## Coyle, Briege

**From:** Campbell, Dr Henrietta
**Sent:** 30 December 2004 09:54
**To:** McCarthy, Miriam
**Subject:** RE: j.jenkins[redacted]

Miriam
Would you put together the BNF advice as given since 2000?
Etta

-----Original Message-----
From: McCarthy, Miriam
Sent: 29 December 2004 14:41
To: Campbell, Dr Henrietta; Carson, Ian
Subject: FW: j.jenkins[redacted]

CMO/ Ian

For information. I suspect in Bob's last paragraph he meant 'there was no case to :mmend'. The current BNF has a warning that injudicious use of NaCl 018%/ Glucose 4% may cause dilutional hyponatraemia.

Happy to discuss

Miriam
-----Original Message-----
From: BOB TAYLOR [mailto:drbobtaylor[redacted]
Sent: 16 December 2004 18:55
To: miriam.mccarthy[redacted]
Subject: j.jenkins@[redacted]

HI,

I was speaking to a consultant intensivist in Royal Manchester Childrens hosp today.

He told me they recently had a child transferred to :hem with dilutional hyponatraemia and cerebral oedema. They reported the case to their Coroner and despite their insistence that they had serious concerns about the care the coroner refused to call an inquest.

It seems that;

1. our article in Archives is still not changing the use of hypotonic fluids.

2. the coroners appear to be interpreting the reporting of deaths inconsistently across the UK.

3. there are probably more cases of hyponatraemia occuring that are not being reported.

4. the BNF changed their "product information" on glucose containing fluids in sept 2003, despite their letter in 2001 that confirmed there was case to amend the product information.

I will keep in touch

bob

**McCarroll, Myrtle**

**From:** Carson, Ian
**Sent:** 29 December 2004 15:18
**To:** Neagle, Heather
**Subject:** FW: j.jenkins[redacted]

Heather,
Note comments about inconsistent actions by HM Coroners.
Yours, Ian.

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Subject: FW: j.jenkins[redacted]

CMO/ Ian

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