15th May 2000

**STRICTLY PRIVATE & CONFIDENTIAL**

Mr W McConnell
Director of Public Health
WHSSB
Area Board Headquarters
Gransha
DERRY BT47

Dear Dr McConnell

**RE: UNTOWARD INFANT DEATH (MISS LC)**

Thank you for your enquiry for updated information. In line with our arrangements towards Clinical Governance, all untoward incidents, major and minor are immediately reviewed.

In light of same, immediately upon the above untoward incident occurring, Dr O'Donohoe, Consultant Paediatrician contacted me to appraise me of the events. As a result, I have initiated an investigation and this is currently being led by Eugene Fee, Acute Services Director and Mr Trevor Anderson, Clinical Director for Obstetrics, Gynaecology and Child Health.

Whilst we await the results of this investigation, I will outline some of the details and share with you further actions taken.

1. This child was admitted with a background of severe diarrhoea/vomiting and dehydration. The SHO had difficulties obtaining a venous access for fluid replacement and called the Consultant Paediatrician into the ward. Dr O'Donohoe attended and gained venous access and commenced the child on a fluid regime for a shocked infant. The child's sodium was noted to be low at 127.

2. The child, some hours later was thought to have sustained some form of seizure. The description however is more in keeping with the child going to decorticate rigid.

3. The Consultant was contacted again and child was immediately transferred to Belfast with Dr O'Donohoe accompanying child.

4. In Belfast the child was judged to be brain dead with no definitive diagnosis.

5. Case went to Post Mortem. Informal reports on the post-mortem indicate gastroenteritis and brain oedema. We await more detailed histological analysis to exclude encephalitis and to provide information on possible coneing, etc.

There are a number of concerns in relation to this untoward incident.

1. The absences of a clear diagnosis and pathophysiological mechanism for death.

2. There are concerns in relation to the rate of fluid replacement at the Erne, essentially the regime for a shocked infant was continued longer than the anticipated two hours.

3. There is an issue in relation to delayed venous access by the SHO's.

In terms of the action taken, whilst more detailed information relating to the events leading up to the incident have been ongoing. I have interviewed Dr O'Donohoe to provide professional advice and support. Dr O'Donohoe feels personally responsible for this child's death.

Notes of the case, including report of events have been forwarded to Murray Quinn for consideration and advice. Whilst we have not received any written report, his initial comments are that the fluid regime was probably irrelevant and cause of death is still not clearly established and encephalitis and other causes remain a significant possibility.

Next stage is full analysis of the investigation report from Dr Anderson and Eugene Fee with a planned review meeting on the case with Murray Quinn.

Initial interview has taken place with the family. Dr O'Donohoe outlining the planned review of the case in line with Hospital Policy is underway and that results of such a review will be shared with them.

I will off course have more details as the full investigation/reports comes online and will happy to share all details with you in due course. Happy to receive any suggestions or additional comments you wish to make.

Yours sincerely

***DR J KELLY***
***MEDICAL DIRECTOR***

***/smc***