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

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

Our Ref: BC-0204-13

Date: 4th July 2013

Dear Ms Beggs,

Re: Conor Mitchell

Further to the Chairman's remarks on the 2 July with regard to the future conduct of the Inquiry, the Inquiry's legal team has commenced its work in relation to the issues surrounding the management of Conor Mitchell's fluid requirements. We now seek your assistance in furthering the work of the Inquiry in that regard.

We would refer you to document **007-073-145 (&146),** which is a letter dated 7 April 2004 from Dr. C. Humphrey (at that time Medical Director of Craigavon Area Hospital Group Trust) to the Dr. H. Campbell (then Chief Medical Officer).

Arising out of the contents of that letter we would ask you to seek the following from your client (the former Craigavon Area Hospital Trust):-

1. Dr. Humphrey's letter indicates that "*the guidance on the prevention and management of hyponatraemia in children was taken forward in Craigavon Area Hospital Group Trust by a group of senior clinicians…*"

   He identified those clinicians as the Consultant Clinical Biochemist, a consultant representative from A&E, two senior paediatricians and a consultant anaesthetist.

   We would be grateful if you could take steps to provide the Inquiry with the names of the clinicians referred to by Dr. Humphrey.

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Furthermore, in the event that it becomes necessary to issue witness statements to these clinicians, please clarify with regard to each clinician that it is appropriate to serve these on your office in the first instance.

2. Dr. Humphrey's letter goes on to identify a number of ways in which the *'hyponatraemia guidelines'* were taken forward within the Craigavon Area Hospital Group Trust after their introduction in 2002:

    - They were adopted throughout the Trust
    - They formed part of the induction for junior doctors
    - Detailed fluid protocols were available for medical staff
    - Junior medical staff were guided to seek consultant input into the management of hyponatraemia in both adults and children

    We would be grateful if you could take steps to obtain from the former Craigavon Trust all relevant documentation associated with the *taking forward* of the hyponatraemia guidelines.

    Without prejudice to the generality of this request the following documentation should be made available to the Inquiry where it exists:

    a. Any records of meetings of the group of clinicians which was assembled by the former Trust for the purposes of taking the guidelines forward, and any other records relating to decisions or actions taken by this group of clinicians for the purposes of taking the guidelines

    b. Any records demonstrating how the guidelines were adopted though out the Trust whether that was through correspondence to staff, memos posted on notice boards, use of handbooks, meetings of staff, presentations to staff, advice or directions to staff, training days etc. The Inquiry is concerned to see any relevant documentation of this class, whether it was intended for medical or nursing staff;

    c. Any records showing how the guidelines were introduced to junior doctors as part of their induction, and any records demonstrating how junior doctors

were guided to seek consultant input in the management of hyponatraemia in children as well as adults. Again, if the guidelines were introduced tom nursing staff as part of their induction, relevant records should be produced;

d. The "detailed fluid protocols" that were made available for medical staff, and if applicable, nursing staff;

e. Any documents relating to any particular steps that were taken to disseminate and implement the hyponatraemia guidelines in those areas of Craigavon Hospital where Conor was cared for before he was admitted to the intensive care unit, namely, the Accident and Emergency Department and the Medical Admissions Unit, to include any documents relating to any training or instruction provided to medical and nursing staff at those locations.

3. Dr. Humphrey's letter also makes reference to the Craigavon Trust's participation in a regional audit of the guidelines which was conducted through the SAC Paediatrics Committee. The Inquiry is in possession of the regional report relating to this audit. However, we do not hold any specific information relating to that part played by Craigavon in this audit.

   Accordingly, the former Trust should be asked to address the following matters relating to the audit:

   a. Identify by name and job title, those who conducted the audit, and those who supervised or managed the conduct of the audit;

   b. Provide a copy of the audit framework (ie. the issues that were being audited, the methodology etc);

   c. Specify the date(s) on which the audit samples were collected;

   d. Provide a copy of the audit report and/or the returns which were made in respect of the audit that was conducted at the former Craigavon Trust.

It is imperative that the Inquiry advances its investigation in relation to this aspect of the terms of reference as expeditiously as possible. Accordingly, we would ask for your

fullest co-operation with regard to the above requests notwithstanding the imminent holiday period. We would ask you to respond to these requests by no later than the 29 July.

Yours sincerely,

Bernie Conlon

Bernie Conlon
Secretary to the Inquiry