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The ROYAL HOSPITALS

Litigation Management
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Private + Confidential

To: Mr Walby

From: [redacted]

Fax: [redacted]

Pages: 7

Phone:

Date: 15/12/04

Re:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

As discussed.

Message

A.49/04/35/J Page: 291

[redacted]

From: Michael McBride
Sent: 15 December 2004 12:28
To: [redacted]
Subject: FW:

For the immediate attention of Mr Walby.
Michael
-----Original Message-----
From: Michael McBride
Sent: 15 December 2004 10:48
To: [redacted]
Cc: Nichola Rooney
Subject:

Peter,

I asked Nichola to copy you the minutes of the meeting with the Roberts family.

At the meeting on my recommendation we clearly indicated that following our case note review and the expert opinion of Prof Young and others that we were significantly confident that their daughters fluid management was a contributory factor to her death amongst the many others involved.

In these circumstances at the meeting with the family we indicated we would be referring the matter to the coroner. At the meeting we sought to determine their view on this action, as we are aware that HRM coroner would wish to be informed of their wishes in arriving at this determination. It is clear that our requirement to refer their daughter's case to the Coroner has the full support of the family.

I need you now to take responsibility for this matter. Nichola will take the lead in liaison with the family. I would ask that you now begin to coordinate notes of meetings and report to date so that you are in a position to share this information with HRM Coroner for appropriate action. It will be for the Coroner to determine as to whether he should have discussions with others at this stage.

Michael

-----Original Message-----
From: Nichola Rooney
Sent: 14 December 2004 17:26
To: [redacted] Heather Steen; Andrew Sands
Cc: Michael McBride; [redacted]
Subject: Roberts meeting

In light of the many questions posed by Mr Roberts and our shortage of time, I have suggested postponing our meeting until early January, with Dr McBride referring the case to the Coroner in the meantime. Mr Roberts is happy with this. We now need to meet again to put some answers down on paper - although I appreciate that some of these will be reiterating what was already said. Michael would also like Dr Walby to get sight of any responses made. Could I ask you to start this process by thinking about/ writing down some initial reponses - and can we perhaps meet Monday Tuesday or Wednesady am next week? Let me know what dates suit. Then we can get a date for the start of January to meet with the family and move the process along.
Regards, Nichola

Message

The ROYAL HOSPITALS [redacted]

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2.

From: Ian Young [redacted]
Sent: 13 December 2004 13:53
To: Nichola Rooney; Heather Steen
Cc: Michael McBride; [redacted]
Subject: RE: Roberts Letter

Nichola

I am happy to be guided by your view as to the family's wishes. Not surprisingly, they do not seem to have absorbed all of the information we gave them. Looking at the detail of the questions, I do not think anything that we say will provide all of the answers they seek. If we meet on Wednesday morning I will have to leave 10.30 as I am sitting on an interview panel. I am free tomorrow 2.30 – 3.30 if we need to discuss the questions, or anytime earlier on Wednesday.

Best wishes

Ian

IS Young
Professor of Medicine, Queen's University Belfast
Consultant in Clinical Biochemistry, Royal Group of Hospitals

Wellcome Research Laboratories
Mulhouse Building
Royal Victoria Hospital
Grosvenor Road
Belfast
BT12 6BJ

[redacted]

From: Nichola Rooney [mailto [redacted]
Sent: 13 December 2004 11:14
To: Heather Steen; [redacted]
Cc: Michael McBride; [redacted]
Subject: Roberts Letter

Just wondered about the best way to deal with the numerous questions. As the desire to go ahead with the coroner and John O'Hara is clearly stated - should I say we can go ahead with this - and delay the meeting if possible - or do we want to try and get some answers down by Wednesday am?? Nichola

A.49/04/35/J Page: 293. 3.

[redacted]

Fro[redacted]
Sent: Nichola Rooney
To: 13 December 2004 10:48
Cc: Michael McBride
Subject: [redacted]
URGENT - meeting dated 07 dec 04

MeetingatRVH7Dec 04[1].doc (32 ...

From Mr Roberts re our meeting. Can you discuss this with me Michael when you get a minute, Thanks, Nichola

-----Original Message-----
From: alan roberts [mailto:[redacted]
Sent: 09 December 2004 20:44
To: Nichola Rooney
Cc: [redacted]
Subject: meeting dated 07 dec 04

Dear Dr Rooney
Thank you for organising our meeting on the 7 December.
It was a difficult discussion for my wife and I but beneficial in our search for answers.

I have attached a note that outlines some of our questions regarding Claires treatment and the direction in which we would like to proceed.

Hopefully we can confirm another meeting for the 16 December

Regards
Alan Roberts

4.

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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 133mmol/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/l 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

[redacted]

From: Nichola Rooney
Sent: 07 December 2004 16:37
To: [redacted]
Cc: Michael McBride; Anna Brownlee; Joan Gallery
Subject: RE: mtg

Thanks Ian - Your contribution was invaluable - and I know the family will be very pleased to meet with you again. - Lets pencil in Wednesday at 9.30am - I could do late Thursday too - but I have a mtg with Prof Crawford [redacted] I will see how available Michael is but think we should aim to go ahead anyway. I will e mail you or call as soon as I get the questions and forward the minutes asap. Best regards, Nichola

-----Original Message-----
From: Ian Young [mailto:[redacted]
Sent: 07 December 2004 15:55
To: Nichola Rooney
Cc: Michael McBride
Subject: RE: mtg

Nichola

I will be in London for most of the rest of this week (apart from after 4pm tomorrow). However, I can be contacted on my mobile [redacted] at any time. I can be free next Wednesday morning up until 10.30 and any time in the afternoon. Thursday would probably need to be late afternoon (after 4pm) for me, although I will obviously do my best to rearrange things if necessary.

I have left a message with David Webb's secretary in Dublin asking him to contact me so that I can talk to him about the situation.

Best wishes

Ian

IS Young
Professor of Medicine, Queen's University Belfast
Consultant in Clinical Biochemistry, Royal Group of Hospitals

Wellcome Research Laboratories
Mulhouse Building
Royal Victoria Hospital
Grosvenor Road
Belfast
BT12 6BJ

[redacted]

From: Nichola Rooney [mailto:[redacted]
Sent: 07 December 2004 11:29
To: [redacted] Heather Steen; Andrew Sands
Cc: Anna Brownlee; Joan Gallery; Michael McBride
Subject: mtg

Thankyou for this morning - the family are very pleased with our efforts. All signs however point to them wanting to take this further. They are going to e mail me any questions and would like to meet next week - perhaps Wednesday or

7.

Thursday morning - although I think they might want to meet with Michael and/or Ian as they feel Heather and Andrew have dealt fully with the main issues regarding Claire's time in hospital. I will talk to you personally about particular issues ral[illegible] In the meantime, could I ask you to hold some time on Wednesday 15th or Thursday 16th morning. Many thanks Nicola

The ROYAL HOSPITALS

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Phone: **Date:** 15/12/04

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