Norris, Hilary

From: Sullivan, Dean
Sent: 01 June 2004 17:36
To: Hamilton, Andrew
Subject: Lucy Crawford 2 of 2

Andrew - here is advance copy of final version of briefing to be circulated tomorrow am

Dean

-----Original Message-----
From: Garrett, Elizabeth
Sent: 01 June 2004 17:30
To: Sullivan, Dean; McCann, Noel; Bill, Jonathan; Shannon, Colm; Mulhern, Kevin
Subject: MINISTERIAL SUBMISSION

mm1-6.doc

FYI
Will be forwarded to secretary tomorrow morning.

Liz
PS/Dr McCarthy

DHSSPS

002-007-017

From Dr M McCarthy
Senior Medical Officer

Date 1 June 2004

1 CMO
2 Secretary
3. Angela Smith

INTERVIEW WITH THE IMPARTIAL REPORTER ON THE DEATH OF LUCY CRAWFORD

Issue: **Further briefing material for Minister's attention in advance of the interview with the Impartial Reporter on Thursday 3rd June.**

Timing: **Urgent**

Recommendation: **That Minister notes additional briefing and revised Q & A.**

DHSSPS

002-007-018

Background

Further to briefing on 28 May, Departmental officials met today with senior management from Sperrin Lakeland Trust to clarify the course of events following Lucy Crawford's death and the rationale underpinning action taken by the Trust. The issues discussed fall within four areas; the reporting and investigation of the death; communication between the Trust and the Crawford family; the scrutiny into Dr O'Donohoe's clinical practice; and status of current proceedings. Q&A and lines to take have been revised to take account of this morning's meeting.

Report and Investigation of Lucy's Death

1. Lucy's death was, as noted in previous briefing, reported to the coroner's office on 14th April 2000. Her death was also reported to Director of Public Health, WHSSB on the same day. Furthermore he was informed in writing in May 2000 that an internal case review was being conducted by the Trust.

2. The investigation of Lucy's death by the Trust comprised an internal case review in which Dr M Quinn, a paediatrician from Altnagelvin Hospital was invited to participate as an independent medical assessor. The terms of reference for the review, Dr Quinn's report, and the Trust's report are attached. (Appendix 3, 4 and 5). The Crawford family was not made aware of the review until October 2000.

3. On completion of the internal review the Trust initiated a number of changes in practice as outlined in Appendix 6.

Communication with Crawford Family

4. The Crawford family did meet with Dr D O'Hara, the pathologist who had conducted the post mortem on Lucy. They also met (on 5th May 2000) with

Dr O'Donohoe, the paediatrician responsible for Lucy's care in the Erne Hospital. It does not appear that Dr O'Donohoe's meeting with the family went well. He was not able to answer the family's questions about the cause of Lucy's death. Subsequent communication between the Trust and the family was made difficult because of this.

5. On 22nd September 2000 the Crawford family made a formal complaint against the Trust. This complaint was made through the Western Health and Social Services Council which was acting at the request of the Crawford family.

6. In October 2000 the Crawford's were advised that an internal review had been conducted. The Trust offered a meeting to discuss the findings of the review. Over the ensuing months the Trust offered on 5 occasions to meet the family but the offers were not accepted.

7. On 27th April 2001 the family's solicitor advised that legal proceedings would be taken against Trust. This was settled out of court in December 2003.

8. The Trust acknowledged that their communication with the family could have been improved and that in retrospect, if they had met with the family as soon as possible after Lucy's death, some of the communication problems could have been avoided. An apology to the family was issued by Mr Mills on 19 March 2004 (Appendix 7).

Dr O'Donohoe's Practice

9. Following the coroner's inquest Dr O'Donohoe's role in the care of Lucy Crawford has been referred to the General Medical Council for consideration. In relation to Dr O'Donohoe's professional and personal conduct between 2000-2002 the Trust has taken a number of actions to assure itself that

Dr O'Donohoe's practice does not put other patients at risk. A summary of actions is attached. (Appendix 8).

Current Proceedings

10. Following the coroner's verdict, the Trust will undertake a root cause analysis exercise into events around Lucy Crawford's death. The terms of reference have been agreed and are attached (appendix 10).

11. Further litigation brought by Mr Crawford against the Trust, following the inquest into Lucy's death, is ongoing and is expected to take some time.

Summary

12. In summary, the actions of the Trust have included the following:

- in the absence of a formal system for reporting untoward deaths, the Trust very appropriately informed the WHSSB, both verbally immediately after Lucy's death, and in writing writing in May 2000.

- There were several offers for the Trust to meet with the Crawford family but the Trust recognise that communication was an area in which they were not successful. The Trust did apologise to the Crawford family.

- In relation to Dr O'Donohoe's practice the Trust have appropriately scrutinised this and have involved professional bodies.

13. I attach the Q&A material (Appendix 1) in which some responses have been revised in light of this mornings discussions with the Trust's senior management.

DR MIRIAM McCARTHY

Senior Medical Officer

DHSSPS

002-007-022

APPENDIX 1

QUESTIONS & ANSWERS

Q1 Are you happy with the investigation conducted by the Trust?

A1 The Trust acted correctly in conducting a case review into Lucy's death, which they commenced immediately after her death and completed within 3 months. To ensure an external perspective, the Trust involved a consultant paediatrician from another hospital. The Review made a number of recommendations and the Trust have taken action to implement these, including improved fluid management practice, and improved arrangements for documentation of prescribed fluids.

Q2 Do you think Lucy's death should be properly investigated by holding an independent inquiry?

A2 The cause of Lucy's death was fully and comprehensively investigated during the coroner's inquest. I accept the coroner's verdict and do not think that an independent inquiry will provide additional information.

I believe it is much more important that we invest our efforts in making sure that a similar tragic death does not happen again. In particular the guidance on the prevention of hyponatraemia issued by the Chief Medical Officer, and our current work to develop a system for reporting adverse incidents will help avoid a similar event in the future.

Q3 Was the Sperrin Lakeland Trust negligent in failing to report Lucy's death to your Department?

A3 No. At the time of Lucy's death there was no formal requirement for Trusts to report a death such as Lucy's to the Department. The Trust did however notify the Director of Public Health at the Western Health and Social Services Board immediately after Lucy's death and also formally advised him that a case review was being conducted. My Department has been working to strengthen arrangements for the reporting of adverse incidents and will shortly be issuing guidance.

Q4 Without a formal system how does your Department expect to hear of untoward deaths?

A4 The current system, in which untoward deaths are reported to the coroner's office provides a mechanism by which unexplained deaths are appropriately investigated. Each year, there are about 15,000 deaths in Northern Ireland, the majority of which occur in hospitals. Almost 3,500 deaths are reported to the coroner annually and approximately 1,400 coroners post-mortems are concluded.

The existing system of reporting deaths is to be strengthened. The Home Office proposals *Reforming the Coroner and Death Certification Service*, proposes that all deaths will be reported to the coroner's office through newly established medical examiners. This will be introduced over a number of years.

Q5 Are you satisfied with the quality care provided by the Trust?

A5 In light of the coroner's verdict I know that the quality of care received by Lucy was of the standard we would expect. I am however satisfied that lessons have been learnt and that appropriate steps have been taken to ensure a similar case does not occur again. These steps include action by the Trust to improve

practices and procedures, the CMO guidance issued to Trusts, and the adverse incident reporting system to be introduced shortly.

Q6 How many untoward deaths are reported to your Department each year?

A6 There are only a small number of deaths reported directly to the Department each year. I know that the Northern Ireland Adverse Incident Centre, which receives reports of any untoward incidents associated with medial equipment and devices, received 241 reports of incidents. Since 1998 there have only been 4 reported cases of deaths related to medical devices.

Q7 Why was Lucy's death not reported to the coroner?

A7 Lucy's death was reported to the coroner's office. Following discussion of the case between the state pathologist and a consultant paediatrician a decision was made that a coroner's post-mortem was not required. This decision was based on the available evidence at the time of Lucy's death.

Q8 The CMO is on record as stating that she knew about Lucy's death in 2001 then corrected her statement the next day. Can you comment?

A8 Let me emphasise the sequence of events. Lucy died in April 2000. Raychel Ferguson died in 2001 and her inquest was held in February 2003. It was only after the inquest into Raychel's death, in which a verdict of hyponatraemia was reached, that the coroner was made aware that Lucy and Raychel may have both died from hyponatraemia. Therefore the CMO was informed of Lucy's death in March 2003, and this she has confirmed on record.

Q9 When were you informed of Lucy's death?

A9 I was formally notified of Lucy's death following her inquest in March 2004. However, the Chief Medical Officer was informed in March 2003 and her office very appropriately brought Lucy's death and Rachel's to the attention of the National Patient Safety Agency, which is responsible for the safety of patients in the NHS.

Q10 Why was Dr Sumner not called in earlier by the Department?

A10 When CMO's guidance was being developed the working group included paediatricians, paediatric intensive care specialists, a specialist in laboratory medicine and a nurse. Dr Sumner, a well-recognised expert on fluid management and hyponatraemia, made a valuable contribution in formulating the guidance and he has recently praised it.

Q11 Will you apologise to Lucy's family for her death?

A11 I know that the Trust have apologised to the Crawford family for failings in the service. I too apologise for the tragic death of Lucy although I know that no words will ease the loss for her family.

Q12 Will you meet the Crawford family?

A12 Yes, I have written to Mr and Mrs Crawford and I have offered to meet with them.

Q12a Are you satisfied with the way the Trust communicated with the Crawford family?

A12a The Trust offered on a number of occasions to meet with the Crawford family and also communicated with them in writing. However in hindsight the Trust have acknowledged that communication could have been much better.

Q13 The CMO appears to disagree with the verdict of the coroner, can you comment?

A13 I want to emphasise that I fully and unconditionally accept the verdict of the coroner regarding the cause of Lucy's death. I also want to stress that the CMO has gone on public record to the Irish News and to yourself endorsing the findings of the coroner.

Q14 Do you think that Lucy's death was due to an idiosyncratic reaction to fluid?

A14 I am not of course a clinician. Hyponatraemia and its cause is a complex matter that I don't pretend to fully understand. What I want to put on public record is that I fully and unconditionally accept the coroner's verdict on Lucy's death. I do know that there is still ongoing debate about fluid management in children and specifically about the risk of hyponatraemia. The prevention and treatment of hyponatraemia is a complex area but I am content that the guidance issued by the CMO which is currently in place will ensure that hyponatraemia can and will be prevented in children.

Q15 Surely the doctor treating Lucy should have been aware of the possibility of hyponatraemia?

A15 Hyponatraemia was not as you have said in your articles, a widely known risk of fluid administration. In fact, there is still considerable debate among paediatricians regarding the most appropriate intravenous fluid therapy for children. The area of fluid administration in a sick child remains a complex area and within the past few weeks a series of articles published in the highly respected paediatric journal.

Q16 Was the doctor involved negligent?

A16 I am not responsible for the individual actions of doctors. The coroner has referred the papers in this case to the GMC and therefore it would be inappropriate to make any further comment.

Q17 There was an article on hyponatraemia in BMJ as far back as 1992, why did it take so long to introduce new guidelines?

A17 Yes, there were some articles on hyponatraemia but it was not something known widely. Following the death of Raychel Ferguson the Chief Medical Officer convened an expert working group as a matter of urgency to develop guidance on the prevent of hyponatraemia. This guidance was published in 2002 providing practical advice for doctors and nurses who manage the care of children in hospital. This guidance is the first of its kind in the UK and has been commended by Dr Sumner, an expert witness called by the coroner to Lucy's inquest.

Q18 There is another inquest into a young boy's death being held this week. Is this yet another death from hyponatraemia?

A18 There is an inquest currently being held and I am content that the coroner will fully investigate the cause of death. Until its completion I cannot comment on this inquest.

Q19 Was the Trust at fault for not alerting you to Lucy's death?

A19 It was not the Trust's fault but it does point out that there was a gap in the arrangements for informing me of such events. This was hampered by the absence of a formal system here or anywhere else in the UK to report untoward deaths within hospitals at the time of Lucy's death. In Northern Ireland there

are about 15,000 deaths each year, 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.

Q20 Should the Chief Executive of the Trust resign?

A20 I am satisfied that the Trust investigated the case properly and I see no reason for the Chief Executive to resign. What I would say, as you have quite rightly pointed out in one of your articles, is that the Erne Hospital is a fine one, with dedicated, able and professional staff.

Q21. Would the new arrangements you have outlined prevented events, such as the Lucy Crawford case, from happening?

A21. These arrangements, taken in conjunction with other initiatives will help to promote safety in the HPSS and should help minimise the risk of something going wrong and causing harm to a service user. But no system can offer a total guarantee that nothing untoward will happen. We can however make sure that through training, through good risk management, through governance and by independent inspection that the safety mechanisms designed to prevent such things from happening are as fail-safe as possible.

Q22. Why has it taken so long to make decisions on Best Practice-Best Care?

A22. Since the consultation exercise was completed in 2002, there have been developments taking place elsewhere which could have a direct impact on the proposals set out in "Best Practice - Best Care". Of particular significance were changes to the directions and legislation governing NICE and the Commission for Health Improvement. Consideration of such developments needed to be

taken account of before taking final decisions on the arrangements required for the HPSS.

Q23. What has been done?

A23 Legislation came into force in February 2003 placing a statutory Duty of Quality on all HPSS providers. From April next the new Regulation and Improvement Authority will be working to improve standards of treatment and care. Just last week, I announced that Brian Coulter would be the Chairman of the new body and work is now under way to get the new organisation established.

Q24. What is the duty of quality on the HPSS?

A24. By placing a statutory duty of quality on chief executives of HPSS organisations we will for the first time be able to ensure the quality of services delivered, in the same way that financial probity is adhered to. The introduction of clinical and social care governance will bring together all existing activity relating to the delivery of high quality services such as education, training, audit, risk management and complaints management.

Q25. To which organisations will the statutory duty apply?

A25. This statutory duty will cover both Health and Social Services and will apply to HSS Boards, HSS Trusts and those Special Agencies which provide services directly to users e.g. The Northern Ireland Blood Transfusion Agency.

Q26. What is Clinical and Social Care Governance?

A26. Clinical and Social Care Governance is a framework within which HPSS organisations are accountable for continuously improving the quality of their

services and safeguarding high standards of care and treatment. Clinical and Social Care Governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

APPENDIX 2

KEY MESSAGES

- The death of a child is tragic and I want to offer my most sincere sympathy to Lucy Crawford's family.

- I fully accept the coroner's verdict on the cause of Lucy's death.

- I acknowledge that my Department did not know of Lucy's death until 2003. In 2000 there was no formal system for reporting deaths such as Lucys. We have developed a mechanism for the reporting of untoward events in the Health Service and will be issuing interim guidance shortly.

- I am satisfied that the cause of Lucy's death was fully and comprehensively investigated by the coroner and I do not think that any further investigation is required.

- The circumstances surrounding Lucy's death and the subsequent inquest raised a number of important issues, which my Department is addressing, including the reporting of untoward events in hospitals, and good records management.

- It is important that we learn from the lessons of Lucy's death and we have done so. Following the death of Raychel Ferguson from hyponatraemia in 2001, the Chief Medical Officer acted immediately to develop guidance that would prevent a similar incident happening again. This guidance has been incorporated into clinical practice since 2002 and is currently being reviewed in light of the verdict on Lucy's death and any emerging evidence.

- Under clinical governance arrangements introduced last year, my Department is strengthening the systems for quality assurance with Trusts. In particular,

work is underway to improve the mechanism for reporting and investigating untoward incidents in hospitals.

- Accurate record keeping, found seriously lacking in Lucy's case is a very important matter within the health service. My Department is currently working to ensure that measures are in place to maintain good medical record keeping.

Distribution List

Dr Carson
Dr Mock
Mr Hamilton
Mr Hill
Mr Sullivan
Mr McCann
Dr Briscoe
Mr Shannon
Mr Mulhern

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002-007-034