

## The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Ms Wendy Beggs  
Directorate of Legal Services  
2 Franklin Street  
BELFAST  
BT2 8DQ

Your Ref: NSC B04/1

Our Ref: AD-0154-10

Date: 20 July-2010

Dear Ms Beggs,

Re Investigation into the death of Adam Strain

Thank you for your letter of 9<sup>th</sup> July 2010.

With reference to the missing laboratory reports detailed therein, I would be grateful if you would provide me with details of:

1. The normal procedure for ensuring that laboratory test reports are inserted in the patient's files.
2. The date of knowledge of the staff of the Belfast Trust involved in Adam's care (both medical and administrative) that these reports were missing.
3. Any efforts made to locate these results prior to 2000 (before the inception of the LabCentre IT system).
4. Any discussions concerning the missing reports in or around the time of the Inquest into Adam's death in June 1996 or during the course of defending the medical negligence action proposed by Adam's mother.

Regarding the information you provided me with about the blood gas analyser machine, in your letter of 7<sup>th</sup> June 2010, I would be obliged if you would gather from your client the following additional information:

5. The identity of the person who checked the machine prior to Adam's transplant procedure taking place.
6. Whether (if so, when and by whom) the clinicians involved in Adam's treatment were told that the machine was producing unreliable results.
7. Any documentary evidence relating to the unreliability of the readings produced by the machine at that time, including any guidance from Instrumentation Laboratory regarding:
  - a) The effect of using heparin on the reliability of electrolyte measurements.

Secretary: Raymond Little Deputy Secretary: Bernie Conlon  
Arthur House, 41 Arthur Street, Belfast, BT1 4GB

Email: [Inquiry@lhrdnl.org](mailto:Inquiry@lhrdnl.org) Website: [www.lhrdnl.org](http://www.lhrdnl.org) Tel: 028 9044 6340 Fax: 028 9044 6341

- b) The margin of error for sodium readings from blood gas analyser machines in 1995.
- 8. If the hospital was told, how (if at all) this was communicated to clinicians, when and to whom.
- 9. The location within the hospital of the blood gas analyzer machine used during Adam's treatment in November 1995.
- 10. Details of personnel trained and authorized to use the blood gas machine in 1995

In addition to the above, I would be obliged if you would ascertain from your client:

- 11. The length of time it would have taken in 1995 to arrange a laboratory test from an operating theatre.
- 12. What arrangements were in place in 1995 for laboratory reports to be provided for out of hours electrolyte testing and early surgery? In particular, was there a resident laboratory technician or an "on-call" technician to assist with such arrangements?

I would be grateful for a response to my letter of 30 June 2010 and my two letters of 7 July 2010.

Yours sincerely,



Anne Dillon  
Solicitor to the Inquiry