INV/421/2008
SUB/504/2008

From: Andrew Browne

Date: 30 July 2008

To: 1. Dr Jim Livingstone (Approved 30/7/08)

2. Michael McGimpsey

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS: MEETINGS WITH THE MITCHELL AND ROBERTS FAMILIES

Summary

Issue:	John O'Hara has extended his Inquiry to include the deaths of Conor Mitchell and Claire Roberts. You are meeting their parent(s) at two separate meetings. This submission is to provide you with briefing for those meetings.
Timing:	Meetings on 4 August (am).
Presentational Issues:	There has been earlier media interest in the Inquiry.
FOI Implications:	This submission is fully disclosable
Special Adviser's Comments:	
Recommendation:	That you note the attached briefing and Q&A material.

Introduction

1. You wrote to the four families now involved in this Inquiry on 11 June offering to meet with them individually so that they could "raise any questions or concerns...in advance of the public hearings" and also so that you could meet them and hear their stories at first hand. To date three families have replied requesting a meeting.

Response by Families

2. Ms Joanna Mitchell and her mother, Judy, will be meeting you for half an hour on Monday 4 August at 10.30 am. Ms Mitchell's present husband is not the father of Conor and he has not indicated that he will come to the meeting. Details of Conor's case are given at Annex B. He was aged 15 when he died in 2003. Ms Mitchell was visibly upset at the recent Inquiry hearing and understandably still finds the whole experience difficult to talk about.

3. Alan and Jennifer Roberts are due to meet you from 11.00 – 11.30am to talk about the death of their daughter Claire, aged 9, in 1996. Details of her case are given at Annex C. It was they who contacted John O'Hara to ask that Claire's case be included in view of similarities to other cases in the Inquiry. Claire's death is still the subject of a police investigation, which was expected to conclude in June but has yet to be finalised.

4. A further meeting is scheduled for 4 September with Mark Durkan and the Ferguson family. As yet, the Slavins have not sought a meeting.

Recommendation

5. Background information and Q&A material is attached as follows:

Annex A – Background to the Inquiry
Annex B – Conor Mitchell, Background Note
Annex C – Claire Roberts, Background Note
Annex D – Q&A Briefing
Annex E – Terms of Reference

6. It is recommended that you note the attached briefing and Q&A. A pre-briefing meeting has been arranged for 10.00am on 4 August. I will attend.

Andrew Browne
Safety & Quality Unit
[redacted]

Cc: Chief Medical Officer
Dr Carolyn Harper
Dr Liz Mitchell
Dr Heather Livingston
Clare Baxter

ANNEX A

Background to the Inquiry

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 E) 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. When the Inquiry was established in November 2004 it was known that the PSNI was already conducting investigations into some aspects of the matters to be considered by the Inquiry in respect of Lucy Crawford. However at that stage nobody was aware, or even suspected, that the PSNI would later wish to investigate the other deaths and the view was taken that the greater good required the Inquiry to go ahead. It was only in January 2005 that the police confirmed that they did not want the Inquiry to investigate the circumstances surrounding Lucy Crawford's death and in July 2005 that they made the same request in respect of Adam Strain and Raychel Ferguson.

4. The Inquiry was suspended on 28 October 2005 and did not resume until 30 May 2008, once the PSNI and Public Prosecution Service had indicated that they would take no further action on the three cases. On 30 May John O'Hara announced that Lucy Crawford's case was being withdrawn from the inquiry but that the deaths of Conor Mitchell and Claire Roberts were being added. The police did not investigate the death of Conor Mitchell but are still awaiting further medical opinion in the case of Claire Roberts.

5. While the Inquiry has been re-established in new offices with a new secretariat it is unlikely that public hearings will be held until early in 2009. A venue for the public hearings is still being sought. The current target date for a final report is September 2009.

6. The Inquiry has cost nearly £1m to date and the current projection is for costs in the region of £4m+.

Annex B

Conor Mitchell: Background Note

1. At the time of his death on 12 May 2003 Conor was 15 years old. He died in the Royal Belfast Hospital for Sick Children after initial treatment in Craigavon Area Hospital.

2. Conor suffered from a chronic and severe form of cerebral palsy known as spastic tetraplegia as well as mild epilepsy. He was very disabled physically but doctors noted his intelligence.

3. On 8 May 2003 his mother took him to A&E at Craigavon Area Hospital having been unwell for 10 days. His GP advised that he be taken to the hospital for observation and assessment. Because of his size and weight he was admitted to an adult ward.

4. At the Inquest on 9 June 2004 the coroner drew attention to the fact that after admission Conor appears to have had a number of seizures that were not recognized or recorded as such by clinical staff and that more notice should be taken of what close relatives, who know the child well, are able to report.

5. Later on the evening of 8 May , Conor did have two seizures in the presence of a paediatric registrar. After the second there was no respiratory effort and resuscitation was attempted. Conor was admitted to Intensive Care and transferred to the RBHSC on the following morning, where he died three days later.

6. Causes of death were recorded as hypoxia, cerebral oedema, ischaemia, seizures and infarction.

7. The coroner's report indicated that "fluid management at Craigavon Area Hospital was acceptable" but there was sufficient doubt for John O'Hara to deem this case as suitable for inclusion in his Inquiry after he obtained advice from an independent medical expert.

8. A particular aspect of this death is that it occurred after new guidance on the prevention of hyponatraemia in children had been issued to the HPSS.

ANNEX C

Claire Roberts: Background Note

1. At the time of her death on 23 October 1996 Claire was aged 9 years old. She died in the Royal Belfast Hospital for Sick Children.

2. Claire had severe learning difficulties and a past history of epilepsy. Prior to her final illness Claire had been free from fits for 3 years. When she came home from school on 21 October having been unwell her GP was concerned about her neurological status and referred her to the A&E Department at RBHSC.

3. Her speech was very slurred and she was drowsy. The hospital decided to admit her with a provisional diagnosis of encephalitis (swelling of the brain). On the following day she was treated for non-convulsive epilepsy.

4. Blood sample results late on 22 October showed hyponatraemia and her fluid management was altered accordingly.

5. On 23 October she had a respiratory arrest and was transferred to Paediatric Intensive Care, where she was recorded as brain stem dead.

6. Her death certificate showed cerebral oedema secondary to status epilepticus.

7. Professor Young, who was asked to review the medical records, indicated that hyponatraemia may have contributed to the development of cerebral oedema.

Annex D

Q & A BRIEFING

Q.1 The Inquiry was set up in 2004. Why has it taken so long to reach public hearings?

A. In January 2005 the PSNI confirmed that they did not want the Inquiry to investigate Lucy Crawford's death in view of their own ongoing investigations. They later made the same request in respect of Adam Strain and Raychel Ferguson. The Inquiry was therefore suspended on 28 October 2005. As you know, it was not re-launched until 30 May this year. (NB: the PSNI is still considering the death of Claire Roberts, although an outcome is expected soon. The parents may ask you to write to the Chief Constable to expedite this, which should be agreed as it was done in other cases.)

Q.2 When are the public hearings expected to take place?

A. John O'Hara hopes that these can be held early in the New Year (2009) and that hearings for each case will last 2-3 weeks

Q.3 What will be happening between now and then?

A. The emphasis will be on evidence gathering and preparation for the public hearings.

Q.4 Has the venue been decided?

A. No. This is a matter for the Inquiry, but I know that options both inside and outside Belfast are being considered.

Q.5 What form will the Inquiry take?

A. The hearings will not be adversarial, ie as in a court case where the prosecution and the defence are in opposition. They will be inquisitorial. In other words it is about asking questions to discover the facts. A limited amount of cross examination may take place through the chair.

Q.6 How long before the Inquiry reports?

A. This depends on when the hearings get started but I hope that we will have a report by September 2009.

Q.7 Is the Inquiry independent of the Department?

A. Completely. Angela Smith MP appointed John O'Hara to chair this Inquiry and report back with his recommendations. While my Department is responsible for meeting the cost of the Inquiry it does not exercise any control over how the Inquiry is conducted and Mr O'Hara has discretion to "examine and report on any other relevant matters which arise in connection with the Inquiry." The secretariat staff are civil servants but not from within this department.

Q.8 Can the Inquiry compel people to give evidence?

A. Yes. Under Schedule 8 of the HPSS (NI) Order 1972 anyone who refuses to attend or give evidence, tampers with evidence or refuses to provide information is guilty of an offence and can be fined or sent to prison for up to 3 months.

Q.9 Will the Department pay all my legal fees?

A. The Department will meet all reasonable legal costs as agreed with the departmental solicitor.

Q.10 Will anyone be held to account?

A. It is the purpose of the Inquiry to discover the truth about the events surrounding and following the deaths of the children concerned and to make whatever recommendations the chairman considers necessary and appropriate. Any issues of misconduct however would be for the employer and, where appropriate, the relevant professional body.

Q.11 What has been done to stop this happening again?

A. In March 2002, on foot of work commissioned by the CMO, the Department issued guidance on the prevention of hyponatraemia in children. This was followed in 2003 by wider guidance to include adults. The Department reported the hyponatraemia deaths to the National Patient Safety Agency (NPSA) in 2003. In autumn 2005, the NPSA established an external reference group on hypotonic fluids, which included several representatives from Northern Ireland, including Dr McCarthy representing the Department. The work of this group has now been concluded and in April 2007 NPSA Patient Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Infusions to Children was issued. In September 2007 the Department issued a further wallchart on paediatric parenteral fluid therapy for children aged 1 month to 16 years.

Q.12 Who is working on the Inquiry and who should my contact be?

A. Your initial point of contact should be the Inquiry Secretary, Raymond Little, who is based in the Inquiry offices in Arthur Street. John O'Hara is supported by

senior and junior counsel and a solicitor (to be appointed). There is also a panel of expert advisors from outside Northern Ireland to advise him on clinical and healthcare matters (Dr Harvey Marcovitch, paediatrician; Ms Carol Williams, nursing advisor; Dr Peter Booker, paediatric anaesthetics; Ms Mary Whitty, NHS management). In addition, three international experts have been appointed as peer reviewers: Desmond Bohn, paediatrics and anaesthetics, Toronto; Allen Arieff, internal medicine and nephrology, California; and Sharon Kinney, paediatric intensive care, Melbourne.

Q.13 Is the decision to drop Lucy Crawford's case not a breach of the terms of reference and will it not weaken the final report?

A. Mr & Mrs Crawford advised John O'Hara that they no longer wanted the death of their daughter to be investigated by the Inquiry. John felt that the wishes of the parents must be respected in a case that has already been protracted and very stressful for the family. I was prepared to accept his view on this and agree that the Crawfords should withdraw, notwithstanding the fact that their daughter had been named in the terms of reference. I believe that the lessons learnt from the investigation of the other deaths will address many of the issues raised by Lucy's tragic death.

Q.14 What is Minister's view of the Inquiry?

A I remain fully committed to the Inquiry. It is important that John O'Hara examines the care and treatment of each child, the actions of the statutory authorities and any other relevant matters that he identifies. I am determined that any lessons to be learned from these tragic deaths should be discovered and acted upon. In the meantime, new guidance has been issued to hospitals on fluid therapy for children.

Annex E

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.