## McCarthy, Miriam

**From:** McCarthy, Miriam
**Sent:** 08 November 2004 16:22
**To:** Willis, Claire; Riddell, Isobel
**Subject:** RE: URGENT RE: Submission on Child Death Review Protocol

Minister
nnounces inquiry.dc

As mentioned by Claire. In briefing we should refer to hyponatraemia as low sodium level in the blood

Miriam

-----Original Message-----
**From:** Willis, Claire
**Sent:** 08 November 2004 12:27
**To:** Riddell, Isobel
**Cc:** McCarthy, Miriam
**Subject:** URGENT RE: Submission on Child Death Review Protocol

Isobel
I gather Heather got back to you last week, I also showed the para on hyponatraemia (10) Miriam McCarthy & she thinks it would be best to use the wording already submitted to Minister, she said she would email it directly to you as I gather there are some differences in the detail of admission.

regards
Clare

-----Original Message-----
**From:** Riddell, Isobel
**Sent:** 04 November 2004 16:21
**To:** Willis, Claire; Neagle, Heather; Carson, Ian
**Subject:** RE: Submission on Child Death Review Protocol

All

Could I possibly have any comments by Monday 8th November

Many thanks

Isobel Riddell

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**From:** Willis, Claire
**Sent:** 02 November 2004 10:24
**To:** Neagle, Heather; Carson, Ian
**Cc:** Riddell, Isobel
**Subject:** FW: Submission on Child Death Review Protocol

Ian/Heather
appreciate your views & advice on this

Heather I think this is the document you commented on during the summer

Claire

**DHSSPS**

-----Original Message-----
**From:** Riddell, Isobel
**Sent:** 02 November 2004 10:09
**To:** Willis, Claire

**Cc:** McGlew, Pat; Bradley, Fergal
**Subject:** FW: Submission on Child Death Review Protocol

Claire

I have prepared a draft submission for Minister relating to a consultation we are taking forward on a child death review protocol for NI for sudden and unexpected child deaths. In view of this morning's announcement relating to an Independent Inquiry into the deaths of the 3 children in NI who died in hospital, I have inserted an additional para (see para 10 of submission).

At the moment the child death review protocol would focus on children who die at home or are presented at A&E dept, via the Ambulance Service or brought to hospital by a family member. There is a need to identify where a parent or carer has been responsible for a child's death and to fully investigate these circumstances and the protocol suggests how professionals and agencies need to take a co-ordinated approach in the management and investigation of sudden unexpected deaths. However, with the recent press coverage, as part of the consultation exercise we are considering asking consultees to consider the protocol in light of existing procedures which cover for example investigations of child deaths as a result of treatment for routine or other medical conditions with a view to extending the protocol if necessary.

Perhaps you could clarify the current procedures which govern investigations of child deaths as a result of treatment for routine or other medical conditions. I would appreciate your views on the content of para 10 and of us inviting comments on the appropriateness of the protocol for such child deaths. You may wish to consult with Dr Carson on the matter also.

I would appreciate an early response.

Regards

Isobel Riddell

[redacted]

<< File: draft submission on Child Death Review Protocol 211004.doc >>

<< File: Annex B final Press Release (Claire information office).doc >>

<< File: AnnexC CDR PROTOCOL - 060904 (2).doc >>
<< File: Annex D cover sheet.doc >>

<< File: Annex D KENNEDY REPORT.pdf >>

**DHSSPS**

# News Release

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

1 November 2004

## MINISTER ANNOUNCES CHILD DEATHS INQUIRY

**Minister with responsibility for Health, Social Services and Public Safety, Angela Smith, today announced that she has appointed Mr John O'Hara QC to conduct an inquiry into the issues raised by the recent UTV Insight programme 'When Hospitals Kill'.**

The Minister said: **"I regard it as very important that the general public should have confidence in the health service and in the standards of performance of all who work in it. This television programme has raised a number of serious issues and allegations which need to be investigated.**

**"The death of a child is tragic and is something which my Department takes very seriously. I have spoken to the families who were involved in the programme and have told them that there will be a fully independent investigation.**

**"I am grateful to John O'Hara for agreeing to undertake this inquiry and I know that he will pursue a rigorous investigation of the issues.**

**NOTES TO EDITORS:**

1. The UTV Insight programme 'When Hospitals Kill' was broadcast on Thursday, 21 October 2004. It focused on the death of three children, Lucy Crawford, Raychel Ferguson and Adam Strain.

Media queries to DHSSPS Press Office on [redacted] or mobile [redacted]

**DHSSPS**



Castle Buildings, Stormont Estate, Belfast BT4 3SJ
Tel: [redacted] Fax: [redacted] E-Mail: press.office[redacted]