Dr Roderick MacFaul

[redacted]

Your Ref:

Our Ref: BMcL-0035-12

Date: 5th December 2012

Dear Dr MacFaul,

Re Inquiry into Hyponatraemia-related Deaths – Raychel Ferguson Preliminary

We would ask you to review your reports and the conclusions which you have reached in light of the witness statements we have now sent to you. You should be aware that we have requested certain additional documentation from the Trusts, the Western Health and Social Services Board and others. We will provide any further relevant documents to you if it becomes available.

Whether you amend your conclusions is entirely a matter for you. We would emphasise that it is only necessary to consider amending your conclusions if this additional material affects the factual basis for any opinion which you may have expressed in your earlier reports, or if the material raises some new relevant issue.

However, we would draw your attention to a number of particular issues which you are asked to address:-

1. Dr. Hanrahan has indicated that when he was treating Lucy on the 13 April 2000, he conducted a number of investigations which returned normal and that he did not re-evaluate his differential diagnosis in light of the outcome of his investigations (answer to question 9, WS-289/1).

   In light of all that was known at that time, what steps, if any, should Dr. Hanrahan have taken in order to reach a definite diagnosis of the cause of Lucy's acute collapse?

2. In her statement, Dr. Caroline Stewart indicates that the normal practice in 2000 was to obtain a verbal consent to conduct a hospital post mortem. She cannot recall what information was given to the parents about the purpose of the post mortem (WS-282/1, answer 6(l). Likewise, Dr. Hanrahan cannot recall the information provided to the parents about the purpose of the post-mortem (WS-289/1, answer 12(c)(iii), although he interprets Dr. Stewart's note as suggesting that consent was taken in writing (WS-289/1, answer to question 12(c)(iv).

Secretary: Bernie Conlon
Arthur House, 41 Arthur Street, Belfast, BT1 4GB
Email: inquiry@ihrdni.org **Website:** www.ihrdni.org **Tel:** 028 9044 6340 **Fax:** 028 9044 6341

What information should have been given to the parents about the purpose of the post-mortem? At that time, should consent for a hospital post mortem have been taken in writing? Please review the answers given in the witness statements and comment on the adequacy of the consent process which was followed in respect of Lucy's post mortem.

3. Dr. Stewart explains (WS-282/1, answer question 22(a) that it was Dr. Hanrahan, Dr. McKaigue, Dr. Crean and Dr. Chisakuta who agreed the following working pathogenesis: dehydration and hyponatraemia, cerebral oedema, acute coning and brain death.

   Dr. Stewart has explained (in answer to question 14) that within the clinical diagnosis section of the autopsy form, she listed cerebral oedema, acute coning and brain steam death (after hyponatraemia) because they "were the sequel of events leading to her death."

   Dr. Chisakuta cannot remember the conversation leading to this view of the working pathogenesis, but he indicates that from his consideration of the notes, he would have been in agreement with it: WS-283/1, answer to question 14(a).

   Likewise, Dr. Crean cannot recall agreeing a working pathogenesis, but he does not disagree with anything recorded on the autopsy form: WS-292/1, answer to question 12.

   In addition Dr. Crean has explained that he recalls having concerns regarding Lucy's fluid management, and he was at that time aware that acutely developing hyponatraemia could cause neurological decompensation: WS-292/1 answer to question 8(b). You will recall that he told the Inquest into Lucy's death that Lucy's serum sodium registered a drop of 10 to 127 within a short period of time, and that "the rate of fall is the crucial factor" [Ref: 013-021-074].

   Dr. Hanrahan has no recollection of discussing the autopsy request form with Dr. Stewart (answer to question 12(d)).

   Consider whether, if this working pathogenesis had been formulated by relevant clinicians at the time of Lucy's death, it should have been reported to the Coroner's Office? Please fully explain the answer that you provide.

4. Dr. Hanrahan had reached the view, at least by the time that he spoke to Lucy's parents (answer to question 14(h)) on the 9 June 2000, that the management of Lucy's fluids was "inappropriate". He did not document this concern (answer to question 7(d)). Moreover, while he was aware that the parents "were unhappy about [Lucy's] treatment" he did not document their concerns either (answer to question 14(d). He thought that they should seek clarification of events in the Erne Hospital since the "sentinel event" took place there, but he does not indicate the areas in which clarification was required, nor does he recall attempting to clarify events himself (answer to question 14(g).

Throughout his statement Dr. Hanrahan maintains that while he may have reached the view that the fluid balance was unusual, and that fluid management was inappropriate, he was also of the view that 127 represented only mild hyponatraemia (eg. in his answer to question 8(c)), and not low enough to lead to cerebral oedema (at answer 17(b), but see also 14(h) and 29(a)).

Dr. Hanrahan considers that he was not an expert in fluid management (Ref: 013-031-115), and that he was deprived of what he refers to as "the most important link in the chain of events leading to her cerebral oedema" (answer to question 16(a)). By this, he appears to mean, the information that was supplied to him at a study day in late 2004 by which he discovered that a repeat U&E test was performed only after a quantity of normal saline had been run in (see question 17, and answers to this question, and answers to question 29).

Please review the evidence which Dr. Hanrahan has now provided. In particular, please comment on whether it was reasonable for him to take the view that a drop in sodium level from 137 to 127 within the period of time when she was treated in the Erne Hospital, could not have led to cerebral oedema?

In this regard, please also comment on Dr. Hanrahan's view that he was unaware of the real extent of Lucy's hyponatraemia because he did not know that repeat electrolytes were taken after a quantity of normal saline had been run in.

5. Dr. O'Donoghue indicates that when it came to certifying the cause of death, he sought advice from the consultant in charge (Dr. Hanrahan) and was advised that the cerebral oedema was due to or in consequence of dehydration: WS-284/1, answer to question 16(b)(ii). He indicates that he no longer holds the view that Lucy suffered a cerebral oedema which was due to or in consequence of dehydration (answer to question 16(d) but rather that the oedema would have resulted from inappropriate fluid administration to treat the dehydration that resulted from gastroenteritis (answer to question 16(b)(iii).

   Dr. Hanrahan does not recall Dr. O'Donoghue seeking his input when the latter completed the MCCD, although he does not doubt that a discussion took place (answer to question 19(e) of 289/1). He also accepts that the cerebral oedema was not due to dehydration, but that instead, it was due to excessive rehydration leading to hyponatraemia (answer to question 19(f)iii).

   Please comment on the implications of the clarification now given in this witness statement. In particular, please analyse the thinking that led to the original certification of the death, and comment on whether given what was known at the time it was reasonable to certify the death as 1(a) cerebral oedema (b) dehydration (c) gastroenteritis.

6. In his statement Dr. Dara O'Donoghue has explained the process by which the medical certificate of the cause of death was completed in Lucy's case. He obtained the advice of the consultant and then proceeded to complete it. He considers that he was an appropriate person to complete and sign the MCCD (WS-284/1, question 13), as does Dr. Hanrahan (WS-289/1, question 19(a)).

   Please review Dr. O'Donoghue's evidence regarding the process leading to the completion of the death certificate, including the role played by him and others, and comment on whether the approach taken was appropriate in all respects by reference to any guidance on such matters

7. In his statement, Dr. Robert Taylor explains his role within and the purpose of the mortality section of the Audit meeting (WS-280/1, answer 3). This is one of the areas in which we await further documentation from the Trust.

   You will note that other witnesses have commented on the Audit arrangements (eg. Dr. Hanrahan, WS-289/1, in answer to question 26) but he says that he has no recollection of the particular discussions relating to Lucy's death.

   You are asked to examine the answers which Dr. Taylor has given and to comment on the adequacy of the audit procedures which the RBHSC had in place at that time by measuring those procedures against the standards to be expected at the time.

8. Dr. Chisakuta has indicated that he was a Member of the Critical Incident Review Group at the RBHSC between January 2000 and August 2010: WS-283/1, page 1.

   However, neither Dr. Chisakuta nor any other witness has indicated that Lucy's death was reported as a critical incident. Indeed Dr. Crean has said that while adverse incident reporting was introduced to the Trust in 2000, it was only rolled out over the following two years and was not "embedded in practice at the time of Lucy's death" (answer to question 15, WS-292/1).

   On the basis of the information currently before the Inquiry, Lucy's death was reported to the Coroner's Office and considered at the Audit meeting, but was not otherwise the subject of investigation or review by the RBHSC.

We would ask you to consider this information and to comment on whether Lucy's death was adequately considered by the RBHSC for the purposes of clinical governance, or whether other steps ought to have been taken given the standards of the time.

Thank you in anticipation for your consideration of these issues. If you have any queries or concerns I hope you will not hesitate to contact me.

Yours sincerely,

pp Brian McLoughlin