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HEADQUARTERS REF NO

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I/Department CRIME OPS

:or/Station/Branch CARE UNIT, ENNISKILLEN

Date 09 June 2005

3JECT **REPORT RE CHILD DEATHS**

TO: D/SUPTS HAMILTON AND STEELE, D/I NICHOLL

Following my email re the initial views of Pamela Acheson DPP on the R v O'Donohoe file (death of Lucy Crawford) I submit the following report to summarise the situation as briefly as I can:

1. Adam Strain (date of birth 4 August 1991) died on 28 November 1995 in the Royal Belfast Hospital for Sick Children (RBHSC). He had suffered from kidney dysfunction through much of his short life and died on the day following kidney transplant. An autopsy on 29 November 1995 found Adam died from cerebral oedema (excess fluid in the brain) due to dilutional hyponatraemia (excess dilute fluids – reducing his blood sodium levels) and impaired cerebral perfusion (reduced blood flow in brain) during renal transplant operation. An Inquest on 18 June 1996 concurred with the findings of the Pathologist. It is believed Adam was given too much fluid, which was low in sodium before and during his operation, inducing hyponatraemia, leading to cerebral oedema and death.

   It appears this was the first such death from dilutional hyponatraemia in Northern Ireland. The Inquest heard references to a paper in the British Medical Journal on 9 May 1992 in which this danger was highlighted. Some of the doctors involved with Adam were aware of this article and others were not.

   It is suspected that the danger of excess dilute fluid being administered to patients, demonstrated by the death of Adam, was not disseminated throughout the paediatric community in Northern Ireland.

   It is also clear that while Adam was a very ill child, his death was caused entirely by the treatment and not by his transplant operation or kidney dysfunction.

2. Lucy Crawford (date of birth 5 November 1998) was admitted to Erne Hospital, Enniskillen on 12 April 2000 with gastroenteritis. She was prescribed a disputed amount of dilute intravenous fluid, suffered a seizure ('coning') in four hours and was pronounced dead at RBHSC on 14 April 2000. No Inquest was held as the Coroner was informed her death was by natural causes.

A death certificate was issued to the family stating cerebral oedema, dehydration and gastroenteritis. After events described below at points 3 and 4 an Inquest was held belatedly in February 2004. Doctor Sumner, a Consultant Paediatric Anaesthetist from Great Ormond Street Hospital gave evidence for the Coroner (he also gave evidence in 1996 at the Inquest on Adam Strain); Doctor Dewi Evans, Consultant Paediatrician in Swansea gave evidence for the family and Doctor John Jenkins, Antrim Area Hospital, gave evidence for the Trust. All disagreed with the causes of death stated on the original death certificate and the unanimous conclusion of the doctors at the Inquest was that Lucy died from cerebral oedema caused by acute dilutional hyponatraemia as a result of receiving excess dilute fluids, with gastroenteritis as an underlying case. All criticised the treatment Lucy was given in the Erne Hospital, Doctors Sumner and Evans being particularly scathing.

At the Coroner's request police attended the three-day Inquest. I was present throughout. I submitted a report recommending a police investigation and this was directed in October 2004. In that month UTV screened an Insight Programme 'When Hospitals Kill' and this uncovered additional information. Police investigated three issues:

(i) Lucy's death – the investigating officer recommended prosecution of Doctor O'Donohoe for manslaughter and Criminal Justice concurred.

(ii) Perverting the Course of Justice – in that the Trust prevented a police investigation by concealing the facts. No prosecution was recommended in this regard. In May 2005 Mr Hugh Mills, Chief Executive of Sperrin Lakeland Trust resigned as a result of pressure from the Lucy Crawford situation and related issues.

(iii) SN7 Coroner's Act 1959 – whether or not information was withheld from the Coroner or false information was given to the Coroner to prevent an Inquest. No prosecution was recommended. I believe the main onus in this regard was on the Pathologist, Doctor O'Hara (now deceased). He did not conclude that Lucy died as agreed at the Inquest and did not see any need to refer for Inquest as he accepted her death was from natural causes.

This file is currently with the DPP (Pamela Acheson) and has been sent for opinion to Gordon Kerr, QC.

I also believe the role of doctors in this case is much more worrying than the role of managers. Lucy died from defective treatment, not from her illness. Doctor Asghar looked at her notes on the morning after her decline and concluded that the fluid regime had caused her deterioration. Doctor Auterson (Consultant Anaesthetist in the Erne) was independently of the same view, but while Doctor Auterson took no action, Doctor Asghar expressed his concerns and on 5 June 2000 wrote to the Chief Executive. Meanwhile the Trust requested Doctor Murray Quinn, a respected Consultant Paediatrician from Altnagelvin, to review Lucy's case notes. He did so, and could not specify why she had died and found nothing wrong with her care. Doctor Asghar was persistent and the Trust invited the Royal College of Paediatrics and Child Health to review Doctor O'Donohoe's performance on two occasions. These experts (one from Belfast and one from London) did not fault Doctor O'Donohoe's treatment. As already stated, neither did the Pathologist. In examining Lucy's case, it is apparent there are two very significant figures: at 2050 hours her blood sodium is 137 mmols/l and at about 0340 hours it is 127 mmols/l. At Inquest it was said this degree of fall in that time period

would have killed her. In reading her notes, it was evident to both D/Chief Inspector Gault (then the SIO) and myself that the blood samples which produced a figure of 127 units were taken after a solution of concentrated sodium was allowed to run freely into Lucy's blood for perhaps 30 minutes and therefore throughout that period her blood sodium was rising. The figure of 127 was not therefore the lowest possible level of blood sodium. None of the doctors who reviewed her case have remarked on this. Doctor Hanrahan (a Consultant Paediatric Neurologist at the RBHSC) when interviewed after caution confirmed this and stated he only became aware of this possibility in December 04 and his estimate was that Lucy's blood sodium was as low as 116 units. For none of the reviewing doctors to remark on this is unbelievable and scandalous. It can indicate only one of two things:

(i) Their reviews are superficial and therefore useless. If this is so, it demonstrates reprehensible disregard for the death of a child.

(ii) That they did become aware of this possibility, demonstrating that Doctor O'Donohoe's negligence was much worse than the figures suggested and chose to conceal the fact. It may be that this should be a matter for further investigation since the failure to identify and disseminate the cause of Lucy's death is directly relevant to the death of Raychel Ferguson. Such failures may be malfeasance in public office, an offence which Pamela Acheson, DPP is considering in relation to the nurses and believes we should consider it more widely.

These possibilities and the confirmed failure of expert doctors with time at their disposal to arrive at a conclusion evident to a more junior doctor at a first read of the notes, instils distrust in me in requesting any opinion from a Northern Ireland doctor with regard to another Northern Ireland doctor. While Doctor Jenkins sought to minimise any negligence, Doctors Sumner and Evans seemed not to wish to conceal anything, demonstrating the benefits of going outside Northern Ireland for a medical opinion on Northern Ireland doctors.

I do not believe that Doctor Sumner or Doctor Evans, in preparing for the Inquest had sight of the reports of Doctor Murray Quinn or the RCPCH reviews. It may be worth considering in future if we should have an independent assessment of these documents. If they were found to be defective and a whitewash, then they were instrumental in preventing an Inquest and in failing to have the danger of dilute fluids highlighted and therefore led to the death of Raychel Ferguson. There may be grounds for investigating their authors for malfeasance in a public office.

3. Raychel Ferguson (date of birth 4 February 1992) died on 10 June 2001 at RBHSC, after an appendectomy at Altnagelvin Hospital. Raychel began vomiting severely after her operation and required fluids. These led to hyponatraemia, causing cerebral oedema and death. An Inquest took place on 5 February 2003 and the cause of death was found to be cerebral oedema and hyponatraemia.

I do not have an in-depth knowledge yet of this case, but it appears the doctors made no secret of the fluid difficulties and it was as a result of Raychel's death that a protocol was developed by the Department of Health, now disseminated widely, advising doctors on the dangers of excess dilute fluids causing hyponatraemia.

A number of issues are raised here:

(i) Was Raychel's death avoidable if proper steps had been taken after previous deaths? If so, who is to blame and is there a criminal offence?

(ii) What was known after Raychel's death that led to a protocol that could not have been known after Lucy's death, or Adam's death?

(iii) I know Raychel's parents are adamant that the nurses told lies at Inquest. This may require to be pursued.

4. Mr Stanley Millar was the Chief Officer of the Western Health and Social Services Council. He had a role in providing support to people who wish to complain about Health and Social Services and in this regard he was assisting the parents of Lucy Crawford. He also received a briefing following the Inquest on Raychel Ferguson and he saw a link between Lucy and Raychel. Mr Millar informed the Coroner of his views and the Coroner announced an Inquest into the death of Lucy. Mr Millar informed the Coroner that he had two questions:

   (i) Were there direct parallels in the events leading up to the deaths of both girls?

   (ii) Would an Inquest in 2000/01 (on Lucy) have lead to the recommendations from the Raychel Ferguson Inquest being shared at an earlier date and the consequent saving of her life?

   Question (ii) is the vital question. If it is confirmed Raychel's death could have been prevented, then offences may have been committed, and may require further investigation.

5. Lucy's Inquest provoked extensive press coverage, on BBC NI and UTV, but particularly in the Fermanagh papers. An Insight Programme highlighted concerns in October 2004 and the Department of Health announced the Inquiry into Hyponatraemia-related Deaths in Northern Ireland, chaired by John O'Hara, QC. The Inquiry is initially reviewing the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson. It may yet broaden its scope if other similar deaths are notified. The Inquiry has delayed discussion of Lucy's death until the criminal matters are attended to. I know Mr O'Hara has been in contact with Sir Alistair Fraser, DPP, since the police file was submitted. At present the Inquiry is gathering papers and inviting written submissions. D/Chief Inspector Gault and I have met Mr O'Hara on a number of occasions and I believe D/Chief Superintendent Wright has done so also. D/Chief Superintendent Wright is aware of these cases and advised initially on the requirements for manslaughter set out in R –v- Adomako.

6. The DPP are reviewing the evidence gathered in relation to Lucy's death. I have spoken at length to the directing officer, Pamela Acheson. She highlighted the probability that no direction can be made on Lucy Crawford alone until Police have investigated the totality of the circumstances around these three deaths and sought evidence on what was known by whom and when and who had a responsibility to highlight dangers and how this role was undertaken. There will undoubtedly be future consultations re the same.

7. Aine McCann (date of birth 1 January 1994) died in the Erne Hospital on 14 December 2002 after admission with vomiting and the administration of fluids. The medical staff who treated Aine were different to those who treated Lucy, but worryingly the fluid regime implemented by Doctor Raza for Aine is explained to the Coroner in a letter by Doctor O'Donohoe.

I have read the Coroner's papers on Aine. He is still seeking medical opinion before holding an Inquest. I am aware there are significant differences between Aine and the other deaths in that Aine developed acute diabetes and this complicated issues. However, Doctor Asghar who identified fluids as the cause of Lucy's death also told me that fluids were the problem in Aine's death. Also I am concerned that a junior doctor commenced fluids as per a protocol and then Doctor Raza arrived and increased the fluid dose. At autopsy what appears to me to be substantial evidence of excess fluids was found.

It is clear the Coroner is uneasy about this Inquest. I believe it is important and urgent that police are prepared for an Inquest verdict that Aine died as a result of her treatment and not her illness. If such should happen, there will be a sustained press outcry in Fermanagh and the police actions will be scrutinised. I therefore recommend that police identify a medical expert, have them consider her notes and obtain an opinion as to the effect of her fluid regime on her condition. It may be that such examination will allay our fears and we would therefore not expect a negative reaction after the Inquest. If such an expert advised there were concerns, police could then seek a full report and consider commencing criminal investigation. The Coroner would have to be told, but the police would then be seen as a proactive and avoid negative publicity. It may be appropriate to use Doctor Sumner, who advised police in Lucy's case.

For information and consideration.

WILLIAM R CROSS
D/SERGEANT

In that case I recommend that we expedite the further medical evidence for R v O'Donohoe.

If need to discuss over weekend try [redacted] but I am in Wicklow and may be out of range, back Monday.

Billy Cross

NICHOLL Tara

From: CROSS Billy
Sent: 10 June 2005 15:37
To: HAMILTON George; STEELE Patrick; NICHOLL Tara
Subject: : child-deaths.doc

[redacted] Ext DISupt Steele.
Wed afternoon.

child-deaths.doc

All,

I forward the attached in response to the recent email from DSupt Hamilton to the effect that HoB is to be briefed by DI Nicholl.

For the information and direction of whoever must make the decision, the following steps need to be considered and myself given direction:

1. Pamela Acheson has said that further medical evidence highlighted by me on the Crawford file should be obtained at once as it demonstrates the degree of negligence better than anything currently on the file. This involves having a medical person estimate the possible lowest level of blood sodium from evidence we obtained at the very end of the enquiry. It will involve taking the notes to such a person, discussing the detail and awaiting a report. I do not believe this can be done well other than face-to-face due to the multiple sources of the information and the complex nature of the enquiry and the significance of the evidence to a possible trial. Dr Sumner, who acted as our medical expert in the O'Donohoe case has recommended that a Dr Bingham, Great Ormond Street Hospital could do this and clearly he will carry some credibility as he is in the paediatric centre for excellence for the UK. This therefore requires a trip to London. I think, unlike during the O'Donohoe case, once the problem is explained and the doctor knows exactly what we require and we have heard what he can be provide, there should be no need to go back to discuss the report.

2. Pamela Acheson discussed the use of medical experts in possible future investigations into Raychel and Adam's deaths. She agreed with me that there may be a danger in using the same expert for each investiagtion. If the defence discredited the expert in one case, they are compromised for them all, and their repeated use by us may damage their independence. She therefore thought we could consider varying the experts used but stated it was important that we selected one's who are at the very top of their profession and who cannot be outgunned at trial. It is clear that any such trial will rely very heavily on expert opinion. She recommended that we take advice from Dr Sumner on who is the best, and that we consider appraoching those doctors who have highlighted the problems with fluids in the medical press. I am aware of the names of some of these but not at prsent if they are alive or dead and where they may be. Clearly, if a direction is made to investigate fully the other deaths, careful consideration is needed into the selection of experts.

3. Aine McCann is more pressing than the others, as one quick review by an expert may discount any negligence and put our minds at rest re the Inquest, and even if the Inquest were negative then police can justify inaction on the basis that they were led by an expert opinion.

4. To expeditiously deal with 1. and 3. above, since 2. can afford to wait I recommend that:
   i. I take the recent evidence re O'Donohoe to Dr Bingham so that the DPP and Gordon Kerr QC have an early report, and that this is done before I go on annual leave on 24/6/05.
   ii. since the money is being spent in going to England re O'Donohoe I would incorporate the McCann situation and arrange, if he agrees, that Dr Sumner takes her notes for an opinion on her care. Furthermore, since we are there, that her notes are also given to Sue Chapman, Nursing Consultant, also in Great Ormond Street (she advised on Lucy Crawford and produced an excellent report). I could explain the background but ask her not to examine the notes without further contact from me. If Dr Sumner advised us that there were concerns, Sue could then be asked to report on the nursing notes without us having to go back to England. Furthermore, while we are in England, Doctor Asghar is presently in Canterbury, one hour from London. He was the first doctor to say there was a problem with Aine's fluids and I interviewed him re Lucy Crawford. If he agreed, I would have him interviewed re Aine and his concerns. If it turns out we are not investigating her case, we have wasted only a half-day, but if we were to investigate on the basis of the reports of Dr Sumner and Sue Chapman's reports, then we would have to send officers to England specifically to see Dr Asghar. Since I think we have to go to England to address 1., I think by incorporating these extra tasks we maximise value for money. I would be reluctant to use Sumner and Chapman for Raychel and Adam, but I think the use of Sumner if he agrees for a preliminary view on Aine will not be damaging and will give us the 'heads-up' we may need.

It may be of course that no one is available at the relevant times to combine all this, or they may not wish to take it on.