Fisher, Ruth

From: Mills, Ursula
Sent: 13 January 2005 13:51
To: Browne, Andrew; Fisher, Ruth
Subject: Cleared final version of PQ4029/04

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PQ4029/04

DATE FOR ANSWER: **TUESDAY 21 DECEMBER 2004**

Iris Robinson (Strangford): To ask the Secretary of State for Northern Ireland, which individuals have been appointed to the Hyponatraemia-Related Deaths Inquiry Team; who appointed each one; what the employment is of each; and what the immediate past posts of each member were. **(205964)**

ANGELA SMITH

I appointed John O'Hara QC as Chairman of the Inquiry into Hypnotraemia-related Deaths. The subsequent appointment of staff and their particular roles are matters for Mr O'Hara.

As is normal practice, to assist him with the administration of the inquiry, the Department offered a number of civil servants to undertake administrative and clerical duties. Previously the Secretary and Deputy Secretary to the Inquiry were employed respectively as the manager of the Office of the Permanent Secretary and the Departmental Private Secretary to the Minister. Of the remainder, one came from the Occupational Health Service; one from the Northern Ireland Assembly; one from the Departmental Typing Pool; and one has returned from a career break. It is understood that Mr O'Hara is also engaging a barrister, a solicitor and some professional experts in the fields of paediatrics, paediatric anaesthetics, nursing and healthcare management.

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Deleted: A secretariat drawn from serving Civil Servants nominated by the lead Department and agreed with the Chairman has been established to support him in this task, as is normal practice. The families of the children whose death is the subject of this Inquiry will also have access to legal representatives.

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BACKGROUND NOTE TO PQ4029/04

1. The families involved have previously raised doubts about the independence of the Inquiry because of the secretary's former post in the Office of the Permanent Secretary and his deputy having served as Minister's PS. It is not departmental policy however to name or discuss the background of serving Civil Servants and the question of the Inquiry's independence has already been well aired.

2. In April 2000, Lucy Crawford, a 17-month-old child, died following admission to the Erne Hospital and subsequent transfer to the Royal Belfast Hospital for Sick Children. The cause of death as recorded on the death certificate issued shortly after her death was "Cerebral oedema, Gastroenteritis, dehydration". Subsequently a Coroner's inquest into her death, completed on 19 February 2004, concluded that Lucy died from:
(a) Cerebral oedema, (b) acute dilutional hyponatraemia, (c) excess dilute fluid.

3. Hyponatraemia (a low sodium level in the blood) is known to be a risk in any child receiving prescribed fluids. It is potentially extremely serious, with a rapid fall in sodium leading to cerebral oedema, seizures and possible death. Hyponatraemia most often reflects a failure to excrete water. Stress, pain, nausea and vomiting are all potent stimulators of a hormone, ADH, that inhibits water excretion. Therefore a sick child, if given excess fluids, may not be able to excrete water adequately. The retention of water may, in severe cases, lead to cerebral oedema (swelling of the brain) and ultimately death.

4. Lucy Crawford was admitted to the Erne Hospital on the evening of 12 April 2000 with poor oral intake, fever and vomiting. At that time a presumptive diagnosis of a viral infection was made. She was dehydrated and required intravenous fluids, which were commenced about 10.30pm. At about 3.00am on 13 April Lucy collapsed, and was transferred to RBHSC at 6.00am, but in a moribund state. She was pronounced dead at 13.15pm on 14 April.

4. Lucy's death was reported to the coroner's office. Advice was sought from the State Pathologist's Department regarding the need for a coroner's post-mortem examination. Following discussion between the state pathologist and a consultant paediatrician at the RBHSC, it was agreed that a corner's post-mortem was not required and a death certificate could be issued. A Hospital post-mortem was conducted.

5. The Sperrin Lakeland Trust conducted an internal review into Lucy's death, concluding that neither the post-mortem nor an independent medical report provided could fully explain Lucy's deterioration. Specifically the review commented that the fluids Lucy received were, in both type and amount, within the accepted range, but cited poor record keeping as leading to confusion over prescribed fluids.

6. It was only in February 2003 following the inquest into Raychel Ferguson's death that the coroner was alerted to the similarities between Lucy Crawford's case and that of Raychel Ferguson a nine-year-old who had died from hyponatraemia. Subsequently an inquest was opened into Lucy's death and an inquest held in February 2004.

7. Following the inquest on Lucy Crawford, attention was drawn to the death of another child, Adam Strain, whose cause of death was similar. Adam died in November 1995, following renal transplant surgery. His autopsy confirmed cerebral oedema due to dilutional hyponatraemia and impaired cerebral perfusion as cause of death.

8. To summarise, the sequence of events were as follows:

November 1995	Adam Strain died.
April 2000	Lucy died
June 2001	Raychel Ferguson died.
	Death reported to coroner.
March 2002	CMO issued guidance on prevention of hyponatraemia.
February 2003	Inquest into Raychel Ferguson's death.
March 2003	Links between Raychel's and Lucy's death identified.
February 2004	Inquest into Lucy's death.

9. Detail of the conduct of the consultant paediatrician involved in Lucy's management has been referred to the General Medical Council, which will, through its normal procedures, consider the case and whether there are grounds for disciplinary action.

10. In 2000, at the time of Lucy's death, the statutory Duty of Quality on HPSS providers had not been introduced. The Trust did however take steps to investigate the reason for Lucy's death. A case review was conducted and a paediatrician from Altnagelvin Hospital was invited to act as a medical assessor.

11. The UTV Insight Programme broadcast on Thursday 21 October raised a number of allegations about the treatment of Lucy Crawford and the subsequent investigation into her death. These included specific references to the actions of individual doctors, the management of Sperrin Lakeland Trust and the Department's Chief Medical Officer (CMO).

12. In light of the allegations contained in the 'Insight' programme you announced an independent investigation into the issues raised by it on 1 November.

13. The Inquiry has been set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC is chair of the Inquiry and a secretariat has been appointed. You announced the terms of reference for the Inquiry on 18 November.

14. The families of the children whose details are the subject of the Inquiry will have access to whatever legal representation they require.

Reply prepared by

Ruth Fisher
Eastern Board Unit
Secondary Care Directorate
Tel [redacted]

Andrew Browne
Eastern Board Unit
Secondary Care Directorate
Tel [redacted]