Young, Christine

From: Mulhern, Kevin
Sent: 07 April 2004 13:24
To: Gowdy, Clive; Campbell, Dr Henrietta; Burne, Alison; Carson, Ian; McCarthy, Miriam; Gardner, Jeremy; Moore, Martin; Shannon, Colm
Subject: Ministerial Statement - Lucy Crawford

To all

Minister has cleared the statement below with one small change in the first sentence, she took out 'following her death.'

I have issued it to Fearghal McKinney, UTV and Denzil McDaniel, Impartial Reporter.

Happy to discuss

Kevin

Statement from Minister with responsibility for Health, Social Services and Public Safety, Angela Smith MP

I would like to express my deepest sympathy to the parents and family of Lucy Crawford.

I am satisfied that the cause of Lucy's death has been properly and comprehensively investigated and I fully accept the coroner's verdict on the cause of death. In his deliberations the coroner did not see a need to refer the case to the Director of Public Prosecution. He did, however, refer inquest papers to the General Medical Council, which is responsible for the registration of medical practitioners, and I await the findings of the General Medical Council in due course.

Dr Henrietta Campbell, the Chief Medical Officer, issued 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. It has been commended by both local clinicians, and by expert witnesses who gave evidence at Lucy's inquest. Following the inquest into Lucy's death the Coroner wrote to the Chief Medical Officer asking her to consider if any changes are required to the current guidance. In response, Dr Campbell has engaged an international medical expert in the speciality of paediatrics to quality assure the guidance in light of the findings of the inquest into Lucy's death.

Under Clinical Governance arrangements introduced last year, my Department is strengthening the

systems for quality assurance within Trusts. Specifically, work is underway to improve the mechanism for reporting and investigating untoward incidents and to ensure the maintenance of good medical record keeping. This latter area was found to be seriously lacking in Lucy Crawford's case and a major lesson learned from this tragic case was the importance of accurate record keeping.

The lessons learned since Lucy's death and the action taken to inform health professionals should prevent a similar tragedy from occurring in the future. My Department will continue to work to ensure that all patients receive high quality care throughout the health service.