The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Ms Joanna Bolton Directorate of Legal Services 2 Franklin Street BELFAST BT2 8DQ

Our Ref: AD-0641-13

Date: 16th September 2013

Dear Ms Bolton,

In future Oral Hearings the Inquiry will want to examine the procedures that are in place to examine serious adverse incidents, and how well such procedures have worked and are working.

Please address the following matters with the Southern Trust:

- 1. In 2003, did the Craigavon Area Hospital have in place a procedure to examine serious adverse incidents?
- 2. If so, and if that procedure had been committed to writing, please provide a copy.
 - Otherwise, please describe the main features of the procedure, and in particular outline how serious adverse incidents were examined within the Hospital/Trust, and the circumstances in which such incidents were reported to the DHSSPSNI.
- 3. Was the death of Conor Mitchell treated as a serious adverse incident under the procedures which were in place in 2003?
 - Please provide any documentation relating to any steps taken at Craigavon Area Hospital to treat Conor's death as a serious adverse incident.
- 4. Was the death of Conor Mitchell reported to the DHSSPSNI, and/or the Chief Medical Officer, whether as a serious adverse incident or otherwise? If so, when was reported, and who was it reported to?

Please provide any documentation relating to any contact between the Craigavon Area Hospital, the DHSSPSNI and/or the CMO in respect of Conor's death.

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5. Did the family of Conor Mitchell raise a complaint in relation to the treatment he received at Craigavon Area Hospital?

If so, please provide any correspondence relating to any such complaint, and any document relating to its consideration or investigation by the Craigavon Area Hospital.

I would be grateful for the Trust's substantive reply by Friday 27th September 2013.

Yours sincerely,

Anne Dillon

Solicitor to the Inquiry