Measures to prevent cases like baby Lucy's

PLATFORM

By Dr Henrietta Campbell
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Dr Campbell writes in response to a platform article in *the Irish News* earlier this week, by Denzil McDaniel, editor of the Impartial Reporter.

THE death of baby Lucy Crawford is a terrible tragedy and I would like to extend my deepest sympathy to Lucy's parents and family.

In events such as this it is important that the ealth service learns from what happened and hat measures are put in place to prevent such a ragedy happening again.

Lucy's death was comprehensively investigated y the coroner and let there be no mistake, I fully ccept his findings. In fact, the coroner referred ucy's case to me as long ago as June 2001 and ince that time I have been working in partnership ith the coroner to ensure that measures are put n place to improve the quality of care in our paeiatric units.

Lucy died from a medical condition called yponatraemia, rightly recognised by the coroner s being brought about by the fluids used in her reatment. It is important to note that the fluids sed in the treatment of Lucy have been in comon use for more than 30 years in all paediatric nits across the globe and have saved many oung lives. However, it is now known that in ome instances these fluids may put some chilren at risk of the potentially fatal condition alled hyponatraemia.

Unfortunately, this condition was not widely recognised amongst health professionals across the UK at the time of Lucy's death.

Having been alerted by the coroner to this issue I convened an expert working group to develop guidance on the prevention of hyponatraemia. This guidance was published in 2002 providing practical advice for doctors and nurses who manage the care of children in hospital. Action is being taken to ensure its implementation throughout Northern Ireland. This guidance has been commended as the first of its kind in the UK and was praised by the coroner and by Dr Ed Sumner, an expert witness called by the coroner to Lucy's inquest.

While there is no doubt that the fluids administered to Lucy were a direct cause of her death, there is still a considerable debate among experts regarding the most appropriate intravenous fluid therapy for children.

Further research is needed in this area and recent medical literature highlights the debate surrounding fluid management in general and hyponatraemia in particular. As a result, I have engaged an international expert in paediatrics to work with this department to ensure that guidance can be kept up-to-date

My role as Chief Medical Officer is to provide advice to the minister and this department on measures to be taken to protect the health of the public. I also have a role to play in setting standards for the quality of medical care. However, I am not responsible or accountable for the delivery of services. Neither am I legally nor clinically accountable for the actions of individual doctors or consultants.

Lucy's death highlighted the need for a formal system to report to me, as the Chief Medical Officer, untoward deaths in hospitals. This is not a straightforward issue as there are 15,000 deaths each year in Northern Ireland, the majority of which occur in hospital.

Approximately 3,500 of all deaths each year are reported to the coroner.

Measures are being taken both by the coroner's office and by the health service to establish a system which will identify untoward deaths and allow early action to be taken.

As Denzil McDaniel pointed out in his article there is nothing which tugs at emotion quite as painfully as the death of a child. As a parent and as a doctor I fully recognise the anguish and pain of the Crawford family. While nothing can recompense for Lucy's death, the health service has an absolute responsibility to ensure that lessons are learned.

As for my part, as Chief Medical Officer, I will continue to work strenuously to play my part in ensuring that the standard of care for children in our hospitals can be assured.