**From:** McKelvey, Siobhan
**Sent:** 30 June 2005 14:53
**To:** Browne, Andrew
**Subject:** FW: Impartial Reporter hyponatreamia stories 30.06.05

Andrew,

You don't seem to be on the circulation list for some reason.

Siobhán McKelvey
WHSSB & DBS Unit
Secondary Care Directorate
[redacted]

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**From:** Deazley, Peter
**Sent:** 30 June 2005 10:10
**To:** McKelvey, Siobhan; Tweed, Heather; Twinem, Elaine
**Subject:** FW: Impartial Reporter hyponatreamia stories 30.06.05

For information

-----Original Message-----
**From:** Moore, Martin
**Sent:** 30 June 2005 09:38
**To:** Gowdy, Clive; Campbell, Dr Henrietta; Hamilton, Andrew; Simpson, Paul; Hill, Don; Sullivan, Dean; Deazley, Peter; McCarthy, Miriam; Maguire, Philip; Baxter, Clare; Edgar, Leona; Dempster, Lesley; Carson, Ian; Carnew, Sholto'
**Subject:** Impartial Reporter hyponatreamia stories 30.06.05

## Minister 'sorry' about wait for answers

The Health Minister, Mr. Shaun Woodward, has told the parents of the three children who died from hyponatraemia related illnesses, how sorry he was that they were still waiting for answers.

The Minister, in a keynote speech on his vision for the health service in Northern Ireland, described the parents of 17-month-old Lucy Crawford as "remarkable" and paid tribute to them and Lucy's brother and sister.

He said they "have had to endure for far too long without proper answers to questions any of us would want answered if it had been our child."

The Minister said there needs to be better management of risk and an understanding and confidence that there can be no compromise on patient safety.

"The public needs to understand that in to-day's high-tech medical world, it is better to build centres of excellence and ask the patients to travel a little further in return for better managed health care," he stated.

Referring to the Risk Assessment Report published several weeks ago which led to the resignation of Sperrin Lakeland chief executive, Mr. Hugh Mills, the Minister said, "One of the lessons of the Sperrin Lakeland Report is that there is a genuine danger of spreading resources too thinly."

He said accountability mattered and when it didn't, all types of accusations started resulting in the

ublic and media assuming there was a cover up.

"The situation escalates. So our system needs more transparency and more accountability."

Referring specifically to the case of Lucy Crawford, the Minister said they need to know if mistakes were made and added that her parents deserved to know.

He also thanked the media for their role in getting an inquiry started.

The Minister said, "To the health professionals, a good media will act as another part of the conscience of our health care system. To the media, make sure you find some space to give credit where it is due. You too can help, through your reporting, providing incentives as well as sanctions for a better system of health care in Northern Ireland."

Referring to the need for change within the Sperrin Lakeland Trust, the Minister said it was evolutionary because it needed to cause least disruption. As Minister, he said it was his job to lead and to ensure that change must be transformatory.

Quoting from the Risk and Governance Review of Acute Hospital Services report presented to the Sperrin Lakeland Trust, the Minister said, "We heard of a considerable number of examples of where adverse clinical incidents had occurred where staff had reported such incidents formally and informally where they received little or no feedback and where nothing had been done about the incident."

The Minister replied, "It is completely unacceptable. It has to change, it must change."

"I think we have to be honest with the public about what in the short term we are able to provide that is safe and which can be staffed and resourced realistically," he said.

Also in his address, the Minister emphasised that the fundamental decision that has been made about the main hospital provision for the Erne and Omagh was not going to change.

"This was a difficult decision. But in the management of the health service and ensuring the safety of our service the strategic direction for the area is the right one," commented the Minister.

**No date fixed yet for Lucy hearing**

The Director of Public Prosecutions is still considering whether anyone will face criminal charges over the death of 17-month-old Letterbreen girl Lucy Crawford, it has emerged.

The inquiry into the hyponatraemia-related deaths of three children in Northern Ireland hospitals held a public hearing last week when it was revealed that no date can be fixed yet for the O'Hara investigation to publicly question witnesses in Lucy's case.

The public hearing into the deaths of Belfast boy Adam Strain and Raychel Ferguson from Derry will begin in October.

But Mr O'Hara could not schedule the case for Lucy, who died in April 2000 after fundamental errors at the Erne Hospital.

Mr O'Hara told last week's hearing in Belfast that the PSNI had completed its investigation into

Lucy's death and passed a file to the DPP on May 23.

Legal representatives for her parents, Neville and Mae Crawford said the family was "disappointed" at the delay, but understood the reason. Mr and Mrs. Crawford attended last Thursday's hearing in Belfast.

Mr O'Hara said the delay was an "unavoidable problem".

"The next stage is the DPP decision," said Mr O'Hara. "It is difficult to know when a decision will be taken."

The inquiry chairman said that if there were criminal charges, it was unlikely there would be a trial before the end of the year.

While Mr O'Hara outlined a proposed a timescale for the rest of the inquiry to go ahead, he also heard objections from the families over his appointment of one of his experts, Dr. Harvey Marcovitch as paediatric adviser.

Dr. Marcovitch was a full time NHS consultant paediatrician from 1977 to 2001, latterly in Oxfordshire where he was also honorary senior clinical lecturer at the University of Oxford. He is now associate editor of the British Medical Journal. From 1985 to date he has acted as an expert witness for claimants and defendants in clinical negligence cases and is a member of the Expert Witness Institute. He is adviser on external relations for the Royal College of Paediatrics and Child Health.

However, Mr O'Hara overruled the family objections, based on an article by Dr. Marcovitch which had been published in the British Medical Journal. Mr. O'Hara said that while it had been written in the "strongest terms", it had related to a particular campaign and Dr Marcovitch was at pains to distinguish that particular campaign from his current post.

Also at last week's inquiry, there were references to thousands of documents received by the inquiry team.

While many have been made public on the website, many others have been held back. In some cases, public bodies have claimed "legal and professional privilege."

This is the subject of discussion between the various legal teams.

In addition, many of the documents relating to Lucy's case are being held back from public view pending the outcome of the DPP deliberations.

Mr Tony McGleenan, barrister for the family of Adam Strain, complained about the treatment of the family, including where they were seated at the inquiry.

He also pointed to the array of legal teams representing the public bodies, compared to the poor entitlement of representation the families were entitled to.