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From: Michael McBride

Sent: 31 March 2006 10:49

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To: Dympna Curley; Jo.McGinley; [REDACTED]; June Champion

Subject: FW: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

Dear all,

For information,

The Department has been informed as per Circular HSS (PPM) 2/2006 and have requested a further background briefing which I will provide.

Handy seen to Coroner, it was a bit long handed for the case

Yours

Michael

From: Michael McBride

Sent: 28 March 2006 11:08

To: Ian Carson Work [REDACTED]

Cc: [REDACTED]

Subject: FW: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

Ian,

See below I notify you as per Circular HSS (PPM) 2/2006.

I requested a review of the case by Ian Young following contact by the Roberts family.

Following this initial report I asked that Peter refer the case back to HM Coroner by RGH in December 2004.

Nichola Rooney has been seeking to support the family.

Yours

cc: Peter Walby

Michael

From: Michael McBride

Sent: 28 March 2006 11:02

To: June Champion

Cc: [REDACTED] Jo.McGinley

Subject: FW: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

June,

As the nominated trust officer can you notify the Department as per Circular HSS (PPM) 2/2006 - Reporting & Follow-up on SAIs

Yours

Michael

From: [REDACTED]

Sent: 28 March 2006 09:11

To: Jo.McGinley

Date: 1/03/2006

Message

Cc: Michael McBride

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Subject: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

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The Inquest into the death of this 9 year old girl will be held in Belfast Coroner's Court on Tuesday 25th April 2006. She died in 1996 in RBHSC and a consented limited hospital post mortem examination of brain was performed. She had had severe learning disability and a history of epilepsy, and a diagnosis of encephalitis was considered on admission. She had a respiratory arrest within two days and died later that day in ICU and a Death Certificate was issued recording the cause as cerebral oedema secondary to status epilepticus.

Following the UTV Insight programme in October 2004 into paediatric deaths from hyponatraemia, Claire Robert's parents contacted the hospital and after a review of the notes it was considered in retrospect that the known hyponatraemia which was treated may have had a part to play in the medical condition leading to death, and after a meeting with the family the death was reported to HM Coroner by RGH in December 2004.

HM Coroner has obtained independent expert reports from 2 consultants in Great Ormond Street and St. Mary's Hospitals. The parents have become involved further by posing detailed questions, and this Inquest is likely to provoke considerable public and media interest.

Dr. Ian Carson had been advised earlier of this case by H M Coroner and it may be appropriate for Dr. McBride to p
D S&PS on notice of the Inquest date.

Peter Walby

31/03/2006

CR - ROYAL

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