Browne, Andrew

From: Browne, Andrew
Sent: 04 April 2006 15:42
To: Carson, Ian
Cc: McCormick, Andrew; Hamilton, Andrew; Mitchell, Elizabeth (Dr); McCarthy, Miriam; Bill, Jonathan; Baxter, Clare; Anderson, Mark; McKelvey, Siobhan; 'tanya.stewart[redacted]
Subject: RE: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts
Attachments: d3n30000.pdf

Dr Carson
I attach a copy of Prof Ian Young's review of Claire Robert's case, which you may have already seen. I can also confirm that John O'Hara mentioned this case to Minister at a meeting on 1 September 2005 as one on which he was seeking further information. It is clearly within the Terms of Reference of the Inquiry for John O'Hara to "at his discretion, examine and report on any other relevant matters which arise in connection with the Inquiry". I presume the Inquiry will want to consider the findings of the Inquest before advising Minister of whether they wish to investigate this case in the manner of the other three and what that might mean for timescales. The PSNI may also wish to consider the findings, and the timescale for any action by the Inquiry may be dependent on what the Police decide and whether any action is directed by the PPS. I imagine that the likely course of events, in the first instance, is that the Coroner will write to John O'Hara after the Inquest and then Mr O'Hara will advise Minister of what action he proposes to take.

In the meantime I have asked Siobhan McKelvey to prepare a note to Minister alerting him to the Inquest and the likely publicity. Do you wish me to convene a meeting to discuss any of this?
Andrew B

From: Carson, Ian
Sent: 29 March 2006 15:41
To: McCarthy, Miriam
Cc: Mitchell, Elizabeth (Dr); Anderson, Mark; Baxter, Clare; Browne, Andrew; Hamilton, Andrew
Subject: FW: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

Miriam,
Please see Andrew's email below. Can you look back at the details of this case, to inform future meeting.
Yours, IWC.
Sonya,
Please await advice from Dr McCarthy regarding future meeting.
IWC

From: Hamilton, Andrew
Sent: 28 March 2006 19:35
To: Carson, Ian; Bill, Jonathan
Cc: Baxter, Clare; Mitchell, Elizabeth (Dr); McCarthy, Miriam; Browne, Andrew; McCormick, Andrew
Subject: RE: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

I think we will need to have a discussion about this case. Ian could you organise for us. I would appreciate more detail particularly re implications for inquiry . We should involve you copy recipients in the meeting..
Andrew

-----Original Message-----
From: Carson, Ian
Sent: 28 March 2006 18:50
To: Bill, Jonathan
Cc: Baxter, Clare; Mitchell, Elizabeth (Dr); McCarthy, Miriam; Browne, Andrew; Hamilton, Andrew; McCormick, Andrew
Subject: FW: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

Jonathan,
Please note email below from Michael McBride regarding an upcoming Coroner's inquest.
Miriam/Elizabeth/Clare,
We maybe should prepare some lines to take in anticipation of media interest.
Yours, Ian

From: Michael McBride [redacted]
Sent: 28 March 2006 11:08
To: ian.carson[redacted]
Cc: Amanda Lennon
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: Amanda Lennon; 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: Amanda Lennon
Sent: 28 March 2006 09:11
To: Jo.McGinley
Cc: Michael McBride
Subject: Email from Mr A P Walby re Inquest touching on the death of Claire Roberts

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 put DHHS&PS on notice of the Inquest date.

Peter Walby

STATEMENT OF WITNESS

STATEMENT OF: IAN YOUNG, CONSULTANT IN CLINICAL BIOCHEMISTRY
Name *Rank*

AGE OF WITNESS (if over 21 enter "over 21"): OVER 21

NOT SIGNED IN POLICE OFFICER'S PRESENCE

I declare that this statement consisting of 2 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

TO BE COMPLETED WHEN THE STATEMENT HAS BEEN WRITTEN

Dated this day of

SIGNATURE OF MEMBER by whom statement was recorded or received

SIGNATURE OF WITNESS

Re: Claire Roberts (deceased) DOB: 10/01/87

I am a registered Consultant in Clinical Biochemistry, and qualified at Queen's University Belfast in 1985 with MB BCH BAO. I am Fellow of the Royal College of Physicians (London), Fellow of the Royal College of Physicians of Ireland and a Fellow of the Royal College of Pathologists.

I was asked to review the medical records of this 9-year-old girl by Dr Michael McBride, Medical Director of the Royal Group of Hospitals. I was asked to give my opinion on whether hyponatraemia may have contributed to Claire's death. This statement is based on my inspection of the medical and nursing notes relating to her hospital admission in 1996. In addition I spoke to Dr Heather Steen, Dr Andrew Sands, Dr Nichola Rooney and to Claire's parents. I have provided an honest and true opinion based on my reading of the notes. However, I did not have access to comments from all of the other medical practitioners involved in Claire's care.

Claire was referred to the Accident and Emergency Department of the Royal Belfast Hospital for Sick Children by her general practitioner on the evening of the 21st October 1996 with a history of vomiting and lethargy. Blood was taken at approximately 22.30 hours for an estimation of urea and electrolytes. It is noted that this revealed serum sodium of 132mmo/l. A "down arrow" is present beside the sodium of 132 mmol/l at 12 midnight on the 21st October, indicating that the sodium was noted to be below the lower reference limit. A subsequent note in the chart by Dr David Webb, Consultant Neurologist, from around lunchtime on the 22nd October 1996, states: "I note (N, biochemistry profile".

Claire received intravenous fluid replacement following admission and throughout the day of the 22nd October with predominantly 0.18% saline / 4% dextrose. There was a progressive deterioration in her clinical condition with evidence of status epilepticus. A record of fluid balance is present, but losses are not accurately recorded so that fluid balance cannot be judged.

A repeat blood sample was taken at around 9pm on the evening of the 22nd October. A note timed 23.30 on the 22nd October records serum sodium of 121mmol/l, and suggests that fluid overload with low sodium containing fluids or syndrome of inappropriate ADH production were considered as possible diagnoses. Intravenous fluid replacement was reduced to 2/3rds of previous values. A note was taken to send urine for osmolality although there is no record of a result.

Form 38/36 (Plain)

SIGNATURE OF WITNESS.....

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STATEMENT CONTINUATION PAGE

STATEMENT OF: IAN YOUNG CONTINUATION PAGE NO: 1

At approximately 3am on 23rd October Claire suffered a respiratory arrest and was noted to have fixed dilated pupils. She was transferred to the Paediatric Intensive Care Unit. At 4am it is noted that pupils were fixed and dilated and there was bilateral papilloedema. A Note at 4.40am on the 23rd October form Dr David Webb indicated the likely diagnosis of syndrome of inappropriate ADH production with hyponatraemia, hypo-osmolality and cerebral oedema following prolonged epileptic seizures. Claire subsequently died on the 23rd October at 18.45 hours. A death certificate was issued indicating cerebral oedema secondary to status epilepticus.

I informed Dr Michael McBride, the Medical Director of the Trust that in my opinion hyponatraemia may have made a contribution to the development of cerebral oedema in Claire's case. I advised that it would be appropriate to consider discussing the case with the coroner for an independent external opinion with access to statements from all of the staff involved in Claire's care.

SIGNATURE OF STATEMENT MAKER: I.C. Young