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The Irish News
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Measures to prevent cases like baby Lucy's

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 vith the coroner to ensure that measures are put n place to improve the quality of care in our paeliatric 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 comnon use for more than 30 years in all paediatric units across the globe and have saved many young lives. However, it is now known that in some instances these fluids may put some children at risk of the potentially fatal condition called hyponatraemia.

PLATFORM

By Dr Henrietta Campbell
Chief Medical Officer
for Northern Ireland

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

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.

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FEARGHAL McKINNEY

Joining us the Chief Medical Officer, Dr Henrietta Campbell. You have ultimate responsibility for learning the lessons from untoward events in hospitals, that's a damning indictment, what happened to Lucy?

DR HENRIETTA CAMPBELL

Well firstly Fearghal, I need the opportunity to say how deeply tragic these 2 incidents have been, and myself and everyone else in the Health Service deeply regrets the death of any child. But for these 2 beautiful children to have died, lessons have been learned, lessons continue to be learned, but sympathy for the families has to be utmost.

FEARGHAL McKINNEY

It does, but what happened to Lucy?

DR HENRIETTA CAMPBELL

With Lucy, we saw the first test of what was a very rare occurrence, written up in the medical journals only recently, and the outcome of Lucy's death,the lessons not learned early enough to prevent a second death.

FEARGHAL McKINNEY

But you're not recognising the coroner's results in that statement, because the coroner said that, Lucy Crawford died as a result of mal-administration of fluids, it was the wrong fluid and it was too much.

DR HENRIETTA CAMPBELL

At that time in the year 2000, the fluids being used in every paediatric unit in Northern Ireland, and in most paediatric units throughout the UK, were the fluids that were being given to Lucy. What we now know is that

from a few cases written up in the medical journals, in some children, a very few children, but enough to be left ...

FEARGHAL McKINNEY

That's ignoring, I'm sorry, that's ignoring what the coroner said. The coroner said the doctor gave the wrong liquid at the wrong dose, nothing to do with how the victim responded to it, that's what happened, isn't it, that's what happened to Lucy?

DR HENRIETTA CAMPBELL

In retrospect, yes. What was being used at that time was in common practice throughout the UK and wider afield ...

FEARGHAL McKINNEY

You're now accepting fully what the coroner said, when did you learn that this untoward event had happened?

DR HENRIETTA CAMPBELL

We learned about this untoward event in Lucy's death when Rachel died, and the coroner saw that he had 2 cases being presented to him, which looked similar in terms of the tragic outcome ... please let me finish. So the coroner noticing a pattern, reported those 2 cases to me ...

FEARGHAL McKINNEY

So without the death of Rachel Ferguson, you wouldn't have known about the death of Lucy Crawford, an untoward event that you should have known about and you wouldn't have known about it, but for the death of Rachel Ferguson.

DR HENRIETTA CAMPBELL

We had no system within the Health Service at that time for the reporting of all deaths of children.

FEARGHAL McKINNEY

So there's no system for telling how, for telling you how a trust of thi Lakeland Trust, mal-administered fluids to a child that led to that's child's death and you don't know about it? Who's fault is that, who's accountable for that, are you accountable, or the Sperrin Trust accountable?

DR HENRIETTA CAMPBELL

Within the Health Service it is recognised that until quite laterally, there
has been no system throughout the UK, please Fearghal I need to finish t important point, throughout the UK, there has been no system of gatherin together evidence from untoward incidents which are very rare, but which together across the UK begin to show a pattern and begin to show that systems need to change.

FEARGHAL McKINNEY

The rarity in this was the administration of the dose and not the victim Why didn't you learn, you are the Chief Medical Officer, ultimately responsible for learning the lessons from this death, and you're telling here tonight that you didn't know about an untoward event, because the systems failed, is that good enough?

DR HENRIETTA CAMPBELL

The rarity in this event and you do have to return to the medicine, the physiology behind these 2 events, you know, you must let me finish. There's no point my coming here and just being shouted at. The public h a right to know what the issues are. The rarity in these 2 events was t abnormal reaction which is seen in a very few children to the normal application ...

FEARGHAL McKINNEY

Sorry, because you seem to be ignoring and you're going back on what you accepted a moment ago, do you accept fully the coroner's findings? The coroner said it was the wrong dose and too much, now you're backtracking on that, do you accept the coroner's findings?

DR HENRIETTA CAMPBELL

In the knowledge of the evidence which has been in the medical journals over the past 4 years since Lucy's death, yes that is true, but in the light of what was known in the medical community throughout the whole of the UK in the year 2000, when poor Lucy died, there were very few people who would have known what was going wrong, apart from one or two experts who had begun to notice the very abnormal reaction in certain children.

FEARGHAL McKINNEY

Yes, and of course when the Trust went to investigate it, you would have thought that they might have identified, wouldn't you, the rarity as you described it, but instead they produced a review which didn't point the finger at mal-administration, which effectively, and technically covered up this death, because you would never have found out about it and you've got ultimate responsibility and you still didn't learn until Rachel Ferguson died.

DR HENRIETTA CAMPBELL

From the papers which the coroner has sent to me, and which I'm now beginning to read carefully, and which the coroner has been sharing with me, we've been discussing these issues. The coroner and I together, both recognise that these 2 tragic deaths brought together as a pattern, then allowed us, to put two and two together and to recognise that there were some strange but rather unique features afoot which needed to be taken into

....

FEARGHAL McKINNEY

But the Sperrin Lakeland Trust didn't conclude that, the Sperrin Lakeland Trust didn't tell you, the Sperrin Lakeland Trust in Lucy Crawford's case kept it to itself, and you didn't know. Now, should somebody in the Health Service in Fermanagh have responsibility for that, should Hugh Mills

consider his position in relation to that?

DR HENRIETTA CAMPBELL

Going back to the year 2000 it would not have been unusual for a doctor c
a
group of experts not to have recognised what happened to Lucy. It is
easier
to do that in the knowledge of what has been presented to us through the
medical journals in the last 4 years.

FEARGHAL McKINNEY

But you are ignoring what I pointed out to you, that you wouldn't have
known
and the Trust was certainly not telling you anything about Lucy Crawford'
death, and yet you now recognise it as an untoward event, an event that t
population in Northern Ireland should learn lessons from, and you haven't
been able to learn those lessons, and didn't learn them in the last 3 or
years, do you accept that fully?

DR HENRIETTA CAMPBELL

Oh I absolutely agree that if we'd had in place a system for the reportin
of all deaths to some central source, untoward deaths that we could have
begun to learn lessons earlier. That brings me back to a point which I
made earlier, the systems were not in place throughout the Health Service
they do need to be in place UK wide to pick up the very rare issues, but
that is being addressed, the National Patient Safety Agency is now in pla
for early indications of untoward incidents, such as this.