HSC Business Services Organisation

Directorate of Legal Services

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Your Ref:	Our Ref:	Date:
AD-0177-10	NSC B04/2	10th January 2011

Ms Anne Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to your letter of 21st October 2010 (AD-0177-10) in relation to Claire Roberts.

In answer to the request for copies of two laboratory biochemistry reports, printed copies of these results which are hand recorded in the medical records are not available.

The result "Na 129" recorded by Dr. McKaigue at 090-022-060 refers to a blood sample taken as part of the process of testing for brainstem death. Dr Taylor records "Na 129 (from 121)" at 090-022-061 but it is not clear which Na 121 test he is referring to. The result of the blood sample taken on 22.10.96 (recorded in the nursing notes at 9.30pm, 090-040-138) is recorded as "Na 121, K 3.3 etc" in the records by the Paediatric SHO Dr. Stewart at 23.30 on 22.10.96 (090-022-056). Dr. Steen refers to these results at 4.00am on 23.10.96 (090-022-057), but she also then records "Na 121, K 3.7 etc" which must refer to a further test sample. The printed reports for Na 129 and the two for Na 121 are not contained in the medical records.

As previously stated in letter from DLS to the Inquiry dated 5th August 2010 in response to AD-0150-10 regarding Adam Strain the Belfast Trust attempted to retrieve results by liaising with their IT department and were informed it was not possible. The old RVH lab IT system was switched off around the year 2000 when both the BCH and RVH labs moved onto the LabCentre IT system. The decision was made by Lab management not to try and copy test results from the old systems as there were too many inconsistencies between the various data formats. The only data that was archived off the RVH system are Cytology/Histopathology results, Biochemistry results were not archived.

The Trust has no documents relating to contact which the Inquiry states that the Roberts family made with the RBHSC following the Insight television programme of 21st October 2004.

The Trust believes contact was not made with the RBHSC but with the Trust directly but it is not documented. The Roberts family should be able to confirm this. There are no documents relating to any response prior to the meeting between Trust staff and the Roberts family on 7th December 2004. It is Dr. McBride's (former Medical Director) recollection that when the matter was brought to his attention he personally asked that Claire's medical records be recovered from file. He reviewed the notes and then felt it appropriate to request Prof. Ian Young, Consultant in Clinical Biochemistry to review the medical and nursing records to ascertain whether hyponatraemia could possibly have been a contributing factor to Claire's death. Dr. McBride also personally verbally asked Dr. Nicola Rooney, Consultant Clinical Psychologist to act to liaise and support the Roberts family at the meeting which took place on 7th December 2004.

In answer to the first set of questions 1-4:

1. The meeting between the Roberts family and members of the Trust staff on 7th December 2004 was the first meeting.

2. There were no subsequent meetings with the Roberts family.

3. Dr. McBride does not recall the date of his request to Prof. Young to review Claire's notes, however it was within a very short period possibly days of Dr. McBride reviewing the notes. Dr. McBride does not recall issuing a written instruction to Prof. Young nor does Prof. Young recall receiving written instruction. There is not any such documentation held by the Trust.

4. Dr. McBride did not request or receive a written report. The Inquiry's referral to "... provision of the written report" is incorrect. No such written report was created. Prof. Young provided Dr. McBride with a verbal report within a short period of time confirming that in his professional opinion hyponatraemia may have contributed significantly to Claire's death. Prof. Young stated at the Inquest (096-008-041 to 048) that his review was as set out in his deposition and that he gave Dr. McBride a verbal report.

In answer to the second set of questions 1-3:

1. In relation to meetings, Dr. McBride clearly recalls requesting a meeting which occurred on 6th December 2004 and included Professor Young and Dr. Steen but he does not recall anyone else being present. It is referred to in email (RVH Coroner's file A.49/04/35/J Page 340) but was not formally minuted. He recollects that at this meeting he decided Claire's death should be referred to HM Coroner. Neither Prof. Young nor Dr Steen recall any other meetings than those of 6th and 7th December 2004. Dr. Sands has no knowledge of any meetings other than that on 7th December 2004. Dr. Rooney has advised that her role was only to facilitate the Roberts family getting information from the medical staff involved in the

care of their daughter and planning the meeting of the 7th December 2004, the minutes of which the Inquiry are in possession of.

2. There were no investigations into Claire's death prior to December 2004.

3. It is routine for deaths in RBHSC to be discussed at monthly audit meetings however the Audit Meeting Minutes of 8th November 1996 following Claire's death only record "Mortality Meeting – 4 cases were presented", and give no further details. Audit Minutes following the Inquest make no reference to Claire Roberts.

Yours faithfully

pp Nicola Dooker

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