HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

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Your Ref:
JOH-0413-13

Our Ref:
HYP/S071/01

Date:
11th October 2013

Mr Justice O'Hara
Chairman of the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-CONOR MITCHELL

I refer to your letter of 4th October 2013 and also to Mrs Begg's response dated 9th October 2013. Your correspondence of 4th October made two specific requests, which were not responded to in Mrs Begg's aforementioned letter. I am instructed by the Southern Health and Social Care Trust instructs as follows: -

"If the Trust can maintain any relevant information from Dr Hogan about the introduction and implementation of the guidelines it should do so immediately and forward to the inquiry."

The Trust has discussed the above request with Dr Hogan who has advised that Dr Barbara Bell was the Head of Paediatrics in 2002 when the Guidelines were issued. Dr Hogan has advised that Dr Bell initiated dissemination and implementation of Actions arriving from the Guidelines, including the paediatric ward in Craigavon Area Hospital's participation in the regional audit of Hyponatraemia, co-ordinated by Dr McAloon and Dr Kottyal, which was published in the Ulster Medical Journal in 2005.

"I am not aware of the identity of the Clinical Directors in the areas were Conor was Treated (The accident and emergency department and the MAU), nor am I aware if they received the Guidelines from Dr McCaughey with directions to implement them, or of the steps which they may have taken complies with this direction."

The Clinical Directors in post in the areas where Conor was treated were Dr Jeff Lee (Medical Assessment Unit) and Mr Ivan Sterling (the accident and emergency department):

Dr Jeff Lee was contacted by the Trust late on Tuesday 8th October 20913. Dr Lee indicated during this conversation that he had no immediate recollection of directions given or his

actions regarding the 2002 guidelines. Mr Ivan Sterling was contacted by the Trust Wednesday 9th October 2013. Mr Sterling indicated that he had no specific recall of receiving the Guidelines or directions to implement them. Dr David Lowry was contacted by the Trust on the Wednesday 9th October 2013. Dr Lowry has indicated that he has no specific recall of receiving the Guidelines or directions to implement them.

The Trust confirms that Dr Barbara Bell was Clinical Director of Paediatrics. The Trust spoke with Dr Bell on Thursday 10th October 2013. Dr Bell advised that she recalls the 2002 Guidelines were disseminated through the usual standard process in place at the time.

Dr Bell agreed with the Clinical Services Manager (the manager for the nursing staff) that the posters sent from the Department of Health were displayed for reference by all doctors and nurses prescribing and administering IV fluids.
Dr Bell asked for the guidance to be incorporated into educational talks by consultants and senior trainees to ensure that all medical staff were aware of the guidelines. Also, the lead trainee would have been asked to ensure that all trainees were aware of the guideline and that on-going reference to the guideline became standard practice.
Dr Bell does not have the documentation.

Finally the Trust confirms that Dr Ian Orr was the Clinical Director of Anaesthetics. Unfortunately the Trust has been unable to make contact with Dr Orr. We have, today, been advised by the GMC that Dr Orr is no longer registered with it. The GMC has provided Dr Orr's address, as per their records, which is in Northern Ireland. The Trust believes that Dr Orr may be living in Scotland at present. A representative of the Trust has attended at the address provide by the GMC today and has left a letter addressed to Dr Orr.

Yours faithfully

JRBo

Joanna Bolton
Solicitor Consultant