HSC Business Services Organisation

Directorate of Legal Services
— Practitioners in Law to the Health & Social Care Sector —

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Your Ref:	Our Ref:	Date:
AD-0640-13	HYPS071/01	20th September 2013

Ms A Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – CONOR MITCHELL

I refer to the above matter and to your letter of 16th September 2013. I am instructed by the Southern Health and Social Care Trust as follows:-

Audit Issue 1
When she issued the Guidelines in 2002 the Chief Medical Officer advised the Medical Directors of Acute Trusts and other relevant clinicians that "it will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences" [Ref: 007-001-002].

(a) Were any steps taken at Craigavon Area Hospital to audit compliance with the (2002) Guidance and any protocols which were developed locally?

The Trust confirms that steps were taken at Craigavon Area Hospital to audit compliance with the 2002 guidelines / IV fluids. To date the Trust has been unable to locate the detailed protocols referred to in Dr Humphrey's letter to the Chief Medical Officer of 7th April 2004.

The table attached hereto summarises the Trust's response in relation to issues b – d highlighted in the above correspondence.

Audit Issue 2

The Trust is progressing the response in relation to Audit Issue 2 and notes that same is due 26 September 2013.

Yours faithfully

Joanna Bolton
Solicitor Consultant

Compliance measure	Person responsible for conducting the audit / compliance and who they reported to	Methodology used to conduct the audit	Units or areas of the hospital which were subjected to audit	Professional disciplines covered by the audit	Period of time during which the audit was conducted and maintained	Results of the audit
Monitoring through clinical incident reporting:	Led by Dr M Hogan, Lead Clinician in Paediatrics	Ongoing review of paediatric clinical incidents	Paediatric team	Paediatrics, nursing, pharmacy, clinical risk manager and a senior manager.	Ongoing	Awareness implementations plan put in place to avoid re-occurence of incidents Example new gentamycin kardex
Stabilisation and Transfer of Critically Ill Children Telelink Audit 2005/2006	Dr Davis SpR Paediatrics , Dr Bell, Consultant Paediatrician	Monthly telelink at regional level	Paediatric Team/ Emergency Dept team / Anaesthetic team/ radiology team	Paediatrics medical and nursing, emergency dept medical and nursing, Anaesthetics medical and nursing and radiology dept	Ongoing	Sharing points of good practise and continuous improvement for the transfer of critically ill infants example in house simulations between emergency dept and paeds set up, requirement for 2 members of medical staff to always accompany a critically ill child
Transfer Audit	Dr B Bell, Consultant Paediatrician	Completion of form	Children's ward Emergency dept, neonatal unit	Medical,nursing and managers	Ongoing	Information sent to Dr Tubman Director of paediatl rc and neonatal transport to inform the needs of the transport team for a 24/7 service
Audit of paediatric resuscitation:	Dr A Chillingworth.	Retrospective review of all paediatric resuscitations between April – July 20	Paediatrics, Craigavon Area Hospital		April – July 2005.	presented at the Area Paediatric Audit meeting on 21 July 2005. Results previously submitted Training need identified and training undertaken