But we need to make sure sugars are within normal range.

2230: Current BM (Blood glucose) 1.7mmol/l
GIR 10mg/kg/min as getting 16 mls/hr of 15% dextrose. Not able to ↑15% dextrose as line won't take ↑fluids.
Plan- To give 15% at 4mls/kg/min +12.5% at 2mls/kg/min.
I calculated the GIR 10+4.1=14mls/kg/min.

9. I reviewed I&S at the beginning of my night shift on 03/11/2015. I have noted that he was being treated for sepsis, possible seizures and hypoglycaemia. He was breathing for himself and was on IV fluids with GIR of 10 mg/kg/min. I have also noted the earlier concern that the long line which was inserted in the daytime in his right hand was suspected to be a possible arterial line because it was bleeding a lot but because of palpable radial artery, well perfused hand and no blanching, it was decided to keep a close eye on the line and use it.

10. He was being treated for sepsis. He had had a lumbar puncture done but

Signed ..... PD ..... Witnessed by PD AVNIR SONI

there was a concern that the CSF sample might have been lost. I have also noted that I&S was now on phenobarbitone and had no further seizures. His parents were present and were upset about various issues as listed above in my transcript. I spoke to his parents as recorded in the above entry. I have no recollection of that conversation so have nothing further to add.

11. I have continued the entry but timed at 2230. It is possible that he had a hypoglycaemic episode at that time. I have written his BG to be 1.7 mmol/l and altered his I.V. fluid regime. According to my notes, we were not able to increase fluids by just increasing 15% dextrose so I made a plan to give 15% and 12.5% dextrose increasing the GIR to 14 mg/kg/min.

12. My next entry is timed at 0300 on 04/11/15 and reads:

Bleeped by SN Nurse W
Sugar 2.8 mmol/l previously 3.4mmol/l
On GIR 14mg/kg/min, In view of borderline sugars, change fluids to 20%dextrose
20% dextrose at 4mls/kg/hr = GIR 13.3 mg/kg/min
12.5% dextrose at 2mls/kg/hr=GIR 4.1
Total GIR 17.4 mg/kg/min
Continue 1 hourly sugar monitoring till stable. Aim for BG >= 3.5 mmol/l.
Signed Soni ST8

13. I was bleeped during the same night shift because I&S 's BG had dropped to 2.8mmol/l. I altered his fluid regime again to increase his GIR. I instructed the nursing staff to keep his BG above 3.5 mmol/l and check his BG hourly until it stabilised.

14. My next entry was on 04/11/15 at 2300 as follows:

Events of the day noted. No further seizures. On glucagon, sugars 7.6-11.4
Fluids currently
12mls/hrof 20% dextrose GIR 10 mg/kg/min
6mls/hr of 12.5% dextrose GIR 3.1
Milk 2.5 mls/hr GIR 0.7
Total GIR 13.8 mg/kg/min
Plan: To check sugar in 1 hour. Aim for total fluids 150 mls/kg/day. ↑feeds to 10 mls 2 hourly.↓20% dextrose as BM allows. Signed Soni ST8

15. I reviewed him at the beginning of my night shift on 04/11/15. I noted the daytime entries. He remained seizure free and had normal activity on CFM.

Signed ..... PD ..... Witnessed by PD Anir Soni .....

The Endocrine team at Alder Hey had been advising how to manage his blood glucose in view of his hyperinsulinism. I have noted that he was commenced on glucagon and his BG was between 7.6-114 mmol/l. I have calculated his GIR and made a plan to increase his feeds and reduce IV fluids as his BG control allowed.

16. I next reviewed **I&S** on 05/11/15 at 2345. My entry reads:

Night spr Dr. Soni
CHI (congenital Hyperinsulinism)
Total fluids 120mls/kg/day
GIR-15% dextrose at 10.3mls/hr=6.4 mg/kg/min, feed at 19mls/2 hours-2.7 mg/kg/min total GIR 9.1mg/kg/min
Not much progress in feeds today.

17. I discussed with Dr Das (Consultant Endocrinologist at Alder Hey Children's Hospital). She was happy for us to go up on feeds and wean down fluids and confirmed we could increase glucagon if needed. She advised to be cautious with fluids as he was on diazoxide and to keep blood sugars above 4 mmol/l. The plan was to increase feeds to 120 mls/kg/day by the next day, to weigh him and inform if concerns. I noted that his weight was 4.010Kgs. I then signed the entry.

18. I have noted the diagnosis as CHI (congenital hyperinsulinism). I noted his fluid regime and his GIR. I have written that there had not been much progress in building up his feeds. I discussed with Dr. Das who was the on-call Endocrinologist at Alder Hey Hospital. She was happy for us to build on his feeds. She advised to keep his BG > 4 mmol/l and to increase glucagon if needed. As he was on diazoxide, she told us to be cautious with the fluids as diazoxide could lead to fluid retention. I asked for him to be weighed and noted his new weight to be 4.010kgs. Sepsis was still one of the diagnoses but I have not written it in my entry as during night shifts, I was doing targeted reviews to make sure his BG remained stable and we made some progress towards normality by feeding him.

19. There are no further entries by me in the notes provided.

Signed ..... **PD** ..... Witnessed by **PD** AVNIR SONI

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ASTHA VASUDEVA SONI

This is Exhibit AVS2 of the witness statement of Dr Astha Vasudeva Soni dated 12 June 2024

Cheshire Constabulary
WITNESS STATEMENT

Criminal Procedure Rules, 16.2; Criminal Justice Act 1967, s. 9; Magistrates' Courts Act 1980, s.5B

URN: 07

Statement of: Dr Astha Soni

Age if under 18 *(if over 18 insert 'over 18')*: over 18 **Occupation:** CONSULTANT PAEDIATRICIAN

This statement (consisting of 4 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.

Signature: PD **Date:** 12/03/20

Check box if witness evidence is visually recorded ☐ Witness personal details should be entered in appropriate section **ONLY.**

1. I am a Registered Medical Practitioner, GMC number PD. I was awarded my primary medical degree, MBBS in March 2003 from the Baba Farid University of Health Sciences, Faridkot, Punjab, India. I undertook my medical studies at the Government Medical College, Patiala, Punjab, India. I enrolled on the degree course in 1997 and completed it in 2002 with my degree being awarded in March 2003. I also undertook internship between January and December 2002 at the Rajindra Hospital, Patiala and then a House Officer placement for 6 months at the General Hospital, Chandigarh from 1 January 2003 to 30 June 2003. I obtained my membership from the Royal College of Paediatricians and Child Health (MRCPH) Part 1 January in 2006. I completed the written Part 2 in January 2007 and the clinical Part 2 examination in October 2008.

Current Post

2. Since March 2016 I have been employed at the Sheffield Children's Hospital as a Consultant General Paediatrician with a specialist interest in diabetes. I have previously set out details of my current post in my witness statements dated 20 May, 11 September and 26 October 2018.

I&S

3. I have been asked to provide a statement setting out my involvement in I&S's care whilst he was at the Countess of Chester Hospital in September 2015. For the purposes of doing so, the Police have provided me with electronic access to copies of I&S medical records, comprising handwritten clinical records, computerised nursing records and prescribing records.

4. I confirm that I have no independent recollection of my involvement in I&S's care in September 2015. I am therefore making this statement based on my usual practice and my review of the entries made in the medical records in order to do my best to reconstruct my involvement.

Signature: PD Signature Witnessed By: PD Astha Soni

5. I&S was born on PD September 2015 at 38+6 weeks gestation. According to the notes, he was born in good condition. There were concerns regarding increased work of breathing a few hours after birth. He was admitted to the neonatal unit and treated for suspected sepsis.

6. From my entry in the notes, I met him for the first time on I&S09/15. I believe I was the Registrar on call on the night shift as I have written my review at 2230. My entry reads:

LP-WCC<5 RCC 27 0 organisms, latest v gas pH 7.269, CO2 7.5
Events of the day noted. Possible sepsis? cardiac cause. Lactate (↑)6.2, sugar 11.8
V: SVIA, sats 100% in air. Pre/post ductal sats100%
CVS:1-11-0 CRT 2 sec, Femorals palpable B/L
Chest: good AE B/L RR 60-70/min No obvious distress
Abd- soft non tender No organomegaly
Sepsis ↑CRP 13 ↑lactate (venous gas)
CNS: quiet, asleep responds appropriately to handling
Imp: likely sepsis
P- BP
Rpt gas in an hour, If CO2 ↑ - might need resp support, NBM for now. Soni ST8

7. I have noted the previous reviews and that he was being treated for sepsis. I wrote the results from CSF microscopy. The results show < 5 White cells and no organisms on microscopy. This meant that diagnosis of meningitis was unlikely. The CSF test was performed by the doctors on previous shift. I have also written results from his latest blood gas. His pH was 7.269 and pCO2 of 7.5. This indicated respiratory acidosis. After examining him, my impression was that he was a baby with sepsis whose blood gas had shown no improvement. His respiratory rate was increased but he was still breathing spontaneously in air and maintaining oxygen levels. I made a plan to repeat the blood gas in an hour's time and recorded that if his blood gas worsened, he was likely to need respiratory support.

8. The second entry I made was almost 3 hours later @ 0015 on 17/09/15. I believe I was asked by nursing Staff to review this baby as his blood glucose (BG) had dropped to 1.3 mmol/l. There is a retrospective nursing entry (initials SB) timed at 0211 hours saying that I had been contacted. I&S was already on IV fluids at 60 mls/kg/day so he was given a 3mls/kg bolus of 10% dextrose and I increased his fluids to 75mls/kg/day. I have noted that would give him glucose infusion rate (GIR) of 5.2mg/kg/min. My plan was to repeat the blood glucose in 15 mins. If it was ok at that point, to repeat 60 minutes later. I asked the nurses to inform me if there were concerns.

9. I made a further entry at 0200 about the test results. I noted the repeat sugar 1.3, lab glucose is 0.7

mmol/l (I believe this was an earlier sample which had been tested by the lab). I advised a repeat bolus @ 3mls/kg to be given, increased fluids to 90mls/kg/day = 10.5 mls/hr, GIR of 6.29mg/kg/min. I recorded his repeat BG after the bolus was 3.2 mmol/l.

10. My next entry in the notes is at 0700, 17/09/15. This was towards the end of my shift. The records show that I&S had borderline BG readings all night in spite of increasing IV fluids and concentration of glucose (dextrose). His fluids had been increased to 150 mls/kg/day of 15% dextrose giving him GIR of 15.6mg/kg/min. It is clear from his prescriptions that he received 2 X 3mls/kg boluses of 10% dextrose and his fluids were increased in quantity and dextrose concentration in stepwise fashion over the night. His blood glucose reading from that night can be found page 29 (investigations). Looking at the notes again now, my impression that night was that I&S 's recurrent and difficult to manage hypoglycaemia was consistent with hyperinsulinism being one of the diagnoses in addition to sepsis.

11. As I&S 's glucose requirements had increased significantly (15.6 mg/kg/min) where normally we expect them to be in the range of 6-10 mg/kg/min, the most likely diagnosis at this point was suspected congenital hyperinsulinism (a condition characterised by and unregulated insulin secretion which is not regulated by the blood glucose level as occurs normally). I have written results for cortisol (289) and mentioned that there were no ketones in his urine in my entry made at 0700 on 17/09/15. This indicates to me that I was thinking about a diagnosis of hyperinsulinism and we had sent bloods for hypoglycaemia screen earlier during the night at 0135 when I&S had low BG. This is the time on the lab reports. Samples for hypoglycaemia screen were collected on 17/09/15 at 0135 and received by the lab at 0305.

12. I&S 's clinical condition at that time and the other available results were suggestive of hyperinsulinism. I discussed I&S with a consultant endocrinologist Dr Jo Blair at Alder Hey which is the local tertiary referral centre. They told me to send them I&S 's details and were going to organise transfer with presumed diagnosis of hyperinsulinism. Alder Hey advised that we should keep his BGs equal to or above 3.5 mmol/l. The insulin and c-peptide result together with low FFA and 3 hydroxybutyrate would have confirmed the diagnosis of hyperinsulinism. There are no results on insulin and c-peptide levels (as the sample was haemolysed so it could not be tested). The results for FFA and 3 hydoxybutyrate became available later but I am not able to interpret them confidently.

13. My next involvement in I&S 's care was on 21/09/15 when I have made an entry timed at 1030. In summary, I reviewed I&S on the ward round. His diagnoses were sepsis and query transient

hyperinsulinism. He was getting better as he had started feeding and IV fluids were being weaned slowly. His glucose requirements were 10.9mg/kg/min. He was on iv fluids (12.5 % dextrose at 12.5 mls/hr) and breast milk at 12 mls every 3 hours which was equivalent to total daily fluids of 142mls/kg/day. My plan was to modify his feeding regime by changing the IV fluids to 10% dextrose at 12.5 mls/hr and to increase total fluids to 150mls/kg/day. Excess fluid to be milk ideally given by a cup or NG feed but he was also having breast feeds. This regime would have given him a GIR of 9.9 mg/kg/min. I updated Dr. Sentiappan (Consultant Endocrinologist) who was happy for us to let I&S breast feed and wean down IV fluids gradually by 1ml every so often, check sugars 1 hour after the change and top up feeds as required.

14. I reviewed I&S again the next day, 22/09/15 and completed the Weekly NNU review sheet and made an entry in the clinical records. I have made two entries in the records. I have filled in the weekly NNU proforma where I have written under problem list - Transient congenital hyperinsulinism (insulin level awaited) sepsis. The other entry from the ward round reads congenital hyperinsulinism ? transient & sepsis. Sepsis was the probable diagnosis. As we did not have the insulin levels back, the diagnosis of hyperinsulinism was still a query and could not be confirmed or discounted. The word transient referred to whether the hyperinsulinism resolved after a few days. Even though clinical suspicion was strong, the insulin level from the hypoglycaemia screen was still awaited hence I have written query (?) congenital hyperinsulinism. His total GIR was 7.29 mg/kg/min on a mixed IV and breast feed diet. He was getting better and we were able to wean him off IV fluids. He was on 7th day of antibiotics. The plan was to continue to wean him from IV fluids every 4 hours if his BG remained greater than or equal to 3.5 mmol/l and establish breast feeding.

15. I had no further involvement in I&S 's care.

Witness contact details	URN:	07			

Name: **Astha Soni**

Home Address: Postcode:

Home Telephone No: Work Telephone No:

Mobile:

E-mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Safe/Preferred means of contact *(specify details for vulnerable / intimidated victims and witnesses only)*:

Gender: Female Date and place of birth:

Former Name: Self-defined Ethnicity Code: 1c1

State **DATES OF WITNESS NON-AVAILABILITY** during following 6 month period:

Witness Care

a) Is the witness willing to attend court? Yes x No ☐ If 'No', include reason(s) on **MG06**.

b) Record on the MG06 what can be done to ensure attendance. YES

c) Does the witness require a Special Measures Assessment as a vulnerable or intimidated witness? *(youth under 18; witness with mental disorder, learning or physical disability; or witness in fear of giving evidence or witness is the complainant in a sexual offence case).* Yes ☐ No X

If 'Yes' submit **MG02** with file in anticipated not guilty, contested or indictable only cases.

d) Has a Needs Assessment been completed? No X If 'Yes', '**standard**' or '**priority**'? *(circle as appropriate)*

e) Does the witness have any particular needs? Yes ☐ No X

If 'Yes' what are they? – Please state below *(Disability, healthcare, childcare, transport, language difficulties, visually impaired, restricted mobility or other concerns).*

Victim Consent

a) I have been given the Victim Information Pack.	Yes	☐	No	☐		
b) The Victim Personal Statement Scheme has been explained to me.	Yes	☐	No	☐		
c) I wish to provide a Victim Personal Statement.	Yes	☐	No	☐		
d) I wish to read out my statement at court (if practicable).	Yes	☐	No	☐	N/A	☐
e) I consent to my details being sent to a Victim Support service.	Yes	☐	No	☐		
f) I consent to police having access to my medical record(s) in relation to this matter *(obtained in accordance with local practice – officer to use pink medical evidence form).*	Yes	☐	No	☐	N/A	☐
I consent to the statement being disclosed for the purposes of civil, or other proceedings if applicable, e.g. child care proceedings, CICA, RTC cases.	Yes	X☐	No	☐	N/A	☐
Child witness cases only: I have had the provision regarding reporting restrictions explained to me.	Yes	☐	No	☐	N/A	☐
I would like CPS to apply for reporting restrictions on my behalf.	Yes	☐	No	☐	N/A	☐

'I understand that the information recorded above will be passed on to the Witness Service, which offers help and support to witnesses pre-trial and at court'.

Signature of Witness:		Print Name:	
Signature of parent/guardian/appropriate adult:		Print Name:	
Address and telephone number (of parent, etc.), if different from above:			
Statement taken by (print name):		Station:	
Date, time and place statement taken:			

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ASTHA VASUDEVA SONI

This is Exhibit AVS3 of the witness statement of Dr Astha Vasudeva Soni dated 12 June 2024

Cheshire Constabulary

WITNESS STATEMENT

Criminal Procedure Rules, 16.2; Criminal Justice Act 1967, s. 9; Magistrates' Courts Act 1980, s.5B

URN:	07			

Statement of:	Dr Astha SONI
Age if under 18 *(if over 18 insert 'over 18')*:	0'18 **Occupation:** CONSULTANT PAEDIATRICIAN

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Signature: PD **Date:** 22/06/21

Check box if witness evidence is visually recorded ☐ Witness personal details should be entered in appropriate section **ONLY.**

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4. I confirm that I have no independent recollection of my involvement in I&S 's care in November 2015. I am therefore making this statement based on my usual practice and my review of the entries made in the medical records in order to do my best to reconstruct my involvement.

Signature:	- PD	Signature Witnessed By:	PD

5. I&S was born at 34+2 weeks on PD 02/16@1919. He was one of the twins (twin 2), weighed 1615 grams and according to the notes, he was admitted to the neonatal unit due to prematurity, had intrauterine growth retardation.

6. I was first involved in I&S care on the night shift 11-12/2/16. I have made an entry in the notes on 12/2/16 at 0740. I believe I was the registrar on-call overnight. My entry reads:

IUGR baby 34/40
Twin 2
hypoglycaemia
Overnight sugars have been btw 2.5-2.3
This am 1.8
Hypoglycaemia down to 1.4 yesterday but cannula tissued +on 90mls/kg/day of feed.
Hypoglycaemia screen was sent by Dr. Harkness when sugar 1.4
Fluids- been on 4mls/kg/hr of 10% dextrose +increase feeds to 120 mls/kg/day (GIR=12.4mg/kg/min)
At present,
On 8mls/hr of 10% dextrose(5mls/kg/hr) +16 mls 2 hourly of DEBM. Total GIR13.9mg/kg/min
Due repeat sugar at 0800
Plan
1 hourly sugars
Prepare 12.5% dextrose
Needs long line in the day
Strict input/output
Signed Soni

7. I believe I was asked to review I&S because his blood glucose reading was 1.8mmol/l in the morning by the nursing staff. I did manage him overnight with regards to the concerns regarding borderline low blood glucose readings and my entry above summarises my involvement overnight.

8. Looking at the nursing notes (page 15), there is an entry by SN (Staff Nurse) Nurse T @ 0241 which confirms that blood sugar had dropped to 1.4mmol/l at the beginning of her shift the previous evening (11/02/16). I&S was recannulated and the hypoglycaemia screen done by Dr Harkness. He gave a bolus of 2ml/kg of 10% Dextrose was given and then IV (intra venous) fluids were restarted at 4ml/kg/hr. Blood glucose was 3.4 mmol/l after 1hr. Blood glucose was stable around 2.3 - 2.5mmol/l overnight. Nurse T has recorded that I&S was discussed with me and I instructed to increase enteral feeds to 120ml/kg. I have written in my notes that overnight BG (blood glucose) readings had been between 2.3-2.5 mmol/l. I have also pointed out that the baby had low BG reading the previous day (1.4 mmol/l) and hypoglycaemia screen was sent by Dr.

Harkness on the evening of 11/6/16. I have written the fluids and GIR (glucose infusion rate).

9. At 0725, Nurse T has made another entry that baby's BG was 1.8 and I was informed. She recorded my instruction to give a bolus of 3mls/kg of 10% dextrose and IV fluids were increased to 5 mls/kg/hr.

10. I have made a plan to check BG every hour. I have asked the nursing staff to prepare 12.5% dextrose and given an instruction to the day staff for a long line to be prepared if the baby needed higher concentration of dextrose. I have also asked for strict measurement of fluid intake and output.

11. I was the on-call registrar for the weekend 20-21/02/16. My next entry is 8 days later on Saturday 20/02/16 at 1244. This is a routine ward round I would conduct for each baby on the neonatal unit on a Saturday. It reads:

Diagnosis: Prematurity
IUGR
CHI- glucagon
Est feeds
Vent-SVIA
Feeds: 12.5 % dextrose at 6.8mls/hr, feeds EBM 6 mls 2 hourly
GIR- 10.8mg/kg/min
Feeds have not been increased over last few days
Sugars stable between 4-6mmol/l, no hypos
O/E-handles well
CVS 1-11-0
Chest- equal AE bilaterally
Abd-soft, non- tender
Imp: stable
Increased feeds as tolerated
Try to wean iv fluids if sugar >6
Increase feeds to 12mls 2 hourly, GIR 13mg/kg/min
Inform if concerns
Signed

12. I have made an entry and written the problem list which I have compiled from the previous entries. I&S was breathing for himself in air. I have noted his fluids and that his GIR was 10.8 mg/kg/min. I have also commented that his feeds have not been increased for a few days and his

blood glucose was stable between 4-6 mmol/l. My examination findings were unremarkable and he handled well. My clinical impression was that he was stable so I made a plan to increase his feeds as tolerated and try to wean his IV fluids if BG was below 6. I have also made a plan to increase his feeds.

13. I saw I&S again the following day, Sunday 21/02/2016. He was reviewed by Dr. Gibbs (consultant paediatrician) at the ward round. He had planned to discuss his condition with the endocrinology team at Alder Hey. I believe that this review is prior to my discussion with the Alder Hey team. My entry is timed at 1700 and reads:

Fluids and feeds on 20mls/2 hours milk +4.3mls/hr 12.5% dextrose GIR=12.8mg/kg/min
Sugars-5.2, 5.4, 5.3, 4.5mmol/l
Total fluids 212 mls/kg/day
On glucagon 5mcg/kg/hr
Tried ringing Dr. Das, Endocrinologist on-call- no answer. Message left on answering phone regarding further plan.
1810-DW Dr. Didi (on-call)
Updated regarding sugars and fluids. Unable to wean IV fluids. GIR still at 12.8mg/kg/min. total fluids 212mls/kg/day
Plan from Dr. Didi
Increase glucagon to 10mcg/kg/min
Reduce 1ml/hr of 12% dextrose if sugars >5 mmol/l
Try to wean during evenings and keep things stable overnight
Discuss with endocrine team tomorrow. Possible will need to restart diazoxide

14. I have made this entry after reviewing I&S. I have noted his fluids and blood glucose readings. I have noted that he is on 212 mls/kg/day. I tried to get in touch with Dr Das Consultant Endocrinologist at Alder Hey but was not able to speak with her and left an answerphone message. At 1810, I have written that I spoke to Dr. Didi who was the on-call doctor for endocrinology and updated him. I relayed to him that we had not been able to wean I&S' IV fluids. Dr. Didi advised a plan to increase glucagon and if his BG remained above 5, to reduce IV fluids by 1ml/hr. He also instructed us to discuss I&S with the endocrine team at Alder Hey next day (Monday) whether we need to restart diazoxide as his condition was not improving.

15. My last entry in I&S records is on Monday 22/02/16 at 0945. I have reviewed him on the ward round. He had an episode of hypoglycaemia at 1012 (as per page 52 clinical notes entry made by Staff Nurse L.Letby). I am not sure if he had a hypo whilst being reviewed on the ward round or he was asked to be reviewed because he had a hypoglycaemic episode. My entry reads:

34+2- D14-36+1
Prematurity
IUGR
CHI
Est feeds
SVIA
On full feeds of EBM@ 20mls 2 hourly +IV fluids 12.5% dextrose at 2.3 mls/hr= 182 mls/kg/day
GIR 10.2 mg/kg/min sugars >4 mmol/l last night
Meds- glucagon 10mcg/kg/min
Cefotaxime and teicoplanin Day 7
O/E- alert and active
CVA-1/11/0
Chest clear, Abdomen- soft and non-tender
Handles well
I&S *had a pre- feed BG of 0.7*
10% dextrose bolus@ 10mls/kg given
Increased 12.2% dextrose to 3.5 mls/hr
Plan- DW endocrine team regarding further plan.
IV cannula
Signed
Rpt BG 20mins after dextrose bolus-1.9 mmol/l
Discussed with Dr, Dharamaraj,
Rpt 10% dextrose bolus @ 3mls/kg
Increase 12.5 % dextrose to 4.5 mls/hr
Recheck BG, if still low give im glucagon (0.5 mg)
They will discuss in team meeting and get back to us regarding medium/long term plan
Neonatal registrar informed.

16. I have listed I&S clinical problems, his fluids, medications and done a clinical review. I have noted that his BG reading were > 4 mmol/l overnight and his GIR was 10.2 mg/kg/min. He had a pre-feed BG of 0.7 so I have instructed the nursing staff to give him a dextrose bolus and then recheck the BG. The repeat BG 20 minutes after the bolus was 1.9 so I rang the endrocrinology team at Alder Hey and discussed the further plan with Dr. Dharamaraj, Consultant Endocrinologist. I documented the plan Dr Dharamaraj gave me of repeating the dextrose bolus, increasing the dextrose infusion, rechecking BG and giving 0.5mg of intra muscular (IM) glucagon if his BG remained low. Dr Dharamaraj confirmed they would discuss I&S in their team meeting and confirm the medium/long term plan. I handed this plan over to the neonatal registrar and had no further involvement in his care.

Witness contact details URN: 07

Name: **Astha Soni**

Home Address:

Postcode:

Home Telephone No: Work Telephone No:

Mobile:

E-mail Address (*if applicable and witness wishes to be contacted by e-mail*):

Safe/Preferred means of contact *(specify details for vulnerable / intimidated victims and witnesses only)*:

Gender: Female Date and place of birth:

Former Name: Self-defined Ethnicity Code: 1c1

State **DATES OF WITNESS NON-AVAILABILITY** during following 6 month period:

Witness Care

a) Is the witness willing to attend court? Yes x No ☐ If 'No', include reason(s) on **MG06.**

b) Record on the MG06 what can be done to ensure attendance. YES

c) Does the witness require a Special Measures Assessment as a vulnerable or intimidated witness? *(youth under 18; witness with mental disorder, learning or physical disability; or witness in fear of giving evidence or witness is the complainant in a sexual offence case).* Yes ☐ No X

If 'Yes' submit **MG02** with file in anticipated not guilty, contested or indictable only cases.

d) Has a Needs Assessment been completed? No X If 'Yes', '**standard**' or '**priority**'? *(circle as appropriate)*

e) Does the witness have any particular needs?

If 'Yes' what are they? – Please state below *(Disability, healthcare, childcare, transport, language difficulties, visually impaired, restricted mobility or other concerns).* Yes ☐ No X

Victim Consent

a) I have been given the Victim Information Pack.	Yes ☐	No ☐	
b) The Victim Personal Statement Scheme has been explained to me.	Yes ☐	No ☐	
c) I wish to provide a Victim Personal Statement.	Yes ☐	No ☐	
d) I wish to read out my statement at court (if practicable).	Yes ☐	No ☐	N/A ☐
e) I consent to my details being sent to a Victim Support service.	Yes ☐	No ☐	
f) I consent to police having access to my medical record(s) in relation to this matter *(obtained in accordance with local practice – officer to use pink medical evidence form).*	Yes ☐	No ☐	N/A ☐
I consent to the statement being disclosed for the purposes of civil, or other proceedings if applicable, e.g. child care proceedings, CICA, RTC cases.	Yes X☐	No ☐	N/A ☐
Child witness cases only. I have had the provision regarding reporting restrictions explained to me.	Yes ☐	No ☐	N/A ☐
I would like CPS to apply for reporting restrictions on my behalf.	Yes ☐	No ☐	N/A ☐

'I understand that the information recorded above will be passed on to the Witness Service, which offers help and support to witnesses pre-trial and at court'.

Signature of Witness:		Print Name:	
Signature of parent/guardian/appropriate adult:		Print Name:	
Address and telephone number (of parent, etc.), if different from above:			
Statement taken by (print name):		Station:	
Date, time and place statement taken:			