Fisher, Ruth

From: Carnew, Sholto
Sent: 17 November 2004 10:31
To: Fisher, Ruth
Subject: 3528, 3526, 3530 and 3592

Ruth

PQs final versions for your information. These have all been answered.

Sholto

3528.doc (35 KB) 3526.doc (40 KB) 3530.doc (54 KB) 3592.doc (54 KB)

PQ3528/04

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

Iris Robinson (Strangford): To ask the Secretary of State for Northern Ireland, whether medical expertise for the inquiry into the death in April 2000 of Lucy Crawford will be sought from (a) outside Northern Ireland and (b) from doctors within the Province. **(197850)**

ANGELA SMITH

Officials are currently finalising the detailed arrangements for the conduct of the Inquiry with Mr John O'Hara QC and I hope to make an announcement shortly. These arrangements will take account of Cabinet Office guidance on inquiries and a copy of the Terms of Reference will be placed in the House library.

_____ Date: _____

BACKGROUND NOTE PQ 3528/04

1. 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.

2. 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.

3. 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.

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 will be set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC has agreed to chair the

PQ3526/04

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

Iris Robinson (Strangford) : To ask the Secretary of State for Northern Ireland, whether the inquiry into the death in April 2000 of Lucy Crawford will have the power to compel witnesses, with particular reference to doctors, to provide evidence; when he expects the inquiry will commence; and whether the actions of the (a) Sperrin Lakeland Trust and (b) DHSSPS in response to the death of Lucy Crawford will be investigated by the inquiry. **(197848)**

ANGELA SMITH

I refer the honourable Member to my answer to PQ 3528/04.

_____ Date: _____

BACKGROUND NOTE PQ 3526/04

1. 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.

2. 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.

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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.

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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 will be set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC has agreed to chair the Inquiry and a secretariat has been appointed. Terms of reference are being finalised and you will announce these on Thursday 18 November.

14. Under Schedule 8 of the Health and Personal Social Services (NI) Order 1972 the person appointed to hold the inquiry may require witnesses to give evidence and produce books and documents. Failure to do so is an offence that is punishable either by imprisonment or a fine. The appointment of John O'Hara and his secretariat has already taken place and the Inquiry will commence once the terms of appointment are announced. The conduct of the Inquiry is a matter

for Mr O'Hara but it is likely that he will wish speak to all the public bodies concerned, including Sperrin Lakeland Trust and the DHSSPS.

Reply prepared by: Mr Andrew Browne

Eastern Board Unit

Room 11, Annexe 1

Castle Buildings

[redacted]

PQ3528/04 ***COPY FOR INFORMATION***

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

Iris Robinson (Strangford): To ask the Secretary of State for Northern Ireland, whether medical expertise for the inquiry into the death in April 2000 of Lucy Crawford will be sought from (a) outside Northern Ireland and (b) from doctors within the Province. **(197850)**

ANGELA SMITH

Officials are currently finalising the detailed arrangements for the conduct of the Inquiry with Mr John O'Hara QC and I hope to make an announcement shortly. These arrangements will take account of Cabinet Office guidance on inquiries and a copy of the Terms of Reference will be placed in the House library.

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PQ3530/04

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

Iris Robinson (Strangford) : To ask the Secretary of State for Northern Ireland, whether the proceedings of the inquiry into the death in April 2000 of Lucy Crawford will be conducted in public. **(198014)**

ANGELA SMITH

I refer the honourable Member to my answer to PQ 3528/04.

_____ Date: _____

BACKGROUND NOTE PQ 3530/04

1. 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.

2. 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.

3. 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.

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	Death reported to coroner.
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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.

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 will be set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC has agreed to chair the Inquiry and a secretariat has been appointed. Terms of reference are being finalised and you will announce these on Thursday 18 November.

14. It is likely that much of the evidence will be submitted in writing to the Inquiry, but it is possible that evidence may be taken from some key witnesses in public. This is a matter for John O'Hara to decide.

Reply prepared by: Mr Andrew Browne

Eastern Board Unit

Room 11, Annexe 1

Castle Buildings

[redacted]

PQ3528/04 ***COPY FOR INFORMATION ONLY***

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

Iris Robinson (Strangford): To ask the Secretary of State for Northern Ireland, whether medical expertise for the inquiry into the death in April 2000 of Lucy Crawford will be sought from (a) outside Northern Ireland and (b) from doctors within the Province. **(197850)**

ANGELA SMITH

Officials are currently finalising the detailed arrangements for the conduct of the Inquiry with Mr John O'Hara QC and I hope to make an announcement shortly. These arrangements will take account of Cabinet Office guidance on inquiries and a copy of the Terms of Reference will be placed in the House library.

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BACKGROUND NOTE PQ 3528/04

1. 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:
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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.

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14. Expert independent opinion on all aspects of these cases will be available to the Inquiry. However it if for John O'Hara to determine what experts he wishes to assist him and whether this assistance should come from Northern Ireland or from further afield.

Reply prepared by: Mr Andrew Browne

Eastern Board Unit

Room 11, Annexe 1

Castle Buildings

[redacted]

PQ3592/04

DATE OF ANSWER: WEDNESDAY 17 NOVEMBER 2004

John Hume (Foyle): To ask the Secretary of State for Northern Ireland, if he will ensure that the families of the children whose deaths are the subject of Mr John O'Hara QC's independent inquiry have access to independent legal representation; and what the (a) terms of reference and (b) scope of the inquiry are. **(198497)**

ANGELA SMITH

I refer the honourable Member to my answer to PQ 3528/04.

_____ Date: _____

BACKGROUND NOTE PQ 3592/04

1. 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.

2. 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.

3. 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.

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9. Details 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.

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13. The Inquiry will be set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC has agreed to chair the Inquiry and a secretariat has been appointed. Terms of reference are being finalised and you will announce these on Thursday 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: Mr Andrew Browne

Eastern Board Unit

Room 11, Annexe 1

Castle Buildings

[redacted]

074-009-051

PQ3528/04 ***COPY FOR INFORMATION***

DATE OF ANSWER: TUESDAY 16 NOVEMBER 2004

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