The ROYAL HOSPITALS

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

HM Coroner
Coroner's Office
Courthouse
37 Church Road
Newtownabbey
BT36 7LA

23rd February 2003

Rachel Ferguson. Date of death 10/6/2001

Dear Mr Leckey,

I am writing back to you with feedback from the Medicines Control Agency (MCA). You gave me permission to release the postmortem report of the above child so that the Medicines Control Agency (MCA) could investigate the intravenous fluids that were used in this case. I have been campaigning to get a ban on the use of 0.18%NaCl /4%Glucose in hospitals.

Last October I requested that the MCA should issue a "hazard notice" to prevent further deaths related to this fluid (0.18%NaCl/4%Glucose). As you can see by their letter, they asked the subgroup on Paediatric Medicines to look at this. They advised that there should be "no amendments to product information".

Very recently a major international journal "Pediatrics" published an article "Prevention of hospital-acquired Hyponatraemia". The Commentary accompanying this article illustrates the complexity of this subject and the controversy. There are clearly two camps with quite clear and reasonable arguments about the use and abuse of this fluid 0.18%NaCl/4%Glucose.

This leaves us all, whether experts or lay public rather confused. It is of little solace to the families of deceased children to be told that their child died from a complex and controversial, but apparently preventable cause.

[redacted]

There have been several initiatives I know of aimed at preventing hyponatraemia;

1. In 2001 Dr Paul Darragh, Deputy Chief Medical Officer chaired a working party to produce a guideline for clinicians on "Prevention of Hyponatraemia". I was a member of this group that produced a guideline for use in NI in all hospital departments where children are seen. This guideline is non-prescriptive in the actual fluid that should be used. Several members of the committee were not happy that 0.18%NaCl/4%Glucose be "banned". Others, like myself were adamant that this fluid should be "named and shamed" so that clinicians would only use it if there was a clinical indication.

2. The second edition of the book "Medicines for Children", widely used throughout the UK is due to be published. I was asked to review/rewrite several chapters and have added a paragraph to the Chapter on "fluids and electrolytes" reminding readers of the potential for hyponatraemia to result from 0.18%NaCl/4%Glucose administration.

3. On-going education to doctors, nurses, paramedics and others within our own hospital and to those in training who will work in paediatric departments throughout NI. Fluid and electrolyte management continues to be a major component of teaching at paediatric resuscitation training days. Eg I have been the Director of the "Advanced Paediatric Life Support (APLS)" course in Belfast and Dublin where this problem has been emphasised over and over again.

I hope this has been helpful and will be delighted to provide further information on this important topic.

Yours truly,

Dr RH Taylor, MA, MB, FFARCSI
Consultant Paediatric Anaesthetist

Cc Mr Peter Walby, Associate Medical Director, RGH Trust