

The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Mr Douglas Jessiman
BTO Solicitors
48 St Vincent Street
Glasgow
G2 5HS

Your ref: LJD/ASE1193
MEDI/3/110

Our Ref: BMcL-0134-13

Date: 22nd August 2013

Dear Mr Jessiman,

Re Raychel Ferguson

I attach copies of my letter to the DLS dated 10 May (Ref: BMcL-0088-13) and of the document "Hyponatraemia in Children" (Ref: 043-101). DLS have responded to the effect that they have sought clarification from Dr Taylor on the questions raised in this letter, but have not yet received any response.

Can you please take instructions from Dr Taylor on the questions raised by the Inquiry and provide a response by 30 August 2013? If it Dr Taylor's position that he is not the author of this document please advise forthwith.

Yours sincerely,



Brian McLoughlin
Assistant Solicitor to the Inquiry

Secretary: Bernie Conlon
Arthur House, 41 Arthur Street, Belfast, BT1 4GB
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The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Ms Wendy Beggs
Directorate of Legal Services
2 Franklin Street
BELFAST
BT2 8DQ

Your Ref: NSCB04/1
NSCW50/1
NSCS071/1

Our Ref: BMcL-0088-13

Date: 10th May 2013

Dear Ms Beggs,

Re Raychel Ferguson (Lucy Crawford Aftermath)

I attach a copy of a document entitled "Hyponatraemia in Children" (Ref 043-101-223 to 043-101-224), which is from papers provided by the Sperrin Lakeland Trust (Esther Millar). The copy in the Inquiry's possession is a little unclear in places. Can the Trust please provide a clearer copy?

Turning to the document itself there are three handwritten notes at the top: "*from BCH, B Taylor*"; "*(Childrens Ward)*"; and "*received from Belfast 10/8/01 via Dr Asghar*".

It would appear that this was sent to the Erne Hospital by a doctor B Taylor on 10 August 2001.

Dr James Kelly has informed the Inquiry that in August 2001 "*Paediatric Unit received a copy of RBHSC Fluid Guidelines to utilise locally*".

Please take the Belfast Trust's instructions on the following questions;

- 1) Who was the author(s) of the attached document?
- 2) When was it written?
- 3) What was its purpose?
- 4) What events, if any, prompted the creation of this document?
- 5) To whom was it circulated?
- 6) Was it in use as an instruction or guideline within the Belfast Trust? If so give full details of when it was introduced as an instruction or guideline, and where it was so introduced.
- 7) Please provide any earlier drafts of this document and the dates of such drafts.

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Yours sincerely,

B. Coulter
B. Coulter

Brian McLoughlin
Assistant Solicitor to the Inquiry

WOM. BCH.
B. Taylor

(Childrens Ward)

Received from
Belfast 10/8/01
via Dr Ashgar.

Hyponatraemia in children

Dilutional Hyponatraemia has been documented in otherwise healthy children following routine elective surgery. It occurs in often female children 3-10 years of age and is associated with "stress". Eg postoperatively.

A fluid for children recommended for many years as a standard is 0.18 NaCl in 4% Glucose. It contains 40 mmol/l of sodium which when administered at the calculated rate (4 ml/kg/hour for the first 10 kgs body weight) provides the daily requirement of sodium and glucose.

0.18 NaCl in 4% Glucose is isotonic *in vitro* ie has the same osmotic potential so will not cause fluid shifts within the body. However in the catabolic (sick) child the glucose is metabolised rapidly causing the fluid to become *hypotonic* thereby leading to massive fluid shifts. At the same time because of the loss of fluid from the circulation often combined with a degree of dehydration a potent anti-diuretic hormone (ADH) response causes the kidneys to retain water resulting in a low volume concentrated urine, high in sodium. This may be compounded by the administration of a "fluid challenge" to elicit an improved urinary output.

This is a "double whammy" excess free water is administered and excess free water is retained. Water is drawn across blood capillaries into the interstitial and intracellular spaces. The child will become "puffy" looking and of greater consequence the brain will swell with the shift of water, leading to seizures and herniation of the tentorium and death. Therefore to prevent hyponatraemia we must limit the free water component of intravenous fluids AND monitor urine output and serum chemistry.

Recommendations;

1. Regular measurement of blood biochemistry, including a baseline measurement and measurements following each intervention, eg, fluid resuscitation or surgery.
2. Maintenance fluids should be calculated separately from "replacement" fluids. The rate of maintenance fluid is critically dependent on Body weight which should be accurately measured or estimated by a professional with substantial paediatric experience.

An accepted guide to maintenance fluid administration is;

For the first 10 kgs body wt give 4 ml / kg / hour (40 ml/hr for a 10 kg infant)
For the second 10 kgs body wt give 40 + 2 ml / kg / hour (60 ml/hr for a 20 kg child)
For each subsequent 1 kg body wt give 60 + 1 ml / kg / hour (70 ml/hr for a 30 kg child)

3. DO NOT give GLUCOSE containing intravenous fluids for fluid resuscitation. This is in keeping with APLS recommendations (use 0.9% NaCl, Normal Saline or other salt solution). You MUST measure blood sugar and administer a GLUCOSE bolus if there is hypoglycaemia (< 3 mmol/L).

4. Maintenance fluids should contain at least 0.45% NaCl in 2.5% Glucose/A balanced

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salt solution such as Normal Saline or Hartmann's does not contain glucose. Regular, 12 hourly, blood sugar estimation is required and must be documented.

5. Measurement of urine output or body weight is mandatory. Daily body weight measurement will accurately assess free fluid but is not feasible in the surgical bed bound child with acute pain. Urine output must be measured and clearly documented. An experienced doctor must assess fluid balance at least twice daily and take appropriate action to correct fluid loss or retention. If urine output is problematic a urinary sodium, potassium and urea should be measured.

6. Care must be exercised when additional fluids are administered as this may seriously complicate the maintenance fluid regimen. Intravenous antibiotics, oral fluids or contrast media are commonly forgotten additional fluids.

Intravenous Fluid Prescription

Infants (up to 1 year of age).

Dilutional Hyponatraemia does not appear to be a common problem in this age group. Blood chemistry and monitoring of fluid balance is as described above.

For normal serum sodium (Na^+ 135-145 mmol/l)
Give 0.18% NaCl in 4% Glucosept at a rate of 4 ml per kg body weight per hour. Eg
For a 5 kg infant this is 20 ml per hour.

For low or high sodium expert advice should be sought.

Children (greater than 1 year of age).

Dilutional Hyponatraemia is well documented in this age group. Blood chemistry and monitoring of fluid balance is as described above.

For normal serum sodium (Na^+ 135-145 mmol/l)
Give 0.45% NaCl in 2.5% Glucosept at a rate as above.

For low or high sodium expert advice should be sought.

REFERENCES

Arieff AI. Postoperative hyponatraemic encephalopathy following elective surgery in children. Paediatric Anaesthesia 1998;8:1-4

Halberstadt M et al, Acute hyponatraemia in children admitted to hospital. BMJ 2001;322:780-2

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