506/253/2006

From: Siobhán McKelvey
Secondary Care Directorate

Date: 19 April 2006

1. Dr Miriam McCarthy –*agreed 19.4.06*
2. Andrew Hamilton **Agreed/AH/20/04/06**
2. Shaun Woodward

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS – INQUEST INTO THE DEATH OF CLAIRE ROBERTS

Issue:	**To provide a summary of issues relating to the imminent inquest into the death of Claire Roberts in 1996 and the likely affect on the Inquiry**
Timescale:	**Inquest to be held on Tuesday 25 April**
Presentational Issues:	**Given the high level of media interest associated with the Inquiry, the inquest is likely to receive media coverage**
FOI Implication:	**Some of the information contained in the submission may not be disclosable in that it could subsequently become evidence that will be considered by the Independent Inquiry into Hyponatraemia-related Deaths.**
Recommendation:	**That you note the position and lines to take**

Background

1. On 1 November 2004 Angela Smith MP announced an Inquiry into the events surrounding and following the deaths of 3 children, Adam Strain, Raychel Ferguson and Lucy Crawford, from hyponatraemia-related causes between 1995 and 2001. Hyponatraemia is a disorder of sodium and water metabolism In recent years, both nationally and internationally, it has increasingly been recognised as a cause of death among children receiving intravenous fluids.

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.

3. The Inquiry is currently in suspension due to police investigations into the three original deaths. An investigation into the death of Lucy Crawford has been completed with a file forwarded to the Public Prosecution Service (PSS); investigations into Adam Strain and Raychel Ferguson are still ongoing but are due to be completed in the near future.

Claire Roberts

4. At a meeting on 1 September 2005 John O'Hara made the Minister aware of the case of Claire Roberts as one on which he was seeking further information. Following the broadcast on 21 October 2004 of a UTV 'Insight' programme, entitled "When Hospitals Kill", into the deaths of three children from hyponatraemia, Claire's family contacted the Royal Group of Hospitals. A consultant in Clinical Biochemistry, Professor Ian Young, undertook a review of the case. Following this, and a meeting with the family, the case was referred back to HM Coroner. An inquest into the death will be held in Belfast Coroner's Court on Tuesday 25 April. HM Coroner has obtained independent expert reports from 2 consultants in Great Ormond Street and St Mary's Hospitals.

5. Claire Roberts was nine years old when she was admitted to the Royal Belfast Hospital for Sick Children (RBHSC) in October 1996. She had a severe learning disability and a history of epilepsy.

- Claire was referred to the A&E Department at the RBHSC by her GP on the evening of 21 October 1996 with a history of vomiting and lethargy. Blood tests revealed a low sodium level which was noted on her medical notes.
- Her condition deteriorated and she developed status epilepticus (epileptic fits that cannot be controlled). Repeat blood tests revealed that her sodium level had fallen significantly.
- Early on 23 October, Claire suffered a respiratory arrest and was transferred to Paediatric Intensive Care.
- She died at 18.45 on 23 October and the death certificate was issued indicating cerebral oedema secondary to status epilepticus as the cause of death.

6. Professor Young, following his review of the medical records, indicated that hyponatraemia may have made a contribution to the development of the cerebral oedema.

Conclusion

7. The inquest into Claire Roberts' death will consider her fluid management and the Coroner may conclude that hyponatraemia was a contributory factor in her death.

8. The Inquest is likely to attract media and public interest. The Inquiry has always been a high profile issue and Trevor Birney, the UTV journalist who produced the original Insight programme, is still actively researching the issue. Claire's parents are also seeking answers regarding her death.

9. The Inquiry is likely to want to consider the findings of the Inquest before advising the Minister whether they wish to investigate this case in the manner of the other three deaths and, if so, what this might mean in terms of timescales. The PSNI may also wish to consider the findings and the timescale for any action by the Inquiry may be dependent on what the Police decide and whether any action is directed by the PPS. The likely course of events, in the first instance, is that the Coroner will write to John O'Hara after the Inquest and then Mr O'Hara will advise the Minister of what action he proposes to take.

Recommendation

8. That the Minister should note this briefing and the lines to take below.

SIOBHÁN MCKELVEY

[redacted]

cc. Dr Carson
Dr Mitchell
Mr McCann
Mr Conliffe
Mrs Stewart, DSO
Mr Maguire
Mr Bill
Mr Magowan

Lines to take

- The death of any child is tragic and I want to extend my sympathy to Claire Roberts' family.

- The Department has already taken a number of steps to improve patient safety including issuing guidance on the prevention of hyponatraemia in 2002. This guidance provides very practical advice for doctors and nurses who manage the care of children in hospital.

- The Terms of Reference of the O'Hara Inquiry on hyponatraemia-related deaths allow it to examine all relevant matters. It is a matter for the Chairman of the Inquiry whether he finds it necessary to examine this particular case further.

- It is a matter for the PSNI whether they feel it necessary to investigate this case.