Alison –
I would need to meet with John Jenkins – will you arrange

HC|95|06
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15 JUN 2004 D
CMO'S OFFICE

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June 11th 2004

Dr John Jenkins
Department of Child Health
The Queen's University of Belfast
Institute of Clinical Science
Grosvenor Road
Belfast BT12 6BL

Dear Dr Jenkins

Having got home from Conor Mitchell's inquest, I feel I must communicate my great unease.

This is the fourth inquest I have attended in Belfast where suboptimal fluid management has been involved.

Again, in the case of Conor who was primarily admitted for the treatment of dehydration, there was no written formal examination for this, such as skin turgor, capillary refill, though they did note his mouth was dry.
There was no calculation of the degree of dehydration nor the fluid deficit and no calculation of the maintenance fluids for a 22kg child. You will see from the enclosed copy of the fluid charts that the first prescription is not even signed. In my opinion, the initial rate of infusion was unnecessarily high. Small fluid deficits can be made good over a few hours. There was a lapse in the infusion for some hours and then 250ml saline were ordered to run over four hours and then a further 250ml over six hours. The basis of these amounts makes no sense to me at all. There was no note of volumes of urine passed, even though it was collected and I could not even find a basic TPR chart.
The fluid management was described in Court as "acceptable"

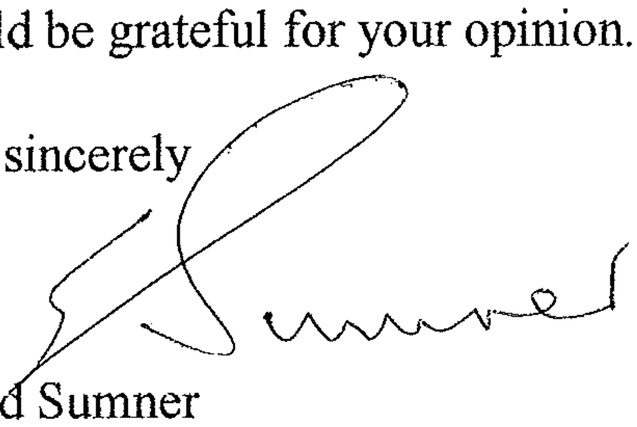
In addition to this, it is quite clear to me that Conor was suffering from unrecognised and therefore, untreated seizure activity over a period of seven hours or so while being nursed in a side room of an adult medical ward. Atypical seizure activity had been seen in the Accident and Emergency department before transfer to the ward, but this was neither recorded in the notes nor was this information passed on to the ward.

My overall impression from these cases is that the basics of fluid management are neither well understood, nor properly carried out.

Has this been your experience? What is the remedy?

I should be grateful for your opinion.

Yours sincerely



Edward Sumner
Consultant paediatric anaesthetist

cc Dr Henrietta Campbell CMO
Mr John Leckey HM Coroner

BLOOD TRANSFUSION CHECK WITH SISTER/STAFF/NURSE/DOCTOR
1. PATIENT'S NAME
2. UNIT NUMBER
3. BLOOD GROUP
4. LAB. REF. NUMBER

THEN: CHECK TEMPERATURE, PULSE, B.P. at 15 min. intervals after putting up blood -- REPORT IMMEDIATELY ANY CHANGE

N.B. Patients receiving intravenous therapy only for periods of longer than 48 hours require potassium replacement as well as sodium replacement if there is any sizeable loss of intestinal contents even if oliguria. They may be oliguric because of potassium deficiency. If in doubt ask for expert advice.

N.B. It is dangerous to correct "acidosis" on the basis of the "base deficit" on the Astrup estimation without knowledge of the plasma Na value. It is permissible for the expert to do this in emergency situations such as cardiac arrest.

10ml/kg. 22kg.

PARTICULARS OF INTRAVENOUS FLUIDS TO BE TAKEN

Bottle	Amount	Type of Fluid	To be added to bottle	Time to be commenced	Time completed	Prescribers Signature	Nurses Signatures
	220 ml	[illegible]	—	T/2 hr.			110 mls at 11[illegible] 110 mls at 114[illegible]
2	1L	N. Saline	20 mmol KCl	8hrs		CE	[illegible]
	1L	5% dextrose	20 mmol KCl	8hrs		CE	
	1L	N. Saline		8hrs		CE	
4	250 mls	N Saline		4hr		CE	[illegible]
3	250 ml	N saline		[illegible]	6hr.	CE	[illegible]
	250 ml	N saline		8hr		CE	

DHSSPS

006-043-407

INTAKE / OUTPUT CHART

Affix Label: Conor Mitchell

31

24 hours beginning 9 a.m.

Date: 8 MAY 2003

VOLUMES IN MLS. ONLY

TIME	INTAKE				OUTPUT			REMARKS
	Oral Type	Intravenous Volume Erected	Intravenous Type	Intravenous Volume In	Urine	Faeces	Vomit / Tube	and Other Routes
9 a.m.								
10 a.m.								
11 a.m.		110 mls	Hartmanns	110				
12 noon		110mls	Hartmanns	110				
1 p.m.		2nd cannula Ven Flon extravasated Dr Totten informed of events						
2 p.m.								
3 p.m.								
4 p.m.		FLUIDS RECONNECTED						
5 p.m.				220				
6 p.m.								
7 p.m.		220 ml Normal saline started to run in over 60						
8 p.m.								
9 p.m.								
10 p.m.								
11 p.m.								
12 m.n.								
1 a.m.								
2 a.m.								
3 a.m.								
4 a.m.								
5 a.m.								
6 a.m.								
7 a.m.								
8 a.m.								

24-HOUR PERIOD ENDING AT 9.00 a.m. ON DATE BELOW

INTAKE			
	By mouth	Ivenous or other routes	Total
Total for 24 hours	ml	ml	ml
TOTAL INTAKE			ml

OUTPUT		
Urine	Faeces	Vomit/Tube
ml	ml	ml
TOTAL OUTPUT		ml

ne: Surname: First Names: Unit No.: 006-043-408

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