

bb Co. *Brangam Bagnall & Co. Solicitors*

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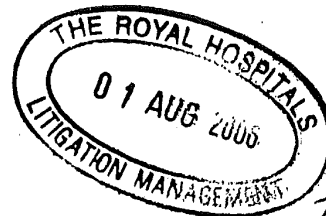
Hildon House, 30-34 Hill Street, Belfast BT1 2LB
Tel: [REDACTED] Fax: [REDACTED] DX No. 485NR
Web: www.brangam-bagnall.co.uk

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



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



Lexcel
THE LAW SOCIETY
OF NORTHERN IRELAND

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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

Encs



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 as being functus officio.

Yours faithfully

A handwritten signature in dark ink, appearing to read 'J L Leckey'.

J L LECKEY
Senior Coroner for Northern Ireland

Enc

A handwritten note in dark ink, possibly reading 'Enc to back of...'. It is written above a horizontal line.

17 JUL 2006

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 c. 8. 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 ~~causes~~ ^{causes}.

Mr. McCrea: I was the Consultant on duty at that time. Claire fell within my remit. I was aware that Claire ~~first came~~ ^{first came} Claire at my 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
 with if the concern was neurological. The
 ICS at 9 p.m. showed a ~~low~~ deterioration
 in 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
 so late. I had no involvement with Adam
 high output renal failure with ^{intervention} surgical cases. I am
 not aware of any protocol issued by the
 hospital following that. Fluid management
 cases such as Charles ^{significantly} has changed in
 our years. The

Heather J Skem.

TAKEN before me this 4th day of May 2006

W. L. Bailey

Coroner for the District of Northern Ireland