HSC Business Services Organisation

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

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:	Our Ref:	Date:
AD-0663-13	HYPS071/01	15th October 2013

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

Dear Ms Dillon

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – CONOR MITCHELL

I refer to your letter dated 8th October 2013 (reference as quoted above) and confirm the Southern Trust has taken instructions from Dr Bell. Using the same numbering as in your letter we confirm Dr Bell has informed the Trust as follows:-

1. In her leadership role as Head of Paediatrics, Dr Bell asked medical staff to comply with the 2002 Guidelines. When Dr Bell stated in response to question 3(c) (iv) of her statement "I ensured the guidance was audited and the results brought to our Paediatric Departmental Meeting" she was referring to the regional audit co-ordinated by Dr J McAloon and published in the Ulster Medical Journal in 2005. Dr Bell ensured that the paediatric medical staff participated in the regional audit.

2. The initial audit (undertaken as part of the regional audit) was undertaken in May 2003 and repeated in June 2003 and January 2004. Dr Bell was Head of Department until May 2003 and thereafter Dr Hogan would have ensured that medical staff in the Paediatric Department contributed to the audit.

3. The regional audit proposed that the management of all patients in receipt of IV fluids between 12:00 and 14:00 hours on the same day in May 2003, and who had also been in receipt of IV fluids in the previous twenty-four hours, would be assessed for compliance with the guidance. The audit was repeated in June 2003 and January 2004.

4. Dr Michael Smith, Consultant Paediatrician, was involved in leading this audit and the audit of cases on the paediatric ward would have been carried out by a team within the Paediatric Department.

5. The audit was undertaken in respect of the inpatient paediatric ward, Craigavon Area Hospital. Dr Bell did not have responsibility for nursing staff within the paediatric ward or for compliance with the 2002 Guidelines within the adult wards.

6. Dr Mike Smith was responsible for collating the results of the audit. It is Dr Bell's recollection that the paediatric medical staff working in the paediatric ward in Craigavon Area Hospital were compliant with the 2002 Guidelines and no changes in practice or action were required.

7. The results of each audit would have been presented to the Paediatric Audit meeting upon completion.

8. Dr Bell's recollection is that the paediatric ward was compliant with the 2002 Guidelines.

9. No change in clinical practice or action was required as a result of the regional hyponatraemia audit as clinical practice was compliant with the 2002 Guidelines.

10. The results of the regional hyponatraemia audit were not retained in Craigavon but were forwarded for inclusion in the regional audit which was collated by Dr J McAloon. There are no specific references to hyponatraemia in Dr Bell's departmental minutes which ceased in March 2003.

Yours sincerely

John Johnston
Solicitor