Your Ref:	Our Ref:	Date:
BC-0079-11	HYP B4/01	13.01.12

Ms Bernie Conlon
Secretary to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 28th November 2011 (BC-0079-11). I am instructed that the General Information section on page 3 explains the reason for the Paediatric Guidelines. The second edition is not still in circulation. The fourth edition will be drafted by staff when time from clinical commitments permit. It is not envisaged that it will be available for up to six months.

Yours faithfully,

JB

Joanna Bolton
Solicitor Consultant
Email: Joanna.Bolton[redacted]
Tel: [redacted]

Your Ref:	Our Ref:	Date:
BPC-00116-12 BC-0040-11	HYP B04/01	13.02.12

Mr Cullen
Secretary to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 27th January 2012.

I am instructed that Dr Moira Stewart has been consulted and she has advised that she cannot assist.

Yours faithfully,

JB.

Joanna Bolton
Solicitor Consultant
Email: Joanna.Bolton[redacted]
Tel: [redacted]

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Your Ref:	Our Ref:	Date:
BPC-0137-12	HYP B04/01	14.02.12

Mr B Cullen
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 13th February 2012.

Please note that we responded to your letter of 27th January 2012 (BPC-0116-12) on 13th February 2012.

Yours faithfully,

JB

Joanna Bolton
Solicitor Consultant
Email: Joanna.Bolton[redacted]
Tel: [redacted]

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Business Services Organisation

irectorate of egal ervices

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
AD-0167-10

Our Ref:
NSC B04/1

Date:
10th January 2011

Ms Anne Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to your letter of 15th September 2010 (AD-0167-10). In relation to the questions posed the Trust has determined the following:

1. (a) If a post mortem is directed by the Coroner decisions regarding the extent of the examination are not made by the clinician or family but by the pathologist and Coroner. If the case is a consented hospital autopsy decisions regarding the extent of the post mortem examination are made by the clinician and next of kin. Limitation of the post mortem may be at the request of the parents e.g. they may request that the brain is not examined if they do not wish the skull to be opened – this is sometimes the case in an autopsy on a stillborn baby. The clinician bases his or her decision to request consent for a full or limited post mortem on the child's clinical history, clinical findings, investigations and questions to be answered by the post mortem examinations, e.g. a clinician may request a brain-only examination if the pathology is known to be confined to the brain or similarly in a child with congenital heart disease but no other congenital abnormalities, the autopsy may be confined to the heart and lungs.

   In 1995 (and 1996 in relation to Claire Roberts) the post-mortem consent form asked only for consent to the post-mortem examination and if limited consent was given this was annotated on the form by the consenting doctor as in the case of Claire Roberts. There were no guidelines or protocols in place at that time.

   (b) I enclose a booklet produced by the Coroner's Service for NI which explains the circumstances in which a death should be reported to the Coroner. The Coroner's

Service for NI have confirmed there has been no change in protocol from 1995 in reporting a death.
(c) A hospital post mortem cannot be performed without consent from the next of kin. This has not changed from 1995.

2. There was no written RBHSC policy in 1996 on measuring and recording fluid losses.

3. (a) There was in 1996 no written policy on the frequency of blood sampling.
(b) There was in 1996 no policy regarding the testing and monitoring of a child's urine & electrolytes in a patient who has potential for electrolyte imbalance.
(c) There was in 1996 no written policy on how to monitor and measure fluid output.

The Trust introduced the enclosed "Policy for the administration of intravenous fluids to children aged from 1 month until the 16th birthday: reducing the risk of hyponatraemia" in 2009 and this is currently in use.

4. There was no written policy in 1995 regarding information giving.

5. There was and is no protocol for admission to PICU.

6. (a) Protocol (unwritten) is that a patient was and is admitted under the care of the relevant consultant on call defined by the on call rota. The protocol (unwritten) is that transfer of care between consultants took and takes place by discussion and contact between consultants either personally or by a junior doctor intermediary.
(b) Protocol (unwritten) is that a consultant should see their patient within a 24 hour period of time of admission and earlier if necessary.
(c) Senior staff in the Emergency Department will have taken APLS (advanced paediatric life support); other staff will have taken BLS (basic life support) regularly to maintain skills and competencies relevant to their practice.

Yours faithfully

pp Nicola Dane

Wendy Beggs
Assistant Chief Legal Adviser

Direct Line: [redacted]
Fax: [redacted]
Email: Wendy.Beggs[redacted]

Your Ref:
BMcL-0044-13

Our Ref:
HYPB02/01

Date:
11th March 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- R FERGUSON (PRELIMINARY)

I refer to the above matter and to your letter dated 9th January 2013, reference as quoted above. My client, the Belfast Trust, responds as follows:-

1. Ms Maureen O'Reilly was the Audit secretary in August 2000 and she would have been responsible for typing the minutes. Ms O'Reilly is no longer employed by the Trust.

2. There are no Trust records to confirm what steps were taken to contact the responsible Consultant and Pathologist.

3. The Trust cannot identify the Consultant or the Pathologist who would have been contacted to attend the meeting and make a presentation.

4. It is not the Trust's position that the Audit List confirms that Drs Crean and O'Hara attended the Audit and each made a presentation. The recording of Dr Crean's name on the Audit List simply confirms that he was the Consultant under whom Lucy was admitted to PICU. The reference to Dr O'Hara is due to the fact that he carried out the post mortem examination.

5. The Trust cannot identify the individual clinicians who attended to make a presentation. You will note that Dr Crean has advised, in his witness statement (reference WS-292-1) that: "I have no recollection if I knew if Lucy's death was discussed at the Audit meeting on 10th August 2000."

You will further note that, Dr McKaigue, in his witness statement (WS-302-2) has stated: "My signature is in the attendance register for the multidisciplinary audit meeting on 10th August 2000, however I have no memory of that meeting or what was discussed".
Dr Hanrahan has also advised in his witness statement that he has no recollection of this meeting.

6. The Clinical Audit Department has confirmed that it holds no other records relating to what was discussed in relation to Lucy at the relevant Audit Meeting.

7. It is the Trust's position that no other record was made of the discussions relating to Lucy which took place at the relevant Audit Meeting.

This completes my client's response to your afore-mentioned letter.

Yours faithfully

JB

Angela Crawford
Solicitor

Your Ref:	Our Ref:	Date:
BMcL-0056-13	HYP W50/1	10th April 2013

Mr B McLoughlin
Assistant Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-RAYCHEL FERGUSON

I refer to the above matter and to your letter dated 28th February 2013. I am instructed that neither the RBHSC Directorate Office nor the Pharmacy Department can locate any information regarding whether there was a proposal or decision, formal or informal, within the RBHSC at any level, to stop using Solution 18 in post operative children, or to change the circumstances in which it was used, whether at local Ward, or Hospital level, prior to 2001.

Yours faithfully

JB

Joanna Bolton
Solicitor Consultant

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Your Ref:	Our Ref:	Date:
AD-0490-13	HYP B4/02	1st February 2013

Ms A Dillon
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- CLAIRE ROBERTS

I refer to the above matter and to your letter dated 8th January 2013 (reference as quoted above.)

Unfortunately, my client the Belfast Health and Social Care Trust has been unable to locate the relevant documents. As these documents had been authorised and issued by the DHSSPSNI, my client respectfully suggests that it would be more appropriate for the Inquiry to return to the Department, regarding this matter.

Yours faithfully

p.p DS
Angela Crawford
Solicitor