## Fisher, Ruth

**From:** Browne, Andrew
**Sent:** 19 November 2004 14:43
**To:** Carnew, Sholto
**Cc:** Nugent, David; Hamilton, Andrew; Fisher, Ruth; McCaw, Darren
**Subject:** FW: COR 599/04: Mr Hume - Raychel Ferguson's case

Terms of ference.doc (31 KB)

Sholto
I have amended paragraph 19 and included the TOR for attachment to the reply. Thanks.
Andrew

-----Original Message-----
**From:** Browne, Andrew
**Sent:** 18 November 2004 17:21
**To:** Nugent, David
**Cc:** Carnew, Sholto; Hamilton, Andrew; Sullivan, Dean; Campbell, Dr Henrietta; Hill, Judith; McCarthy, Miriam; Fisher, Ruth; McCaw, Darren
**Subject:** COR 599/04: Mr Hume - Raychel Ferguson's case

John Hume.pdf (54 KB)

cor 599 04 oncerns regarding .

Sholto
Draft reply attached.
Andrew

HOUSE OF COMMONS
LONDON SW1A 0AA



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DATE : 9.11.04

Mrs Angela Smith
Parliamentary Under Secretary of State
Department of Health, Social Services and Public Safety
Castle Buildings
Stormont Estate
BELFAST
BT4 3PP

Dear Angela,

My office has been contacted by Mrs Marie Ferguson, mother of Raychel Ferguson.

Marie expressed a number of concerns about the inquiry that you announced recently into the death of her daughter Raychel, Lucy Crawford and Adam Strain.

I am aware that details of the inquiry may be announced later this week. Given the concern of the families, and the public at large, it is very important that the terms of reference, personnel and conduct of the inquiry are such that they will lead to full public confidence in its process and findings. This is clearly also important from the point of view of medical professionals and hospital authorities that this is the case.

Mrs Ferguson feels strongly that the inquiry should be independent, public and transparent, and that the families and their legal representatives should be fully involved in all aspects of the inquiry. It is not clear yet whether this will be the case.

I am also aware that the Western Health and Social Services Council has expressed a number of concerns which concur with the concerns expressed by the families.

It is also very important that the families should have full legal representation at the inquiry so that their concerns and questions are represented, and to ensure that they are appropriately involved with and informed about the proceedings of the inquiry.

I would appreciate your consideration of the points raised in this letter.

Yours sincerely

John Hume

John Hume

**COR/599/04**

From: Ruth Fisher
Eastern Board Unit
Secondary Care Directorate

Date: 18 November 2004

1. Andrew Browne – *agreed/AB/18.11.04*
2. Angela Smith

**CONCERNS REGARDING INDEPENDENT INQUIRY**

| | |
|---|---|
| **Issue:** | **Letter from John Hume MP, on behalf of his constituent Mrs Ferguson.** |
| **Timescale:** | **Due 19 November 2004.** |
| **Presentational Issues:** | **The setting up of the Inquiry into the issues raised by the recent UTV Insight programme 'When Hospitals Kill' continues to attract considerable media interest.** |
| **Recommendation:** | **To issue a reply as in the attached draft.** |

**Background**

John Hume, MP wrote to you on 9 November on behalf of his constituent, Mrs Marie Ferguson, mother of Raychel Ferguson. Mrs Ferguson has raised a number of concerns following your announcement of an Independent Inquiry into the issues raised by the recent UTV Insight programme 'When Hospitals Kill'.

2. In light of the allegations raised in the UTV Insight Programme, broadcast on Thursday 21 October, you announced an independent inquiry into the deaths of Lucy Crawford, Raychel Ferguson and Adam Strain. This is to be conducted by Mr John O'Hara QC.

3. Mr Hume has stated that it is very important that the terms of reference, personnel and conduct of the Inquiry are such that they will lead to public confidence in its process and findings. Mrs Ferguson feels strongly that the Inquiry should be independent, public and transparent, and that the families and their legal representatives should be involved in all aspects of the Inquiry. Mr Hume further states that the Western Health and Social Services Council concur with the concerns expressed by the families.

**Independence of the Inquiry Team**

4. The Inquiry is independent from Government and is to be chaired by John O'Hara QC. He is primarily responsible for taking forward the detailed arrangements of the review.

5. A dedicated Inquiry Team has been established to support with the conduct of the Inquiry. They will operate from offices in Adelaide Street, Belfast.

**Scope and Terms of Reference of the Inquiry**

6. The Terms of Reference of the Inquiry were published on 18 November. It is thought that they provide the necessary breadth to enable the concerns of the families and the wider public to be fully addressed so as to restore public confidence in our health care system.

**Powers of the Inquiry**

7. The Inquiry is being established under Article 54 and Schedule 8 of the 1972 Health and Personal Social Services Order 1972. Under this legislation John O'Hara has wide ranging powers to require <u>any</u> person to attend and give evidence or to furnish information on any matter in question at the Inquiry. This should allay public concerns, as the Inquiry has the power to call on all of the key people involved.

**Conduct of the Inquiry**

8. The Inquiry will gather all available documentary evidence, obtain written submissions and then decide who needs to give oral evidence to the Inquiry. It is anticipated that, save in exceptional circumstances, this evidence will be given in public. In addition, all formal statements provided to the Inquiry are to be placed in the public domain. The final report of the Inquiry will be published.

**Legal Representation**

9. The families of the children whose details are the subject of the Inquiry will have access to whatever legal representation they require. John O'Hara can recommend to the Department that it should pay for legal representation where it is necessary and where there are not other means by which that representation can be funded.

**Provision of Expert Advice to Inquiry**

10. Mr O'Hara will certainly require access to professional paediatric and NHS general management advice. The Department has provided him with a list of appropriate candidates from both disciplines.
To avoid any possible conflict of interest, this advice will be obtained from outside Northern Ireland and the source of advice will be determined by Mr O'Hara himself. He may require input from other experts as the Inquiry develops.

**Guidance on the Prevention of Hyponatraemia**

11. Following the inquest into Raychel Ferguson's death, the Chief Medical Officer convened a small working group to develop guidance on the prevention of hyponatraemia in children as a matter of urgency. The Guidance, issued in March 2002, emphasised that every child receiving intravenous fluids requires a thorough baseline assessment; that fluid requirements should be assessed by a doctor competent in determining

this; and that fluid balance should be regularly monitored. Following this advice will prevent children from developing hyponatraemia.

12. The guidance has been issued as an A2 sized poster for display in all hospital units where children may receive IV fluids or rehydration.

13. CREST has also issued guidance on the management of hyponatraemia in adults (June 2003).

14. Following a review of this guidance, the CMO has set up a group to develop a care pathway for fluid management in children.

**Procedures for the Investigation of Hospital Deaths**

15. All deaths that are not due to natural disease must be referred to the Coroner. The Coroner will investigate all such deaths, which will include circumstances such as:

- sudden or unexpected deaths;
- deaths where the cause of death is unknown or a doctor is unable to issue a medical certificate stating the cause of death (death certificate);
- all unnatural deaths (including accidents, suspected suicide or suspicious deaths);
- deaths thought to be due to negligence;
- deaths occurring during surgery or anaesthesia; and
- deaths from any cause other than natural disease.

16. The Coroner will decide on the need for a post mortem examination and subsequently if an inquest is required. The Coroner's investigation is supported by the Police Service for Northern Ireland.

17. A Safety in Health and Social Care Steering Group was established by the Department following the publication of the consultation document "Best Practice, Best Care" in April 2001. In July it issued interim guidance (HSS (PPM) 06/04) to the HPSS and Special Agencies on the reporting and management of serious adverse incidents. This includes a requirement for all HPSS organisations and Special Agencies to have nominated a senior manager at Board level who will have overall responsibility for the reporting and management of serious adverse incidents within the organisation. In addition, if the senior manager considers that the incident is likely to:

- be serious enough to warrant regional action to improve safety or care within the broader HPSS;
- be of public concern; or
- require an independent review,

then he/she is required to provide the Department with a brief report within 72 hours of the incident being discovered. These reports are shared with the Chief Medical Officer and other professional and administrative staff as appropriate.

18. The Department has also established a multi-agency group comprising Departmental officials and representatives from the Police Service of Northern Ireland, the Health and Safety Executive (HSE), and the Coroners' service to develop a memorandum of understanding for the investigation of death and serious incidents in hospitals. This will take account of a recent memorandum of understanding issued for consultation in England and Wales: "Investigating patient safety incidents (unexpected death or serious untoward harm): a protocol for liaison and effective communications between the NHS, Association of Chief Police Officers and HSE".

**Recommendation**

19.I recommend that you reply along the lines of the attached draft. This has been expanded to cover more than the questions raised directly by Mr Hume in the knowledge that the reply will be passed to Mrs Ferguson and may help to address some of the issues that she will almost certainly wish to raise with you at your meeting next week.

Ruth Fisher
Ext [redacted]

**Copy Distribution:**
CMO
CNO
Andrew Hamilton
Dr Miriam McCarthy
Dean Sullivan

John Hume MP

[redacted]

Our ref: COR/599/2004

November 2004

Thank you for your letter of 9 November regarding your constituent, Mrs Marie Ferguson, and the Independent Inquiry into the death of her daughter Raychel, Lucy Crawford and Adam Strain.

The death of a child is one of the worst things that can happen to any parent. I appreciate that the death of Raychel in a hospital setting and the subsequent investigation and publicity must be very difficult for Mr and Mrs Ferguson as parents and for their wider family circle as well. I want to offer my most sincere sympathy and assure Mr and Mrs Ferguson that the Independent Inquiry that I have set up will rigorously examine all the issues.

I regard it as very important that the general public should have confidence in the health service and in the standard of performance of all who work in it. That is why I have appointed John O'Hara QC to conduct an independent Inquiry into the issues raised by the recent UTV Insight programme.

I am confident that the Terms of Reference of the Inquiry (attached) provide the necessary breadth to enable the family's concerns and those of the wider public to be fully addressed so as to restore public confidence in our health care system and help bring closure for those most affected by these tragic deaths.

The Inquiry is independent from Government and the hearing of oral evidence will be conducted in public, save in exceptional circumstances as may be determined by the Chairman. All formal statements provided to the Inquiry are to be placed in the public domain and the final report will be published.
The Inquiry is being established under Article 54 and Schedule 8 of the Health and Personal Social Services (NI) Order 1972. This legislation gives Mr O'Hara wide-ranging powers to require any person to attend and give evidence or to furnish information on any matter in question at the Inquiry.

I have asked Mr O'Hara to report by 1 June 2005, but if he requires additional time to complete his investigations I will consider this. Obviously it is in everybody's best interests to complete this investigation as quickly as possible. I am aware of the investigation being conducted by the PSNI and there is a possibility that it could have an impact on the progress of Mr O'Hara's work, but I know it is his intention to proceed as efficiently and speedily as possible.

The Inquiry will have access to whatever professional advice the chairman deems necessary, including clinicians and NHS general management advice. To avoid any possible conflict of interest, this advice will be secured from outside Northern Ireland and the source of advice will be a matter for Mr O'Hara.

The proceedings will allow families to have access to appropriate legal representation and advice in preparing their case and to protect their interests during the course of the Inquiry. The involvement of legal representation during the course of the proceedings is at the discretion of John O'Hara. He will be able to determine the degree to which costs incurred by witnesses should be met, but it is anticipated that the Department will meet all reasonable costs.

The current system for the investigation of hospital deaths provides for the coroner to investigate all unexplained or unexpected deaths. Following a Home Office review and the ongoing work of the Shipman Inquiry, proposals are being considered for the reform of the coroner and death certification service.

We are continuing to take steps to ensure the very highest safety and quality standards in our health services. In July the Safety in Health and Social Care Steering Group issued interim guidance to the HPSS and Special Agencies on the reporting and management of serious adverse incidents. In addition, my Department has also established a multi-agency group comprising Departmental officials and representatives from the Police Service of Northern Ireland, the Health and Safety Executive, and the Coroners' Service to develop a memorandum of understanding for the investigation of death and serious incidents in hospitals.

Following the inquest into the death of Raychel, the Chief Medical Officer acted immediately to develop guidance that would prevent a similar incident happening again. This guidance has been incorporated into clinical practice since March 2002. Guidance has also been issued on the diagnosis and treatment of hyponatraemia in adults.

However we are not complacent and we regard the death of any child in hospital as a tragedy from which every possible lesson must be learnt and acted upon. That is why I have set up this Inquiry and will act upon its findings. I have also arranged to meet with Mr & Mrs Ferguson next week so that I can address their concerns in person.

# TERMS OF REFERENCE

To hold an Inquiry into the events surrounding and following the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson, with particular reference to:

(i) The care and treatment of Lucy Crawford, Raychel Ferguson and Adam Strain, especially in relation to the management of fluid balance and the choice and administration of intravenous fluids in each case.

(ii) The actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson.

(iii) The communications with and explanations given to the respective families and others by the relevant authorities.

In addition, the Inquiry will:

(a) Report by 1 June 2005 or such other date as may be agreed with the Department, on the areas specifically identified above and, at the discretion of the Chair of the Inquiry, examine and report on any other relevant matters which arise in connection with the Inquiry.

(b) Make such recommendations to the Department of Health, Social Services and Public Safety as the Chairman considers necessary and appropriate.