Your Ref: NSCB04/1
NSCW50/1
NSCS071/1

Ms Angela Crawford
Directorate of Legal Services
2 Franklin Street
BELFAST
BT2 8DQ

Our Ref: BMcL-0017-12

Date: 6th November 2012

Dear Ms Crawford,

Re: Raychel Ferguson Preliminary

Arising out of the Inquiry's investigation into the death of Lucy Crawford, please provide to the Inquiry all additional documentation of the Belfast Trust, its predecessor Trust, and /or the RBHSC as described more particularly below.

1. Any PICU and/or RBHSC and/or Royal Group Trust policies, protocols, or guidance (whether as recommended by the Paediatric Intensive Care Society[1] or otherwise), which were in existence in April 2000 and which touched upon the information to be provided by a transferring hospital when a patient was being transferred to the PICU in the RBHSC from another hospital.

2. Any current policies, protocols or guidance touching on the matters in 1. above.

3. Any PICU and/or RBHSC and/or Royal Group of Hospitals Trust policies, protocols, or guidance, in existence in April 2000, touching on the communications which should take place between the PICU or RBHSC and the referring hospital, when a patient transferred to RBHSC from another hospital dies in the RBHSC.

4. Any current policy, protocol, or guidance touching on the matters in 3. above.

5. Any discharge policies of the RBHSC/Royal Trust in existence in 2000.

6. Any risk management policy or clinical governance policy of the Royal Trust or the RBHSC in existence in 2000.

7. Any policy of the trust or RBHSC in existence in 2000 touching on the reporting and/or investigation of clinical incidents, and/ or unexplained and unexpected deaths.

[1] Paediatric Intensive Care Society(1996) Standards for Paediatric Intensive Care, Sheffield PICS

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8. Any Royal Trust/RBHSC guidance for doctors on the referral of cases to the Coroner, and the information to be provided to the Coroner in making such referrals, in existence in 2000.

9. All records of communications, not already provided, between the RBHSC and/or the Royal Trust, and the Erne Hospital and/or Sperrin Lakeland Trust, touching on the death of Lucy Crawford including correspondence, emails, records of meetings, or any other documentation.

10. Dr Geoffrey Nesbitt, Medical Director Altnagelvin Hospital has stated in his witness statement to the Inquiry[2] that following the death of Raychel in June 2001 he contacted Dr Chisakuta in the RBHSC "*about their use of No.18 Solution in postoperative surgical children*" and was told by Dr Chisakuta that RBHSC "*had changed from No.18 Solution six months previously because of concerns about the possibility of low sodium levels.*"
Arising from this please provide all of your clients' documentation relating to any decision or proposal made prior to June 2001, regarding any change in the use of Solution 18 in the RBHSC, including emails, correspondence, minutes of meetings, guidance, or any other documents whatsoever, within RBHSC and/or the Royal Hospital Trust, and from the RBHSC or Royal Trust to any other persons or bodies in relation to this matter.

11. In the note of a meeting between Dr James Kelly and Dr Moira Stewart on 1 June 2001[3] Dr Stewart is recorded as having told Dr Kelly that "*RVH ward guidelines would recommend N-saline and not 1/5th normal as the replacement fluid.*"[4]
Arising from this the Inquiry requires the ward guidelines referred to by Dr Stewart as being in existence in 2001, and all of your clients' documents pertaining to those ward guidelines on fluids, including documents relating to the genesis and development of such guidelines, the reasons for them, the implementation of the guidelines, and all communications within the Royal Group of Hospitals Trust, the Royal Victoria Hospital, and/ or the RBHSC, and from the Royal Trust, the RVH, or the RBHSC to any other person or body, relating to the guidelines.

12. In a document provided by your clients to the Inquiry[5] it is recorded that Lucy's death was discussed in the mortality section of an RBHSC Audit meeting chaired by Dr Robert Taylor on 10 August 2000. The Inquiry requires all documentation relating to that Audit meeting including any briefing documents considered by the meeting in relation to Lucy, the minutes of the meeting, and any documents containing, or referring to, the list of attendees at that meeting, the consideration

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[2] WS-035/1 page 9
[3] 036a-027-066 to 036a-027-067
[4] 036a-027-067
[5] 061-038-123

given to Lucy's death and the causes thereof at that meeting, the conclusions reached about Lucy's death at that meeting, and any follow up action agreed and/or taken following that meeting.

13. The Inquiry further requires any documentation in existence in August 2000 touching on the purposes of the mortality section of Audit meetings, the decisions as to which cases are referred to such meetings, the processes to be followed in such discussions and in the follow up and dissemination of lessons learned following such meetings/discussions.

14. The Inquiry has been provided with documents from UTV, Sperrin Lakeland Trust, Altnagelvin Trust and the DHSSPS containing or relating to exchanges from or between communications/press officers in relation to the deaths of Raychel and Lucy. Some of these documents contain copies of communications appearing to emanate from the Press Office of the Royal Hospitals Trust.[6] The Inquiry requires all documents pertaining to the treatment, care, and death of Lucy and/or Raychel issued, received, created, obtained or held by the Press Office of the Royal Group of Hospitals, including emails, notes of meetings, telephone discussions, briefings, draft briefings, and communications of any kind within the press office, and between the press office and the RBHSC, Dr Hanrahan, Dr Crean, the Royal Trust, and any other person or body, in relation to these matters.

As the oral hearings relating to Lucy/Raychel are scheduled to start shortly, a full response to this letter is requested by close of business on Tuesday 27th November 2012.

Yours sincerely,

Brian McLoughlin
Assistant Solicitor to the Inquiry

[6] See for example 069B-016-051