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:
BPC-0125-12
BC-0063-11

Our Ref:
HYP B04/01

Date:
17.02.12

Mr B Cullen
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letters of 31st January 2012 (BPC-0125-12) and 2nd November 2011, annex 2a (Paediatric Directorate Clinical Audit Meetings).

As requested I now enclose random minutes for 08.02.95, 15.03.95, 13.04.95 09.06.95, 14.05.96, 12.06.96, 08.08.96, 12.09.96, October 1996, 08.11.96, and 10.12.96.

I am instructed that these had inadvertently not been disposed of by RBHSC staff.

Yours faithfully,

JRB

Joanna Bolton
Solicitor Consultant
Email: Joanna.Bolton[redacted]
Tel: [redacted]

Providing Support to Health and Social Care

ISO 9001 SGS UKAS QUALITY MANAGEMENT 005

Lexcel Practice Management Standard The Law Society of Northern Ireland

INVESTOR IN PEOPLE

CONFIDENTIAL

ROYAL HOSPITALS TRUST

Medical Audit Meeting

Date: 8 February 1995 **Venue:** Function Room, RBHSC

Specialty: Paediatrics/Radiology **Attendance:** See Register

---

TOPIC: Audit of Radiological Screening Examinations Requested by RBHSC

POINTS OF NOTE: Identified Problems:

(1) [redacted]

(2) [redacted]

[redacted]

ROYAL HOSPITALS TRUST

Medical Audit Meeting

Date: 15 March 1995 **Venue:** Function Room, RBHSC

Specialty: Paediatrics **Attendance:** See Register

TOPIC: Mortality

POINTS OF NOTE:

Three mortality cases were presented.

DECISIONS/ACTION:

- If a child presents dead on arrival the Senior House Officer on duty must complete the appropriate protocol form.
- For skeletal surveys a babygram is not recommended.

TOPIC: Theatre Utilisation for Emergency Operations

POINTS OF NOTE:

- During 1994 the total number of operations performed in Theatre 2 was 2209, 510 of these were emergencies and 1699 were elective.
- There were 702 emergency operations outside normal working hours.
- Total time spent in theatre for elective and emergency cases = 58 and 52 minutes per case respectively.
- NCEPOD have reported that Children operated on at night are more likely to have complications. They recommend that there should be a designated 9 am - 5 pm emergency operating theatre.
- Junior doctors working hours are to be decreased to 56 hours per week. As a result, Consultant staff will come under more pressure.
- Paediatric and Orthopaedic surgery are major contributors to out of hours emergency surgery.
- At night, RBHSC does not provide Recovery Nursing staff.
- The majority of out of hours surgery is carried out before midnight.
- Seasonal variations in the study were accepted.
- Surgeons have been asked to leave an hour at the end of theatre sessions for emergency cases. As a result elective cases have decreased.
- All emergency cases requiring plastic surgery would appear to be performed at the UHD.

- In appropriate cases it may prove more beneficial to wait until the next day, if feasible, rather than operate straight away.

- Significant amount of emergency orthopaedic surgery performed at night.

- Some of the work carried out at night could be performed during the day.

- Results suggest that emergency surgery has disrupted operating lists.

DECISIONS/ACTION:

NCPEOD recommend that no Paediatric Surgery should be performed outside normal working hours when life-threatening and then only by the most experienced staff. Therefore, we should be aiming at increasing the number of emergency cases carried out during working hours in order to improve quality standards.

Explore resource implications of providing an emergency theatre.

13 April 1995

Mortality Meeting

Five cases were presented and discussed.

Joint meeting with Dermatologists

9 JUNE 1995

MORTALITY MEETING

4 Cases presented.

The Pathologists reported that the percentage PM rate illustrated a dramatic drop (f). The reasons for this were discussed, it was felt that many doctors may now feel that with patients being hospitalised for a long period of time and having had CT or MRI scans, that little is gained from a PM. The Paediatric Pathologist said this was not the case and also pointed out that the reduction in PM was also a National trend.

Out-Patient Survey

Points of note:

1.

2. No clinics were abandoned, the % of clinics unattended by a consultant reduced from 13 in 1993 to 3 in 1995.

3. All clinics (medical and surgical) regularly over-ran by long periods and the feeling was this was due to overbooking. The optimal number to be seen is yet to be defined.

4. DNA rate has decreased from 22.7/22 to 13 % for both medical and surgical respectively.

5. Deficiencies in the Audit data collection form are to be addressed for future outpatient surveys.

6. Individual consultant staff will be sent a summary of the data collected.

CONFIDENTIAL

ROYAL HOSPITALS TRUST

MEDICAL AUDIT MEETING

Date: 9 February 1996 Attendance: See Register

Speciality: Paediatrics

MORTALITY MEETING

Case presentations were illustrated by slides of pathology from the paediatric pathology team and the forensic and neuropathologists.

* a problem was found with regards to the management of critically ill children within the RBHSC when an intensive care bed cannot be obtained.

AUDIT OF THE STANDARD OF DISCHARGE LETTERS (INTERFACE AUDIT)

Discharge summaries should be informative to general practitioners and include

(1) Primary diagnosis + co-morbidities
(2) Discharge medication (name, dose, frequency and duration)
(3) Significant test results (both +ve and -ve)
(4) Suggested follow-up arrangements (where, when, by whom, why)
(5) Information given to parent re diagnosis and prognosis
(6) Adverse (significant) inpatient events

Two GP's looked at handwritten and typed discharge letters (n=28). Four charts had no letters, one had only a handwritten letter which was completely illegible leaving 23 case notes studied. Of these 23 had hand written letters and 11 had typed letters.

LETTERS

Deficiencies noted in not recording co-morbidities, complications and adverse events.
Discharge drugs were well recorded as were follow-up arrangements.
Information given to parents was usually not recorded.
There was a time delay (>2 weeks) in about 30% of the typed letters.

A new standard discharge letter (handwritten) was presented and discussed as a means of (1) facilitating the recording of useful information to GP's and for (2) improving the accuracy and depth of coding.

The mean number of coded diagnoses for inpatients (m = 1.7, for 1994/95) was presented for each consultant.

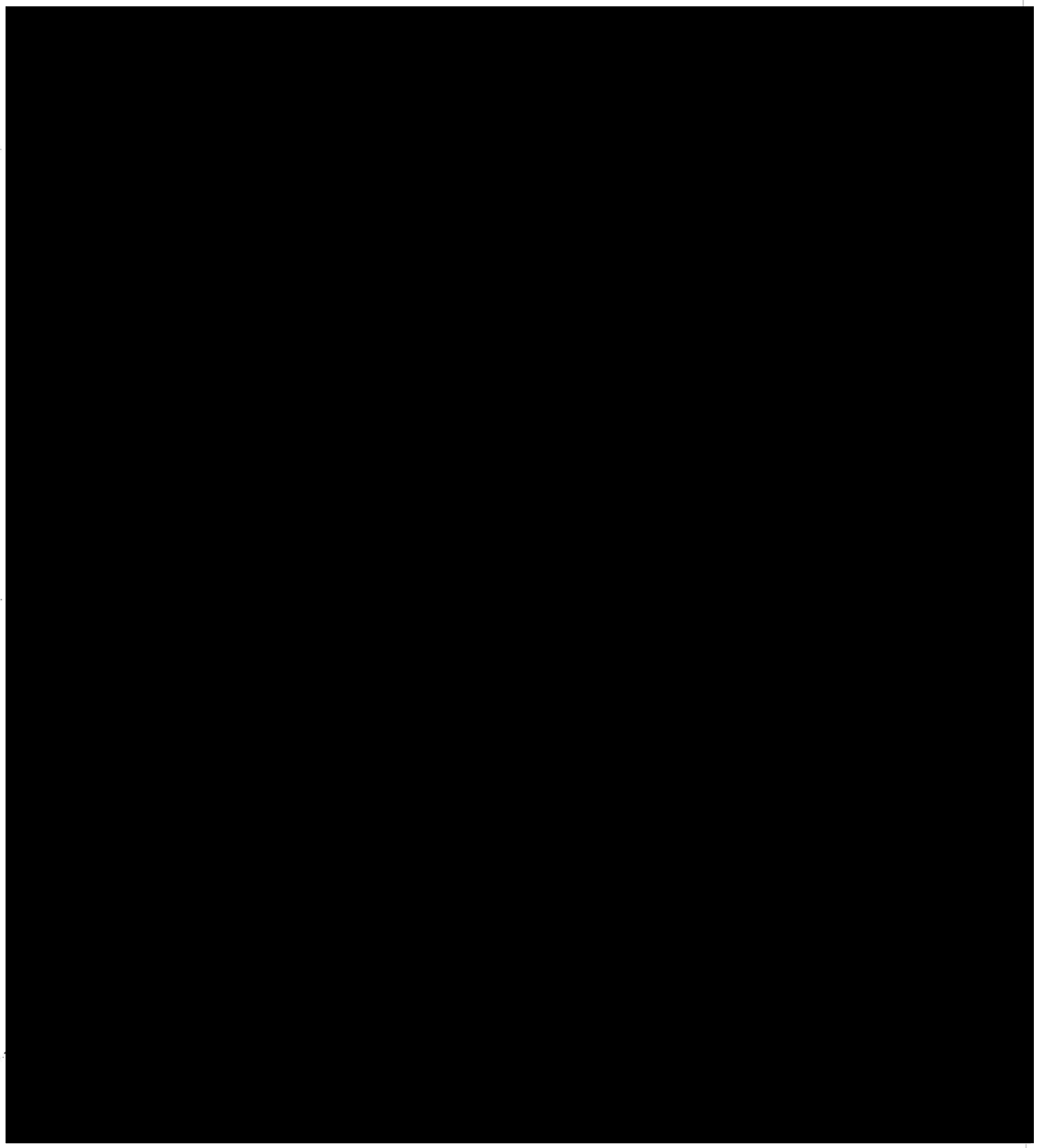
After the implementation of the new discharge form this topic should be audited.

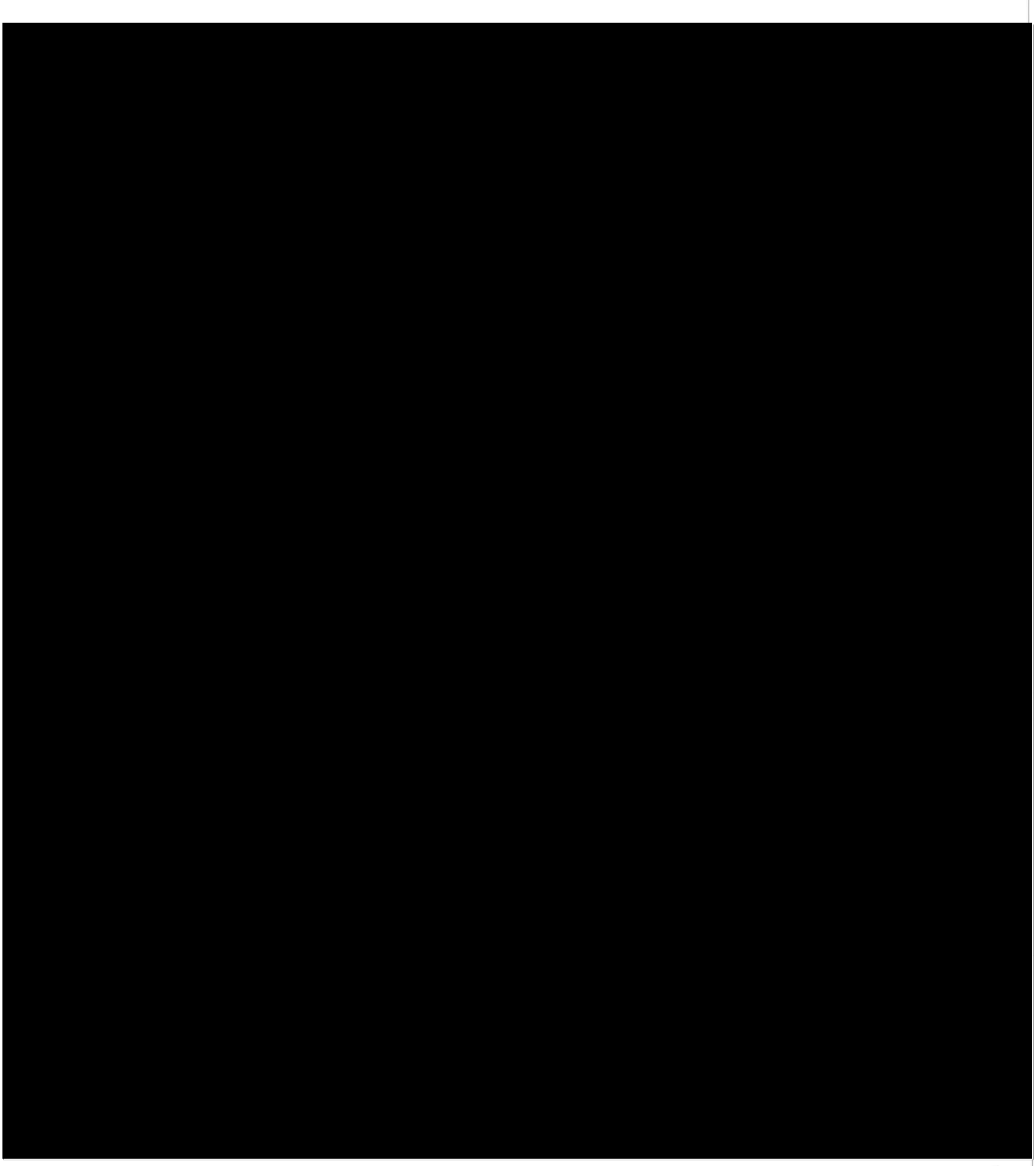
DATE: 14 May 1996

1. **Mortality Meeting**

   Four cases were presented and discussed.

2. **Multi-professional audit of IV Gammaglobulin Infusion Service provided for children with hypogammaglobulinaemia**





PAEDIATRICS

Date: 12 June 1996

1. Mortality Meeting

Three cases presented.

2. Audit on Outcome of GP Referrals to the A&E Department

Background

There are inadequate resources in Medical OPD to ensure urgent and semi-urgent referrals are seen quickly. Therefore, over a 6 week period in June/July 1995 all unnamed consultant referrals were recorded. There were 8 urgent referrals and 25 semi-urgent referrals over that period. Four GP's contacted Medical OPD directly by phone.

Aims:

The purchaser has expressed concerns about the type of patient seen at A&E and wishes us to examine our caseload to see if a more appropriate system could be introduced.

Results

An audit of GP referrals over a 6 week period in Oct-Nov 1995 identified:

191 patients referred by GP
43 (22%) admitted
55 (28.8%) treated and discharged
35 (18%) observed for 2 - 4 hours
46 (24%) benefiting from consultant paediatric input
7 (3%) referred for xray alone
5 (2.6%) with other problems (ENT/Ophthamology)

In total 46 patients = 7.6 patients per week referred by GP's to the A&E Department would have benefited from consultant paediatric input. A further 10 patients per week are seen by the A&E Consultant. 6 patients per week are referred to Med xxx as urgent or semi-urgent cases.

Therefore, not taking into consideration the shortfall of new patient slots in Med xxx, but looking only at urgent and semi-urgent referrals to this hospital, there are at least 24 patients per week who require paediatric consultation. These figures do not take into consideration non-GP referrals to A&E, although some of these will be included in the number of patients seen by the A&E consultant.

It is important to note the number of GP referrals who required a short period of observation in the A&E Department. It would suggest that an audit of:

1. **all patients attending A&E who require observation for 2 or more hours**
2. **all patients admitted to the wards for observation but are discharged home the following day should be undertaken to clarify if a short-term observation unit would be beneficial.**

Recommendations

1. **The setting up of a Rapid Response Clinic (RRC) in the A&E Department**

Advantages:

1. **Is the setting from which most referrals will come**
2. **Will show the purchaser our desire to change our A&E Services rather than add to our Medical xxx services.**
3. **Will give more consultant support to the A&E junior staff and nursing staff**
4. **Instant availability for therapeutic measures eg nebulisers**
5. **Availability of trained nursing staff for triage**

Disadvantages:

1. **Lack of space in present setting. This will be overcome once the new block is opened. Indeed, there may be a shortage of Medical xxx facilities in the new block.**

CONFIDENTIAL

ROYAL HOSPITALS TRUST

CLINICAL AUDIT MEETING

Date: 8 August 1996 **Venue: Function Room**

Speciality: Paediatrics **Attendance: See register**

==========

Topic: Mortality

5 cases of mortality were presented and discussed.

Topic: [redacted]

[redacted]

PAEDIATRICS

Date: 12 September 1996

1. ***Acute Upper Airway Obstruction in PICU***

[redacted]

2. ***Audit of PICU Deaths***

Objective

To evaluate the numbers of infants and children who died in the PICU in 1994.

Results

Total admissions 298, Deaths 27 (9.1%)
5 deaths (19%) were children admitted from the RBHSC wards
6 deaths (22%) were children admitted from the A&E Dept
16 deaths (59%) were children transferred from other hospitals
Of note is the fact the no child died following transfer from the theaters at RBHSC despite this being a major source of admission to PICU (24%)

Management of children prior to death was also audited.

16 children died (59%) despite full treatment
7 children died after treatment was withdrawn (in most of these cases (5) Brain Stem Death was formally tested and the parents consent sought for withdrawal of treatment.
5 children died (19%) after treatment was with-held following discussion with parents.

Discussion

The overall mortality rate of 9.1% is similar to that of other PICU's.

Full treatment was continued in the majority of children prior to death and in 7 cases where the outlook was hopeless treatment was discontinued. This decision was reached in a short period of time (1-6 days). In the remaining 5 children outlook was so poor that active treatment was with-held. The period of time to make this decision was much longer (1-26 days). The audit underlines the need for compassionate care to be given to children with poor outlook and their parents in the PICU.

3. ***Audit of SHO's views of postgraduate at RBHSC***

Background

Ad hoc interview audit carried out with 16/21 of SHO's finishing their contracts on 31 July 1996.

Conclusions/Recommendations

1. It was recoganised that much excellent education is taking place at unit level but that not all doctors are able to access this.
2. There needs to be protected time to encourage postgraduate education.
3. There is required to be specialty related teaching in rotation, held at hospital level, rather than ward level, this should have a "hands on" type format and should be arranged prospectively and advertised in advanced.
   It is believed that this would not involve consultants in any extra work.
4. There are particular problems in terms of education on the surgical side - the details of which have been addressed and an attempt is being made to work these through.
5. The Day Care Unit presents special difficulties which require new and radical thinking.

A unit based syllabus should be developed with the aims of fulfilling core curriculum or log book requirements, both for paediatricians and trainee general practitioners, respectively.

Several contractural issues were identified which should be addressed.

CONFIDENTIAL

ROYAL HOSPITALS TRUST

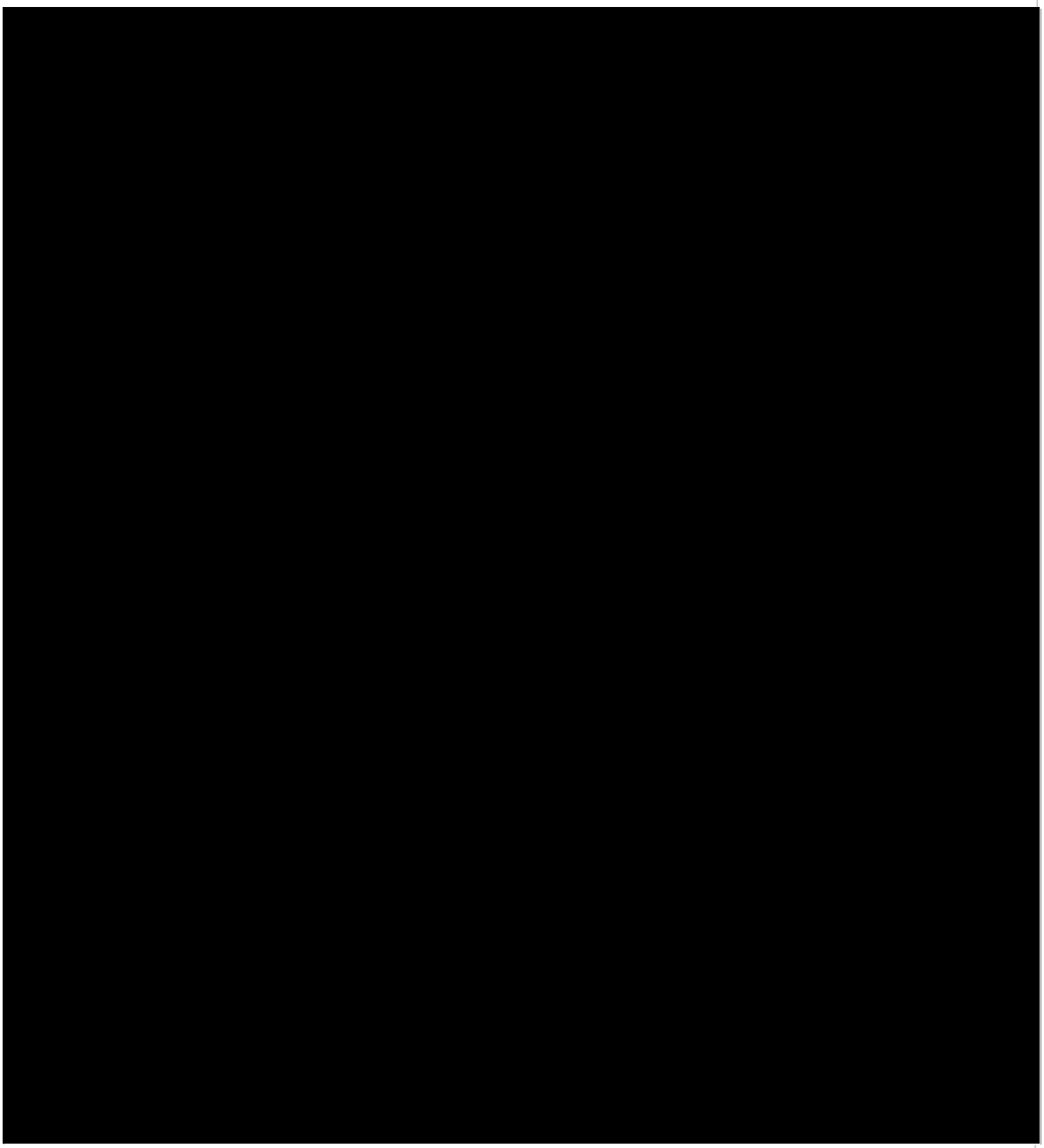
PAEDIATRIC AUDIT MEETING

OCTOBER 1996

Mortality Meeting

4 Cases were presented

[redacted]



CONFIDENTIAL

ROYAL GROUP HOSPITALS

PAEDIATRIC DIRECTORATE CLINICAL AUDIT MEETING

Date: 8 November 1996 **Venue: Function Room**
RBHSC

Attendance: See Register

Mortality Meeting

4 cases were presented

Audit

Topic
Depth of Coding

The depth of coding was reviewed. This showed that there is room for considerable improvement, particularly in certain areas. The amount of work carried out is not being reflected accurately in the coding. The importance of accurate coding was pointed out, it will be of particular importance when the directorate progresses to cost per case.

Topic
Case Note Review

A number of charts are audited on a monthly basis

Results
Demographic information was generally well recorded, however source of Referral and Contracting Board could be improved.
Height and Weight were poorly recorded as were Development history and Immunization details.
Satisfactory details of information to parents was only recorded in 26.1% of the cases.
All entries in the case write up were signed and dated, however 35.2% were timed and 6% had the name printed.
In all cases the patient had been seen by a senior doctor.
In only 26% of the cases did each page of the notes have the patients unique ID number (this is an A standard of the Kings Fund)

In the final discharge summary in the case notes a final diagnosis was recorded in 61% of the cases and an on-going problem list in 50%
Details of information given to parents/child was only recorded in 10% of the cases.
A written medication plan was provided in 33% of the cases
In the discharge letter (hand written) only 4% contained information that had been given to parents.
The full discharge letter was completed within 14 days in 55% with a copy going to relevant people in 32%
On the operation note the signature (legible) grade of surgeon was not included in any of the 3 cases.

The case note review will continue on a monthly basis.

Topic
Patient Satisfaction Survey Medical Outpatients Department

Questionnaire designed on basis of document "Excellent Service" (a study of patients' needs and perceptions) which was carried out by Royal Hospitals Nursing Development Units (1995).

Aim
Pilot questionnaire in OPD
Identify areas of patient dissatisfaction and make recommendations for change.

Objective
On the basis of results from pilot questionnaire, present final draft to Royal Hospitals Quality Steering Group and recommend it be printed in Corporate fashion and be used in Out-Patient clinics across the group.

Results
Pilot indication 17.4.96 -23.4.96 in Medical OPD
Sample = one of convenience
n= 53 completed out of 100

Recommendations
More input from Domestic Services to toilet area
OPD information booklet to go out with new appointments
Keep parents better informed of reasons for delay
Identify area for feeding and changing
Ensure regular supply of toys and reading materials
Decide frequency of re-survey.

ROYAL GROUP HOSPITALS

PAEDIATRIC DIRECTORATE CLINICAL AUDIT MEETING

Date: 10 December 1996 Venue: Function Room RBHSC

Attendance: See Register

The meeting began with Dr Shields handing over the role of Audit Co-ordinator to Dr Taylor.

A discussion followed with the staff present about the future running of the audit programme, the following was noted:

1. The audit meetings should start as usual with the Mortality meeting - each case presentation should have a time limit and the consultant supervising the case should have the opportunity to express problem areas in the management of the case in a non-hostile environment.
Those presenting cases should indicate to Dr Taylor how long they will require.

2. The directorate should continue doing 3 or 4 multiprofessional audits each year and would encourage the team approach to audit.
Each unit should now be thinking about a suitable topic so that a date for presentation can be arranged in advance.

Audit topics which involve the clinical audit staff should have an audit request form completed and passed to Dr Taylor for approval.

Staff are also encouraged to do audit topics within their own resources. Reports of these audits should be forwarded to Dr Taylor.
In addition it is important that each unit continue to do the case note review audit and the completed forms should be returned to the Clinical Audit Department on a monthly basis.

3. Participants expressed frustration that it had not been possible to implement many of the changes recommended in many of the audits because of resource limitations. This was discussed with the Directorate Manager, who felt that the audit results and recommendations were helpful for him when putting forward business cases for future change. However, with limited resources these changes could not all be implemented immediately and the directorate needed to look again at how it used existing resources.

Date of next meeting
Tuesday 14 January 1997