HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

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Your Ref:	Our Ref:	Date:
BMcL-0059-13	HYPB02/01	19th April 2013

Mr B McLoughlin
Assistant Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS- RAYCHEL FERGUSON PRELIMINARY

I refer to the above matter and to your letter dated 11th March 2013 (referenced above). I am instructed as follows:-

1. My Client has now been able to locate a copy of the 2nd Edition of the 'Paediatric Medical Guidelines' and a copy of same is enclosed herewith. However, I would ask you to note that these Guidelines do not relate to general fluid management: the only reference to fluid management in this edition relates to the management and treatment of diarrhoea (see pages 84 to 87 inclusive).
   As regards our responses to the below-mentioned letters, I would advise as follows:-
   a) We responded to your Mrs Conlon's letter dated 28th November 2012 (ref: BC-0079-11) on 13th January 2012 (further copy of said letter attached).
   b) We also responded to Mr Cullen's letter dated 27th January 2012 (ref: BPC-0116-12) on 13th February 2012 (further copy of said letter attached).
   c) Incidentally, we also replied to a connected letter from your Mr Cullen (ref: BPC-0137-12 dated 13th February 2012 by way of letter dated 14th February 2012, a further copy of which we also enclose, for the sake of completeness.
   Kindly re-check your records for your original copies of the above letters and please also confirm receipt of same.

2. My client has instructed me that, as a matter of courtesy, the authors of every chapter in the handbook received a copy of the entire handbook. It is also the Trust's understanding that copies of the handbook were also provided to junior doctors at Induction. However, in relation to the second edition, the Trust understands that not every junior doctor received a copy of this edition as there were limited copies of same, at the relevant time, due to limited resources in this area.

3. I will revert to you, on this issue.

4. I await instructions from my client in relation to this issue and I will revert to you further, as soon as possible.

5. Coding practice usually involved using a combination of sources, namely the discharge pro forma, the PICU coding sheet and also the patient's full case note. However, it was not always possible for all of these sources to be examined by the Coder: one or other of these sources may not have been available to the Coder at the time.

   This issue of documentation usage would also have been hampered by resource problems. Process changes also occurred at various times whereby documentation type was varied. In fact, depending on how difficult it was to retrieve information, it may not have been possible, in a small number of cases, to apply coding practice.

6. As explained previously, there is no evidence of a copy of a discharge letter having been filed in Lucy Crawford's RBHSC casenotes, therefore, the Trust, at this stage, clearly cannot confirm or deny that a discharge letter was sent to Lucy's GP. This is despite strenuous efforts on the part of our client to investigate whether such a letter was issued.

   Nor is it possible for the Trust to check with the recipient of the letter (namely Lucy's GP) as to whether a discharge letter was ever issued. As you are aware, a deceased patient's GP Notes are no longer held by the GP after the patient's death.

   Furthermore, as our client cannot locate the discharge letter, it is clearly not possible for our client to identify the author of any such letter.

   As per our previous correspondence in this regard, the Trust again would point out that a copy of the Inpatient/Outpatient Advice Note had been forwarded to Lucy's GP, and a copy of same has been placed with Lucy's Casenotes. My client regrets that it can be of no further assistance to you, in this matter.

7. The Clinician who completed the counterfoil was Dr Dara O'Donoghue and he has confirmed that, as far as he is aware, no further information was provided. However, he informs my client that he completed the response as 'Yes' in case any further information should be required at a later date. The Inquiry may wish to approach the Registrar for Deaths directly in order to confirm whether it holds any further information in relation to this matter.

8. As per our letter dated 10th January 2011, in response to Ms Dillon's letter dated 15th September 2010 (ref: AD-0167-10 - copy attached for information), the Coroner's Office confirmed that there has been no change in protocol from 1995 to that date, in reporting a death.

   The Trust is no longer in possession of a copy of the Coroner's Office earlier booklets and I would suggest that the Inquiry Team contacts the Coroner's Office for copies of same.

9. The Trust can confirm that, despite strenuous searches for the documents requested, it has been unable to locate same at either local or directorate level. The Trust regrets that it can be of no further assistance to you, in this matter.

10. A response to your letter dated 9th January 2013 (BMcL-0044-13) was sent to you by our Ms Bolton on 11th March 2013. A response to your letter dated 28th February 2013 (BMcL-0056-12) has been sent to you on 10th April 2013. As regards your Ms Dillon's letter dated 8th January 2013 (AD-0490-13), a response dated 1st February 2013 has also been sent to you. Please re-check your records for copies of the above letters and kindly confirm receipt of same. I attach further copies of said responses, for your ease of reference.

I will revert to you regarding the Trust's responses to questions 3 and 4, as soon as possible.

Yours faithfully

AM Crawford.

Angela Crawford
Solicitor