ROYAL HOSPITALS

Litigation Management Office, 4th Floor, Bostock House, RVH – Tel: [redacted]

Our Ref: A.49/04/35/J
Your Ref: RGH/I/134/GB

24th July 2006

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

Dear Gary

Re: Claire Roberts (deceased)

I refer to my letter dated 16th June 2006 (copy enclosed) with regards to the above named and await your reply with regards to H M Coroner's Verdict.

Yours sincerely

A P Walby FRCS Ed
Associate Medical Director

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

Enc

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 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 result 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 cause.

Mr. McCrea: I was the Consultant on take at that time. Claire fell within my remit. I was aware that Claire first came 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

I would have expected Dr Webb to be contacted prior if the concern was neurological. The GCS at 9 p.m. showed a deterioration that for 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 Brangam Bagnall's high output renal failure with intervention. Strauss. That related to surgical care. I am unaware of any protocol used by the Hospital following that. Fluid management in cases such as Claire's has significantly changed in recent years. The

Heather J Stern.

TAKEN before me this 4th day of May 20 06

Coroner for the District of Northern Ireland