

The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

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

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

Our Ref: BMcL-0043-13

Date: 8th January 2013

Dear Ms Crawford,

RE: RAYCHEL FERGUSON PRELIMINARY

Thank you for your letter of 14 December part replying to mine of 6 November 2012. Arising out of your responses please deal with the following matters.

At point 3 you say that there would have been a letter from one or more consultants back to the referring consultant giving clinical information when a patient died. Arising from this please take your client's instructions on the following matter. Was such a letter was issued following the death of Lucy Crawford? If so please provide a copy.

At point 5 you advise that there was a policy TP 12/00 in relation to the discharge of patients but the Trust cannot locate a copy. You have provided an index from November 2005 of applicable policies. We note from the index that there was an earlier version of this policy TP11/95. Is it possible to locate a copy of this? The Inquiry also notes from the index that there was a policy TP 5/00 "Death of a patient-Informing a GP". Please furnish a copy of this policy to the Inquiry..

At point 6 you refer the Inquiry to a Risk Management Strategy document dated March 2001. The Inquiry had asked for any risk management or clinical governance policy in existence in 2000 (Lucy Crawford's death was April 2000). We would be grateful for details of the policies applicable in 2000.

At point 7 you have provided copies of Trust Policy TP9/00 "*Adverse Incident Reporting*" and IR 1 Form "*Procedure for Adverse Incident Reporting*" (March 2000). Please take your client's instructions on the following matter. Was Lucy Crawford's death reported under policy TP9/00 and/or under the Procedure for Adverse Incident Reporting? Please confirm your client's position to the Inquiry. If the death was so reported please provide all documentation relating to such report.

At point 11 you advise that Dr Stewart is almost certain she told Dr Kelly that in RBHSC they would have followed APLS Guidelines. Arising from this please take your client's instructions on the following questions. Was it the policy or practice in RBHSC or any part of RBHSC to follow the APLS guidelines in relation to fluid management in children? If so, when was such a policy or practice adopted? Did the policy apply throughout RBHSC or was it limited to PICU? Was such policy or practice in writing? If

Secretary: Bernie Conlon

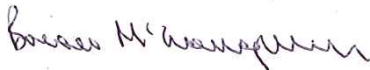
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so, please provide a copy of the document(s) containing it. Was the existence of such policy or practice communicated to any person or body outside the RBHSC? If so please provide details.

I look forward to hearing from you as soon as possible in relation to the above and in relation to the outstanding matters requested in my letter of 6 November.
I have received your letter of 3 January and will write separately in response to that letter.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Brian McLoughlin', with a stylized, cursive script.

Brian McLoughlin
Assistant Solicitor to the Inquiry