Witness Statement Ref. No. 069/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Gerard Collins

Title: Mr

Present position and department/employer:

Head of Standards and Guidelines Unit; Department of Health, Social Services and Public Safety

Length of time in post: One year and 5 months

Previous position and department/employer in 1995:

Executive Officer Grade 1, Department for Economic Development

Previous position and department/employer in 2000:

Business Consultant, Business Development Service, Department of Finance and Personnel

Previous position and department/employer in 2001:

Project Manager, Welfare Reforms and Modernisation Programme, Social Security Agency, Department for Social Development

Membership of Professional Bodies:

None

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) Describe in detail how and when you first became aware of the deaths of Adam, Lucy and Raychel.

I first became aware of the death of Lucy Crawford through television and media coverage of the inquest into her death in February 2004. I recall that the deaths of other children were mentioned at the time, but I was not aware that this was a reference to Adam Strain and Raychel Ferguson.

(ii) Explain the steps taken by your division to ensure that lessons were learned from the deaths of these children.

My Unit (Standards and Guidelines Unit) was established in January 2004, two years after the publication by the Department of guidelines on the Prevention of Hyponatraemia in Children Receiving Intravenous Fluids. Since its inception, my Unit has been responsible for facilitating the development of standards for a range of care services including Independent Health Care. Responsibility for leading the development of the standards was delegated to a team of health care professionals seconded from the Health and Personal Social Services. The standards for these services do not cover specific clinical practice; rather they focus on management procedures, environmental standards, record keeping, recruitment, and equipment.

The draft Independent Health Care standards are based on nationally agreed standards and best practice guidance produced, for example, by the Royal College of Surgeons. I am not aware if the team, and the various working groups that developed the standards, incorporated lessons learned from the deaths of the children into the standards. However, the draft standards for independent health care set specific criteria for the admission of children into private hospitals for treatment and surgery, and for the qualifications and experience of professionals providing services to children.

Particular areas of interest (Cont'd)

(iii) What steps were taken by your division to establish the standards in England and Wales in relation to the fluid management of children?

Since its establishment in February 2004, Standards and Guidelines Unit has been responsible for facilitating the development of standards for specific services that will be regulated under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. It has also focussed on developing a process for the local review and dissemination of guidance developed by the National Institute for Clinical Excellence (NICE), as well as establishing links with the Social Care Institute for Excellence and the Scottish Medicines Consortium.

It has not been part of the Unit's remit to establish standards for specific clinical practice and I have no knowledge of standards in England and Wales in relation to fluid management in children. As far as I am aware there are no guidelines published by NICE for this particular area of treatment.

(iv) Explain the involvement of CREST in the issues arising from the deaths of Adam, Lucy and Raychel to include who involved CREST, when and for what purpose.

I was not a member of DHSSPS at the time that CREST was initially approached by the Department and asked to issue guidelines (being developed by a Regional Enquiry Group) following the deaths of the children. However, the minutes (075-066-210) of the CREST meeting of 8 November 2001 indicate that the Department had approached CREST regarding the dissemination and 'kite marking' or branding of guidelines on the Prevention of Hyponatraemia in Children Receiving Intravenous Fluids. Dr Miriam McCarthy from the Department attended that meeting and informed the members of CREST that a problem had come to the attention of the Department through clinicians, who reported an increase in the condition and felt in need of urgent guidance. Dr McCarthy advised that a working group (the "Regional Enquiry Group") had been quickly convened - comprised of Paediatric Anaesthetists and Surgeons, Public Health Medicine, Nursing and Chemical Pathology specialties - to develop guidance (in the form of an A2 sized wall chart) which would be targeted at junior staff and non-specialists and which was intended to highlight awareness.

CREST members agreed that the guidelines should be circulated to the relevant specialists in laminated card format with an accompanying letter signed by the CMO. It was also agreed that a small working group - comprising Drs Russell, Fitzpatrick, Montgomery and Trinick, a Renal Physician and a nurse - should be convened to take the initiative forward. I understand that the guidelines were subsequently issued direct from the Department in February 2002 under cover of a CMO letter.

The CREST sub-group then focussed on guidelines for the prevention of Hyponatraemia in adult patients and produced a set of guidelines which it issued to the HPSS in June 2003. Minutes of the meetings of this sub-group are at 075-073-276, 075-074-279, and 075-075-282.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: G Collins **Dated:** 7/July/2005