Norris, Hilary

From: sharon.lindsay[redacted]
Sent: 07 April 2004 18:14
To: miriam.mccarthy[redacted]
Cc: andrew.hamilton[redacted] ian.carson[redacted]
elizabeth.mitchell[redacted] glenda.mock[redacted]
dean.sullivan[redacted] colm.shannon[redacted]
Subject: Submission: SUB/179/2004 INQUEST VERDICT ON LUCY CRAWFORD


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DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Restricted & Personal

From: Sharon Lindsay
Private Office
To: McCarthy Miriam (Dr)
Date: 07/04/2004

Action Copy: Hamilton Andrew (Mr)
Carson Ian (Dr)
Mitchell Liz (Dr)
Mock Glenda (Dr)
Sullivan Dean (Mr)
Shannon Colm (Mr)

SUB/179/2004:INQUEST VERDICT ON LUCY CRAWFORD

The Minister has seen and read your submission of 06/04/2004 and has agreed the statement, with a small amendment, for issue and has noted the lines to take.

The first paragraph of the statement should be amended to remove "following her death".

Many thanks.

Sharon Lindsay (Private Office)

Castle Buildings Tel: [redacted]

OffName

DHSSPS

002-002-006

MEMO

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poibl

www.dhsspsni.gov.uk

MINISTERIAL SUBMISSION

From: Dr M McCarthy

Date: 6 April 2004

To:
1. CMO
2. Secretary
3. Angela Smith

cc: Dr Carson
Mr Hamilton
Dr Mitchell
Dr Mock
Mr Sullivan
Mr Shannon

INQUEST VERDICT ON LUCY CRAWFORD

Issue: **The recent inquest verdict on Lucy Crawford, a toddler who died in 2000, and the subsequent requests for media interviews with the Minister.**

Timing: **URGENT.**

Presentational: **Given the high profile of this case Minister may be asked to comment on the case during the course of other upcoming events.**

Recommendation: **Minister declines to be interviewed but agrees a line to take and a statement to be issued by the Department.**

DHSSPS

Background

Lucy Crawford, a 17 month old child died following admission to the Erne Hospital with a history of vomiting and fever in April 2000. The inquest, completed on 19 February 2004, concluded that Lucy died from (a) Cerebral oedema, (b) acute dilutional hyponatraemia, (c) excess dilute fluid. A Verdict On Inquest is attached for information (Annex A). Lucy's inquest followed the inquest into another death from hyponatraemia, in a 9 year old girl, Raychel Ferguson, who died at Altnagelvin Hospital in June 2001. There were a number of similarities in the two cases with the administration of excess diluted fluid being cited in both as contributing to the death.

1. Hyponatraemia (low sodium levels) is known to be a risk in any child receiving intravenous fluids. It is potentially extremely serious, with a rapid fall in sodium leading to cerebral oedema seizures and death. Hyponatraemia most often reflects a failure to excrete water. Stress, pain and nausea are all potent stimulators of a hormone which inhibits water excretion.

2. Following the inquest into Raychel Ferguson's death the Chief Medical Officer convened a small working group to develop guidance on the prevention of hyponatraemia in children as a matter of urgency. The Guidance, issued in March 2002, emphasised that every child receiving intravenous fluids requires a thorough baseline assessment, that fluid requirements should be assessed by a doctor competent in determining a child's fluid requirements, and fluid balance should be regularly monitored. A copy of the guidance is attached Annex B. Last month, CMO wrote to Trust Chief Executives requesting assurance that the guidance had been implemented throughout Trusts.

3. Furthermore, following the inquest verdict on Lucy Crawford's death CMO has engaged a national expert to quality assure the guidance in light of the findings of the inquest and any new evidence available.

Presentational Issues

4. The inquests into Lucy and Raychel's death both attracted considerable media attention, most recently with an ITV documentary 'The Issue' covering the events around Lucy's death. This was televised on Thursday 25 March and included an interview with the Chief Medical Officer.

5. Following broadcast of 'The Issue' its host Fergal McKinney and a second journalists, Denzil McDaniel from the Impartial Reporter have requested interviews with the Minister.

6. As legal proceedings against Sperrin Lakeland Trust are still pending I advise Minister to decline the interview bids but to approve the release of a statement as attached Annex C.

7. I also attach Lines to Take (Annex D). Both the lines to take and the draft statement have been agreed with the DHSSPS Information Office.

Recommendation

8. Minister declines to be interviewed but agrees to release the attached statement.

9. Minister agrees attached lines to take.

DR MIRIAM McCARTHY

Senior Medical Officer

DHSSPS

DRAFT

ANNEX C

MINISTERIAL STATEMENT

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.

ANNEX D

LINES TO TAKE

I want to extend my sympathy to the parents and family of Lucy following her death.

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.

I am very concerned about this incident, and am determined that the lessons we learn from this unfortunate event will prevent a similar case occurring in the future.

The Chief Medical Officer has already issued guidance to all doctors and nurses involved in treating children in hospital. This guidance raises awareness of hyponatraemia, a rare but potentially serious problem, and provides clear and practical advice on how to prevent it. The Chief Medical Officer has also engaged an international medical expert to quality assure the guidance in light of the findings of the inquest into Lucy's death.

We must ensure the very highest quality standards in our Health Services. I intend to put in place new arrangements to ensure that serious untoward events are brought to the attention of my Department without delay.