



Belfast Health and Social Care Trust

Chief Executive
Colm Donaghy

Chairman
Prof. Eileen Evason (Acting)

21 November 2013

Private & Confidential

Mr & Mrs Roberts
C/O Ferguson & Co Solicitors, Belfast
7th Floor Causeway Tower
9 James Street South
Belfast
BT2 8DN

Dear Mr & Mrs Roberts

I refer to our recent meeting in Banbridge on Tuesday 12th November 2013.

I agreed to respond to you on a couple of issues. First the letter of 16th October 2013 sent from the Directorate of Legal Services to your solicitor and secondly the Serious Adverse Incident raised in 2006 in respect of Claire.

In relation to the letter from the Directorate of Legal Services, as I indicated to you on Friday 15th November 2013, I believe that some of the wording in the letter is insensitive. I accept that your reason for pursuing Claire's case is to as far as possible, ascertain the truth.

In discussion with the Directorate of Legal Services they have indicated that Professor Kirkham's evidence is legally relevant to Claire's case should a defence be mounted. The Directorate of Legal Services has also indicated that in legal correspondence they have a professional responsibility to highlight relevant available defences and it was not their intention to cause further upset. I can assure you, that given the shortcomings in Claire's care the Trust has no intention of defending your claim and I reiterate again our unreserved acceptance of liability.

I apologise for any additional hurt or distress the letter of 16th October 2013 has caused your family.

In relation to the Serious Adverse Incident (SAI) report form I have investigated the circumstances and can confirm that Dr McBride requested that the form was

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completed in March 2006 as the Inquest into Claire's death was imminent and at that time the SAI criteria included alerting the DHSSPS about matters of public concern.

As Dr McBride indicated in his oral evidence to the Inquiry he had not reported the SAI because he believed there was no further regional learning to be shared at that time as the Regional Guidance on fluid management had been issued in 2002. There was then to be both a Coroner's Inquest and a Public Inquiry which would take precedence over any internal review and would inevitably produce wider regional learning when concluded. Therefore the report form remains in the Belfast HSC Trust database pending the publication of the Inquiry's findings.

We can discuss further at our next meeting if you would find it helpful.

Yours sincerely


Colm Donaghy
Chief Executive