SUB/207/2005

From: Andrew Browne
Secondary Care Directorate

Date: 20 May 2005

1. Dean Sullivan
2. Secretary
3. Shaun Woodward

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Issue:	**Minister has requested briefing on the current Inquiry into hyponatraemia-related deaths chaired by John O'Hara QC.**
Timescale:	**Routine.**
Presentational Issues:	**None at present, although there is significant media interest in the Inquiry.**
FOI Implication:	**This submission is fully disclosable.**
Recommendation:	**That Minister notes the current position on the Inquiry.**

Background

1. On 1 November 2004 Angela Smith MP announced an Inquiry into the events surrounding and following the deaths of 3 children from hyponatraemia-related

causes between 1995 and 2001. The announcement came after the broadcast on 21 October 2004 of a UTV 'Insight' programme entitled "When Hospitals Kill", which raised a number of serious issues and allegations. Hyponatraemia is a disorder of sodium and water metabolism and is the most common electrolyte abnormality in hospitalised patients. Treatment requires careful fluid management.

2. The Terms of Reference (Annex A) given to John O'Hara QC, who was appointed to chair the Inquiry were wide-ranging and gave him discretion to report on any relevant matters that arose in connection with the Inquiry, including any further deaths that came to light. However the main focus is on the three children named in the Terms of Reference.

(a) **Adam Strain**

Adam Strain was a 4-year-old who died at the Royal Belfast Hospital for Sick Children on 28 November 1995 following renal transplant surgery. He had a long history of poor health but the cause of death as recorded by a coroner's post mortem was cerebral oedema due to dilational hyponatraemia and impaired cerebral perfusion during renal transplant. Mr Leckey, the coroner for Greater Belfast drew this death to CMO's attention in December 2001.

(b) **Raychel Ferguson**

Raychel was a 9-year-old girl admitted to Altnagelvin Hospital on 7 June 2001 with appendicitis. She had an appendectomy but developed seizures the following day and was transferred to the Royal Belfast Hospital for Sick Children where she was pronounced dead on 9 June. Shortly afterwards the death was drawn to CMO's attention (although the inquest was not held until February 2003) and work began in

August 2001 to produce guidance on the prevention of hyponatraemia in children. A committee was convened in September and guidance was issued on 25 March 2002.

(c) **Lucy Crawford**

Lucy Crawford died on 14 April 2000, aged 17 months. She had been admitted on the previous day to the Erne Hospital in Enniskillen suffering from fever and vomiting. Intravenous fluids were administered but she collapsed and was transferred to the Royal Belfast Hospital for Sick Children in a moribund state and was later pronounced dead. A coroner's post mortem was not requested, but CMO was informed of Lucy's death in March 2003 by Mr Leckey after he had received correspondence about the case from the Western Health and Social Services Council highlighting the similarity to Raychel Ferguson's death. In February 2004, Mr Leckey conducted an inquest into the case and referred it to the CMO and GMC, but not the DPP. Mr Leckey expressed "serious concerns about the quality of the medical care Lucy received whilst a patient in the Erne Hospital", which is part of the Sperrin Lakeland Trust.

3. The circumstances surrounding these deaths have already been the subject of a number of investigations. Altnagelvin initiated a Critical Incident Investigation into the death of Raychel Ferguson. Sperrin Lakeland Trust carried out an internal review into Lucy Crawford's death. This death has also become the subject of a PSNI investigation. All three deaths were reported to the coroner and inquests were carried out into the deaths of Raychel Ferguson and Lucy Crawford.

4. The various investigations have received widespread media coverage, particularly by UTV and the Impartial Reporter (a Fermanagh newspaper). In

March 2004 UTV featured Lucy Crawford's case on a current affairs programme "The Issue" and again in October 2004 when the "Insight" edition "When Hospitals Kill" was broadcast. The nature of this coverage has been a source of concern to the Department, and the Permanent Secretary wrote to Alan Bremner, Controller of Programmes at UTV on 29 March 2004 to complain about the way in which the CMO had been treated.

In addition to the issues raised by UTV and other media sources around the role and responsibilities of the Department, and particularly the CMO and Permanent Secretary, the investigation will focus on three other key areas.

Other Issues

5. **The clinical management by hospitals of patients suffering from hyponatraemia**

In all three cases it appears that there were shortcomings in the fluid management of the children. There is still considerable debate among paediatricians regarding the most appropriate intravenous fluid therapy for children in hospital. The guidance that CMO issued in March 2002 on the prevention of hyponatraemia in children was the first of its type in the UK and it was followed a year later by guidance in respect of hyponatraemia in adults. Nevertheless the media has picked up on the fact that articles had appeared in the medical press as early as 1992 (and possibly before) about hyponatraemia and have asked why more was not done sooner. It should be noted that since issuing guidance the CMO has also followed up with letters to Trust Chief Executives in regard to compliance and in arranging for an international expert to quality assure the guidance in light of emerging evidence.

6. **Trusts' accountability for events and quality issues**

While this affects both Altnagelvin and the Royal Hospitals, Sperrin Lakeland Trust in particular has come in for sustained criticism in respect of the nature of the communication between the Trust and the Crawfords and the way in which the event was investigated. Allegations of a cover-up persist. Since 2003 there has been a statutory duty of quality on all HPSS providers and an independent Regulation and Improvement Authority has now been created, but these developments have come about since Lucy's death. The coroner spoke of "serious shortcomings in medical record keeping and the understanding of the nurses as to the fluid regime that had been prescribed". He also commented on the quality of medical care in respect of two doctors, one of whom declined to given evidence at the Inquest and the other has now returned to Pakistan.

It should be noted that in the events surrounding the resignation of Hugh Mills from Sperrin Lakeland Trust yesterday some of the media have again referred back to Lucy Crawford's death.

7. Reporting of Adverse Incidents in the HPSS

Despite arrangements introduced in England as far back as 1994 on foot of the Allitt Inquiry this has always been a problematic area for the NHS. Frank Dobson, then Secretary of State for Health, described the current system as "a bit of a shambles" in 1999. In May 2000 the Chief Medical Officer in England published "An Organisation with a Memory", which emphasised the need for better reporting systems. Northern Ireland established a Safety in Health and Social Care Group and is moving towards a Service Level Agreement with the National Patient Safety Agency. In July 2004 the Department issued guidance to the HPSS on reporting adverse incidents, but questions will be raised about the procedures in place at the time the 3 children died (1995-2001).

The Inquiry

8. The Terms of Reference were published on 18 November 2004. The families, supported by their MPs through a series of PQs, expressed concern about a number of aspects.

They would have liked to be more closely involved in shaping the Terms of Reference; they expressed doubt about the independence of the Inquiry secretariat; and they sought assurances on the level of legal support that they would be granted and on how the Inquiry would be conducted.

9. On 17 December, Mr O'Hara published his detailed proposals for the procedure of the Inquiry and relevant matters. These were the subject of a public hearing on 3 February 2005. The proposals responded to the points raised by relatives and their legal representatives:

- The Terms of Reference remained unchanged;
- The powers of the Chairman under Schedule 8 of the HPSS (NI) Order 1972 allow him to require documents to be furnished and witnesses to attend;
- The Inquiry would be inquisitorial, rather than adversarial, in nature but limited cross examination would be allowed;
- Documents would be published on the Inquiry website (The Inquiry has already gathered over 80 Lever Arch files);

- Written statements will be sought before the summer and oral evidence will be heard in October and November;

- The Inquiry will be supported by counsel (Monye Anyadike- Danes) and a solicitor (Fiona Chamberlain) and will appoint specialist advisers from outside Northern Ireland as required;

- Families may appoint counsel but it was suggested that one QC might act for all three;

- The Secretariat (of seconded DHSSPS staff) will remain unchanged but is responsible only for management and administrative work;

- The Inquiry aims to report by the end of March 2006, but does not intend to give any individual or organisation criticised within the Report an opportunity to see the relevant sections in advance of publication.

10. The cost of the Inquiry was originally estimated at about £500,000. However given the level of legal involvement now envisaged, the need to hire a venue for the oral hearings and the extension of the Inquiry to March 2006, the current estimated cost has risen to £1.95m.

11. Because of the PSNI investigation into the death of Lucy Crawford, the Inquiry has been proceeding with the investigation of the other two deaths. The Department received confirmation today that the PSNI investigation has now concluded with a file being forwarded to the DPP. It is not yet clear how this will affect Mr O'Hara's Inquiry.

The Department's Response

12. A member of the Departmental Solicitor's Office (Tanya Stewart) and Andrew Anthony of Tughan's Solicitors, on behalf of CMO through the Medical Defence Union, are co-operating to agree one counsel to represent both the Department and the CMO. The legal team is being supported by Departmental officials who are working not only to respond to the various requests for information, whether from the Inquiry or in response to PQs, FOI requests etc, but also to address some of the issues raised in the context of risk management and adverse incident reporting.

13. A short public session of the Inquiry is scheduled for 23 June to report on progress. Minister will be advised of any significant development.

Conclusion

14. Minister is asked to note the background and circumstances surrounding this Inquiry. It is understood that requests have been received in the Private Office from both John O'Hara and Mae Crawford (Lucy's mother) for early meetings. Further briefing will be supplied as necessary.

ANDREW BROWNE

[redacted]

cc. CMO
Mr Hamilton
Mr Hill
Dr Mitchell
Mr McCann
Mr Conliffe
Mrs Stewart
Mr Bill
Mr Magowan