

Your reference: FC-386-05

15 August 2005

Miss Fiona Chamberlain
Solicitor to the Inquiry
The Inquiry in Hyponatraemia-related Deaths
3rd Floor
20 Adelaide Street
Belfast
BT2 8GB

Dear Miss Chamberlain

Re: Inquiry into Hyponatraemia -related Deaths

Thank you for your letter of 08 July 2005 and your further clarification with regard to the information requested. I can confirm that adverse clinical incidents/near misses are recorded on an incident report form (IR1 form) and subsequently entered onto a software package for data collection and analysis. The Trust Board does not review a summary of incident reports on a monthly basis, but receives an annual summary of adverse events, both as part of a clinical governance report and an annual health and safety report.

The Trust Board or its Excellence and Governance Subcommittee will receive briefings on specific adverse events where the circumstances warrant it.

We have interrogated our incident reporting system and have identified one incident involving a child that meets your criteria for disablement as a result of fluid management problems and/or hyponatraemia. This case involved a child who had a cardiac arrest during an infusion of potassium chloride. We have identified no cases where disablement as a result of hyponatraemia has been reported.

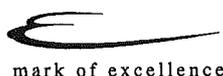
I trust you will find this further information of assistance.

Yours sincerely

William McKee

WS MCKEE
CHIEF EXECUTIVE

PATRON: HRH The Duchess of Kent
The Royal Victoria Hospital
The Royal Jubilee Maternity Services
The Royal Belfast Hospital for Sick Children
The Dental Hospital



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