bb Co. Brangam Bagnall & Co. Solicitors

Hildon House, 30-34 Hill Street, Belfast BT1 2LB
Tel: [redacted] **Fax:** [redacted] **DX No. 485NR**
Web: www.brangam-bagnall.co.uk

Our ref: RGH/I/134/GB/LS

Your ref: A.49/04/35

31st July 2006

Mr A P Walby FRCS Ed
Associate Medical Director
Litigation Management Office
4th Floor
Bostock House
Royal Victoria Hospital
Grosvenor Road
BELFAST
BT12 6BA

THE ROYAL HOSPITALS
01 AUG 2006
LITIGATION MANAGEMENT

2/8/06

Dear Mr Walby

RE: CLAIRE ROBERTS - INQUEST

Thank you for your letter of 21st July received at this office on 24th July.

I enclose a copy of a letter received from the Coroner dated 11th July 2006 together with a copy of the Coroner's longhand note in relation to the additional evidence given by Dr Steen.

The Coroner now considers that his involvement in this matter has concluded.

Unfortunately I do not think there is any benefit to be gained by corresponding with the Coroner further in this case. I would hope that Mr O'Hara QC will have seen all of my correspondence.

Continued...

Also at Commercial Mews, 69-71 Comber Road, Dundonald, Belfast BT16 0AE
Tel: [redacted] Fax: [redacted] DX No. 3873NR

Partners: George D. H. Brangam, Gary Daly
Associates: S. A. Crothers, Eimer Coll
Solicitors: Caroline Hannan, Mark Harvey, Maeve Colgan, Sinead Owens, Judith Jones

Continuation to Mr A P Walby **31st July 2006**

Should you wish to discuss this matter or require further assistance, please do not hesitate to contact me.

Yours sincerely

Gary Daly
for Brangam Bagnall & Co

[redacted]

Encs

Coroners Service for Northern Ireland

JOHN L LECKEY LL.M.
SENIOR CORONER
FOR NORTHERN IRELAND

Brangam Bagnall & Co
Solicitors
Hildon House
30-34 Hill Street
BELFAST
BT1 2LB

Your ref: RGH/I/134/GB

11th July 2006

Dear Sirs

RE: CLAIRE MARGARET ROBERTS 29200-2004

I have received your letter of 4th July.

As requested I am enclosing a copy of my longhand note in relation to the additional evidence given by Dr Steen. The contents of that note (halfway down the first page) are reflected in the Verdict. Whenever that note was read back in open court the contents were not queried by either Dr Steen or the legal representatives.

As I have now concluded the inquest I regard myself and being functus officio.

Yours faithfully

J L LECKEY
Senior Coroner for Northern Ireland

17 JUL 2006

Enc

Tel: [redacted] Fax: [redacted]
May's Chambers, 73 May Street, Belfast. BT1 3JL
www.coronersni.gov.uk

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of 20 , at inquest touching the death of , before me Coroner for the District of as follows to wit: –

The Deposition of DR. HEATHER STEEN

of (Address)

who being sworn upon her oath, saith

I produce a draft death certificate C8. I would not object to Professor Young's formulation. If a CT scan had been taken & had shown cerebral oedema I think that would have been attributed to encephalitis & her seizure. Claire's fluid regime in 1996 was normal. The blood test results at 11.30 p.m. should have led to a clinical re-assessment & the test should have been repeated. Simultaneously there should have been a reduction in fluids. After 3 a.m. her condition was not retrievable & may not have been at 11.30 p.m. At the time I thought she died from cerebral oedema due to neurological ~~reasons~~ causes

Mr. McCrea: I was the Consultant in take at that time. Claire fell within my remit. I was aware that Claire ~~first saw Claire at~~ was in the ward at 9 a.m. on the Tuesday morning. I cannot recall if I examined her prior to that. My recollection is that when I contacted the ward I was told Dr Webb had seen her & had taken over her management. I was not

would have expected Dr Webb to be contacted right if the concern was neurological. The GCS at 9 p.m. showed a ~~det~~ deterioration then her management should have been discussed with a consultant. Neither I nor Dr Webb was contacted — until 3 a.m. I agree that intervention at 11.30 p.m. would have been too late. I had no involvement with Adam Strain. That related to high output renal failure with surgical intervention ~~cases~~. I am unaware of any protocol issued by the hospital following that. Fluid management in cases such as Claire's has changed significantly in recent years. ~~The~~.

Heather J Steen [signature].

TAKEN before me this 4th day of May 2006

[signature] Coroner for the District of Northern Ireland