HSC Business Services Organisation

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

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Your Ref:
AD-0190-10

Our Ref:
NSC B04/1

Date:
22 December 2010

Ms Anne Dillon
Solicitor to the Inquiry
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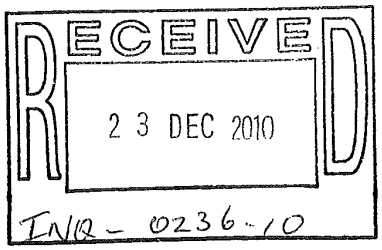

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to your letter of 29th November 2010.

In response to the questions posed the Trust has determined the following:

1. Current medical notes relating to a patient admitted to a ward are kept in the chart trolley. Where there are a large number of such charts, while the most recent ones would be kept in the trolley, historic charts would be requisitioned to the ward and kept at the Nurses' Station.

2. (a) In 1995 there were no formal RBHSC policies of protocols in place in relation to the recording of discussions between clinicians and among clinicians, patients and family members. Routine practice however would have been that decisions based on such discussions or conclusions from such discussions would have been recorded in the clinical notes, chronologically by the doctor involved, if considered to be of significance.

   (b) Although there was no policy or protocol in RBHSC in 1995 for allocating responsibility for patients by doctors, standard practice was that Consultants, while retaining responsibility for their own specific patients could delegate some of their care to junior medical colleagues while requiring regular liaison regarding any significant change in a patient's condition. When a Consultant was not immediately available responsibility would be handed to Consultant colleagues e.g. Consultants and junior doctors would work out of hours on on-call rotas to provide continuous patient care.

Yours faithfully

pp Nicola Dodd

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