INV 120/04

TAB F

KEY CURRENT ISSUES AT ALTNAGELVIN

LUCY CRAWFORD AND RAYCHEL FERGUSON CASES

Background

1. 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.

2. 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.

3. 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.

4. 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.

Current Position

5. The death of Lucy Crawford continues to attract considerable media interest from the 'Impartial Reporter' newspaper and UTV. UTV now appears to be preparing to broadcast an 'Insight' programme on the Lucy Crawford case. It is likely that this programme will air on 21st October 2004.

6. The Minister was approached by UTV in June to do an interview on the Lucy Crawford case. This request was declined because of Ministerial commitments. No further approach has been received from UTV.

3. UTV has not, and will not, let us know what slant the Insight programme will take. However, staff in the Sperrin Lakeland Trust are concerned that it will personally attack the Chief Executive, Mr Hugh Mills, and the doctor involved in the case, Dr O'Donohoe.

4. The General Medical Council has now referred Dr O'Donohoe, to its Professional Conduct Committee. The GMC has placed no restrictions on Dr O'Donohoe's practice. No date has yet been set for the full hearing.

Lines to take

- 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 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.

- 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, is that the Erne Hospital is a fine one, with dedicated, able and professional staff.

- 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 Lucy's. Today we are developing a mechanism for the reporting of untoward events in the Health Service.

- 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.