Business Services Organisation

Directorate of Legal Services
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Your Ref:	Our Ref:	Date:
BMcL-0017-12	HYP B4/02	14th December 2012

Ms H Win
Assistant Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – RAYCHEL FERGUSON PRELIMINARY

We refer to the Inquiry's letter dated 6th November 2012 reference BMcL-0017-12 and confirm we have taken our client's instructions. Using the same numbering as in your letter we confirm as follows:

1. The Trust is not aware of any policy, protocol, or guidance in existence in April 2000 relating to patients being transferred to PICU from another hospital. We would refer the Inquiry to paragraph 6(j) of Dr McKaigue's witness statement reference WS-302/1.

2. A copy of the Clinical Resource Efficiency Support Team (CREST) document entitled 'Protocol for the Inter Hospital Transfer of Patients and their Records' is attached along with the Trust's Standards and Guidelines Committee policy entitled 'Inter Hospital Transfer of Patients and their Records'.

3. The Trust believes that in April 2000 when a patient who had been transferred from another hospital to PICU died the referring team would have been made aware of the death through informal communications by telephone which took place between the referring hospital and PICU (usually these consisted of regular enquiries being made by the referring hospital to ascertain the patient's clinical course). There would also have been a letter from one or more consultants back to the referring consultant giving clinical information when a patient died.

4. The Trust does not have a policy in relation to informing a referring hospital regarding a child's death. Please however find attached the current Trust policy entitled 'Guidance on actions to be taken after a Patient's death' although this document does not refer specifically to informing a referring hospital.

5. The Trust believes that the policy entitled 'Discharge from hospital - policy and guidelines TP12/00' was operational in 2000 however the Trust cannot locate a copy of same (as per attached Index).

6. We would refer the Inquiry to the document entitled 'A Strategy for Effectively Managing Risk - March 2001' which is contained within Dr McBride's first witness statement (WS-269-1 page 553-575). A copy of this document is attached for ease of reference.

7. The Trust Policy TP9/00 'Adverse Incident Reporting' is attached. Also attached is the Trust document entitled 'Procedure for Adverse Incident Reporting – IR 1 Form - March 2000'.

8. We would refer the Inquiry to paragraph 1(b) of our letter to the Inquiry dated 10th January 2011 in response to the Inquiry letter of 15th September 2010 reference AD-0167-10. A copy of our letter is attached for ease of reference.

9. To the best of the Trust's knowledge all records or communications held by the Trust have already been provided.

10. Answer to follow.

11. Dr Stewart has been consulted by the Trust on this question and she has informed the Trust that she has checked her report to SL Trust and it cites APLS (Advanced Paediatric Life Support) guidelines and does not refer to RVH ward guidelines. She has informed the Trust that Dr Jim Kelly may have noted "RVH ward guidelines" in his summary of their meeting but she does not think Dr Kelly quoted her verbatim. Dr Stewart believes she would always have referred to the hospital as RBHSC and not RVH. Dr Stewart further advised that she is almost certain that she told Dr Kelly that in RBHSC they would have followed APLS guidelines however given the passage of time she cannot be sure of the actual words used.

12. Answer to follow.

13. Answer to follow.

14. Enquiries to the press office in The Royal Hospitals were noted and answered by individual press officers and not collated centrally. There was no central paper or electronic file which held all information regarding any enquiries (internal or external) regarding hyponatraemia-related deaths.

An electronic search to try to locate any emails has been carried out but there was no mail archive system capturing emails being processed in legacy Royal Hospitals Trust.

A search of the Belfast Trust Mail Archive has been carried out and no further emails relating to exchanges from or between communications/press officers in relation to the deaths of Lucy Crawford or Raychel Ferguson have been identified other than those already in the possession of the Inquiry.

Yours faithfully

John Johnston
Solicitor