From: Andrew Browne
Safety, Quality & Standards Directorate

Date: 2 June 2008

1. Dr Maura Briscoe
2. Michael McGimpsey

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS: MEETINGS WITH FAMILIES

Issue:	John O'Hara QC held a public hearing of the Inquiry on 30 May at the Hilton Hotel. He announced that the Inquiry, which has been suspended since 2005, would recommence. You had agreed to offer separate meetings to the each of the four families involved once the recommencement was announced.
Timescale:	Routine
Presentational Issues:	There has been significant media interest in this Inquiry.
FOI Implication:	This submission is fully disclosable.
Financial Implications:	N/A
Legislative Implications:	N/A
Executive Referral:	N/A

Recommendation: That the Minister uses the draft letters attached to invite each family to meet with him if they so wish.

Background

The Inquiry was set up in November 2004, but suspended in October 2005 to allow the PSNI to investigate the three deaths (Lucy Crawford, Adam Strain and Raychel Ferguson) named in the Terms of Reference (Tab A).

Police investigations into these 3 cases have been completed and the Public Prosecution Service has directed no further action. This cleared the way for the resumption of the Inquiry, which was announced on Friday 30 May at a short hearing in the Hilton Hotel attended by about 40 people, mostly lawyers and family members.

As discussed with you on 29 May, Mr O'Hara announced that the Crawford family wish to withdraw from the Inquiry but that two new cases were being added, namely those of Claire Roberts and Conor Mitchell.

Meetings with Families

On 13 February 2008 you replied to a letter from Mr Mark Durkan MP MLA on behalf of the Ferguson family (INV/78/2008 refers) saying that you would be happy to meet with Mr Durkan and the Fergusons once Mr O'Hara announced his proposals for the future of the Inquiry. Last week you confirmed that you would like to offer a separate meeting to each family.

The four cases now before the Inquiry are:

(a) **Adam Strain**

Adam 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, having been born with abnormal kidney function. He had 5 operations in his first year and was put on dialysis in 1994. The

cause of death as recorded by a coroner's post mortem was cerebral oedema due to dilutional hyponatraemia and impaired cerebral perfusion during renal transplant. Mr Leckey, the coroner for Greater Belfast drew this death to the former CMO's attention in December 2001.

(b) **Claire Roberts**

Claire was a 9-year-old girl with severe learning difficulties who had a medical history of epilepsy. She was referred to the RBHSC A&E Department by her GP on 21 October 1996 with a history of vomiting and lethargy. She was admitted and a diagnosis of encephalitis/encephalopathy was made at an early stage. She was treated for non-convulsive epilepsy but died in intensive care on 23 October. The death certificate indicated cerebral oedema secondary to status epilepticus. The coroner carried out an inquest in September 2005 and hyponatraemia was implicated as one of a number of underlying causes of death.

(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 10 June. Shortly afterwards, the death was drawn to the former CMO's attention and work began in August 2001 to produce guidance on the prevention of hyponatraemia in children. A working group was convened in September, led by Dr McCarthy, and guidance was issued to the HPSS on 25 March 2002. The inquest into Raychel's death was held in February 2003 and concluded that she died from cerebral oedema, secondary to dilutional hyponatraemia.

(d) **Conor Mitchell**

Conor was a 15-year-old boy with significant physical disability and a history of epilepsy. He was admitted to Craigavon Area Hospital with vomiting and general malaise. He was treated with fluids and antibiotics but his condition deteriorated. He had a number of seizures and suffered respiratory arrest. He was transferred to RBHSC but his condition failed to improve and he died

on 12 May 2003. The coroner's report was ambivalent about the extent to which hyponatraemia contributed to the death.

Recommendation

Draft letters are attached inviting each of the families to meet with you on a mutually convenient date. Detailed briefing will be provided in advance of these meetings taking place.

ANDREW BROWNE
[redacted]

cc. Dr Andrew McCormick
CMO
Dr Carolyn Harper
Dr Liz Mitchell
Clare Baxter

Mr & Mrs A Roberts

[redacted]

Dear

Inquiry into Hyponatraemia-related Deaths

John O'Hara QC met with me recently and informed me of his intention that the circumstances surrounding the death of your daughter Claire in 1996 be included within the Terms of Reference of his Inquiry. On the understanding that this was acceptable to you, I had no hesitation in agreeing.

I realise, however, that exposure to the scrutiny of a public inquiry can seem very daunting to those involved and I am writing to you therefore to offer to meet with you so that you can raise any questions or concerns with me informally in advance of the public hearings. Also I would like to meet you and hear your story at first hand.

I can not imagine the pain and enduring sense of loss that Claire's death must cause you. For that I can only offer my sincerest sympathy. However while I can not change the past I want to ensure that we learn from Claire's tragic death and for that I look forward to receiving John O'Hara's report.

I hope that you will be able to meet me at a mutually convenient time. Please contact my diary secretary, Lindsay McMullan, on telephone [redacted] to arrange a suitable date.

Michael McGimpsey MLA
Minister for Health, Social Services and Public Safety

Ms Joanna Mitchell
[redacted]

Dear

Inquiry into Hyponatraemia-related Deaths

John O'Hara QC met with me recently and informed me of his intention that the circumstances surrounding the death of your son Conor in 2003 be included within the Terms of Reference of his Inquiry. On the understanding that this was acceptable to you, I had no hesitation in agreeing.

I realise, however, that exposure to the scrutiny of a public inquiry can seem very daunting to those involved and I am writing to you therefore to offer to meet with you, and your husband, so that you can raise any questions or concerns with me informally in advance of the public hearings. Also I would like to meet you and hear your story at first hand.

I can not imagine the pain and enduring sense of loss that Conor's death must cause you. For that I can only offer my sincerest sympathy. However while I can not change the past I want to ensure that we learn from Conor's tragic death and for that I look forward to receiving John O'Hara's report.

I hope that you will be able to meet me at a mutually convenient time. Please contact my diary secretary, Lindsay McMullan, on telephone [redacted] to arrange a suitable date.

Michael McGimpsey MLA
Minister for Health, Social Services and Public Safety

Mark Durkan MP MLA
Constituency Office
23 Bishop Street
Derry
BT48 6PR

Dear

Inquiry into Hyponatraemia-related Deaths

You wrote to me on 4 February requesting that I meet with your constituents, Mr & Mrs R Ferguson of [redacted] I undertook to arrange a meeting once John O'Hara's proposals for the future of the Inquiry were known. You will be aware that a public hearing was held on Friday 30 May in Belfast.

I would now like to offer a meeting so that Mr and Mrs Ferguson can raise any questions or concerns with me informally in advance of the public hearings. Also I would like to meet them and hear their story at first hand.

I can not imagine the pain and enduring sense of loss that Raychel's death must cause her parents. For that I can only offer my sincerest sympathy. However while I can not change the past I want to ensure that we learn from Raychel's tragic death and for that I look forward to receiving John O'Hara's report.

I would be grateful if your secretary would contact my diary secretary, Lindsay McMullan, on telephone [redacted] to arrange a suitable date.

Michael McGimpsey MLA
Minister for Health, Social Services and Public Safety

Mr & Mrs J Slavin

[redacted]

Dear

Inquiry into Hyponatraemia-related Deaths

I realise that exposure to the scrutiny of a public inquiry can seem very daunting to those involved and I am writing to you therefore to offer to meet with you so that you can raise any questions or concerns with me informally in advance of the public hearings. Also I would like to meet you and hear your story at first hand.

I can not imagine the pain and enduring sense of loss that Adam's death must cause you. For that I can only offer my sincerest sympathy. However while I can not change the past I want to ensure that we learn from Adam's tragic death and for that I look forward to receiving John O'Hara's report.

I hope that you will be able to meet me at a mutually convenient time. Please contact my diary secretary, Lindsay McMullan, on telephone [redacted] to arrange a suitable date.

Michael McGimpsey MLA
Minister for Health, Social Services and Public Safety

TERMS OF REFERENCE

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY
THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1972

In pursuance of the powers conferred on it by Article 54 and Schedule 8 to the Health and Personal Social Services (Northern Ireland) Order 1972, the Department of Health, Social Services and Public Safety hereby appoints Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson, with particular reference to:

(i) The care and treatment of Adam Strain, Lucy Crawford and Raychel Ferguson, especially in relation to the management of fluid balance and the choice and administration of intravenous fluids in each case.

(ii) The actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson.

(iii) The communications with and explanations given to the respective families and others by the relevant authorities.

In addition, Mr O'Hara will:

(a) Report by 1 June 2005 or such other date as may be agreed with the Department, on the areas specifically identified above and, at his discretion, examine and report on any other relevant matters which arise in connection with the Inquiry.

(b) Make such recommendations to the Department of Health, Social Services and Public Safety as he considers necessary and appropriate.