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Meeting held at Belfast Royal Victoria Hospital on 7 December 2004 to discuss the treatment of our daughter Claire Roberts

8 December 2004

Compiled by Mr Alan Roberts

Dr Nicola Rooney arranged the above meeting at my request to discuss concerns my wife and I have following the treatment of our daughter at the Belfast Royal Victoria Hospital for sick children. These concerns have been ongoing over the years and were highlighted following the Insight television programme broadcast on 21 October 2004, by UTV.

Claire was admitted to hospital on Monday 21 October 1996 at approx. 7:15

We had a detailed discussion with Dr N Rooney, Dr H Stein, Dr A Sands and Professor Young and as a result of this meeting we would like to raise the following questions.

1. What was Claire's initial diagnosis on admission to the hospital?
   Claire's symptoms were, lethargy, vomiting and disorientation which are typical of Hyponatraemia.
   Were these symptoms interpreted as a viral infection?
   Was Claire's condition underestimated i.e.Were the Doctors concentrating on a viral infection, when a more serious illness was building which required early diagnosis?
   Was Hyponatraemia considered at this stage?

2. Claire's sodium was checked at 8:00pm on Monday 21, reading 132mmol/l. Should this level have raised concerns and should it have been checked and monitored every 1 – 2 hours?
   Was this an early indication of Hyponatraemia, which is defined as a sodium level less than 135mmol/l?

3. Claire had a blood test at 9:00pm on Tuesday 22 to check her medication levels. This was processed at 11:00pm but critically highlighted her sodium levels had dropped to 121mmol/l. This would indicate that this was not a specific test to check sodium levels and Claire's symptoms had been misdiagnosed.
   Did a Doctor examine Claire between 5:00pm and 11:00pm on Tuesday 22?
   Why was Claire's sodium level unchecked for 27 hours?
   How many blood tests were carried out on Tuesday 22?
   How were Claire's water retention and water excretion levels monitored?
   Were tests carried out on Claire's urine?

4. Claire was administered a number of anticonvulsant and antibiotic drugs throughout Tuesday 22.
   Did this mixture of medication compound and worsen Claire's symptoms given that her sodium levels were falling?
   Should this medication have been stopped?
   What impact would the medication have on Claire if she was suffering from Hyponatraemia?

5. Was the incorrect type of fluid administered to Claire?
   If this were the case, what were the implications for Claire?
   What impact would the combination of both strong medication used along with an incorrect fluid type have on Claire?
   Did this combination speed up the process of falling sodium levels?

6. My wife and I were with Claire most of Tuesday 22 and left the hospital at 9:30pm. During that time we were not unduly worried about Claire's condition and no indication or concern was directly expressed by any Doctor. In fact I do not recall speaking to a Doctor on Tuesday 22 and took that as a positive with regard to Claire's condition.
At our meeting on the 7 December Doctor Sands indicated that on Tuesday 22 he considered Claire's condition to be serious.
If Claire's condition was considered as dangerous or serious on Tuesday 22 why was this concern not urgently highlighted to my wife or I?
Why was Claire not admitted to Intensive Care if her condition was serious?
Would parents leave a seriously ill child in hospital alone?

7. When Claire's blood test results were returned on Tuesday 22 at 11:00pm, showing a low sodium level, who co-ordinated the subsequent treatment?
Was the correct action taken with regard to the type and quantity/reduction of fluid given?
At this stage had Claire's condition deteriorated too much for remedial action?
At what time was Claire admitted to Intensive Care?
Had Claire's condition deteriorated so much in Allen Ward that the Intensive Care Unit were unable to do anything to save Claire?

8. Follow up meetings in January 1997 with Consultants and Doctors at the Royal Hospital and the Post Mortem report (our condensed version) dated 21 March 1997 defined the cause of death as Cerebral Oedema linked to a viral infection. No statements were made about Hyponatraemia.
Given that Claire's sodium levels dropped so suddenly within a 27 hour period ie. Acute Hyponatraemia, why was this condition not defined?
Does the full post mortem report make any reference to Hyponatraemia or sodium levels?

9. Professor Young explained that the fluid type administered to Claire would not be given to a patient at the Royal Hospital today who has sodium levels lower that 135mmol/1 and that such patients would have their sodium levels reviewed every 1- 2 hours.
What were the guidelines in October 1996 for a patient whose sodium levels were less than 135mmol/l?

10. Professor Young stated that the fluid type administered to Claire had a definite input into her death. He indicated that the input level would be difficult to quantify.
As Parents I feel that this question centres around our heartache and search for answers, therefore it is very important for us that this issue is investigated and answers given.
We have struggled for over eight years to understand and accept how an unknown viral infection could be the cause of Claire's death and are again devastated to realise that Hyponatraemia now appears to be a more accurate cause.
Will the cause of Claire's death be reviewed by the Belfast Royal Hospital?
Given that Claire's death was sudden, unexpected and without a clear diagnosis, why was the Coroner not informed or an inquest held?
Why did it take the broadcasting of a television programme to raise issues and concerns regarding the death of our daughter?

It is clear from our meeting on 7 December that senior medical staff are aware of shortcomings regarding Claire's treatment.
We therefore request that Claire's case is referred to the Coroner for further urgent investigation with the desire that the case is made part of the current ongoing inquiry led by Mr John O'Hara, QC.

Please note that as our discussions are ongoing the above questions do not form an exhaustive list.

Mr Alan & Mrs Jennifer Roberts