Fisher, Ruth

From: Mills, Ursula
Sent: 13 January 2005 13:53
To: Fisher, Ruth; Browne, Andrew
Subject: CLAERED FINAL VERSION OF PQ4023/04

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DHSSPS

073-024-110

PQ4023/04

DATE FOR ANSWER: TUESDAY 21 DECEMBER 2004

Iris Robinson (Strangford). To ask the Secretary of State for Northern Ireland, what assessment he has made of the explanation of the Chief Medical Officer of Northern Ireland to the parents of Lucy Crawford regarding their daughter's death. **(205958)**

ANGELA SMITH

It would be inappropriate for me to comment on any matter relating to the death of Lucy Crawford. John O'Hara QC, as Chairman of the Inquiry into Hyponatraemia-related deaths, has been tasked to examine and report on all matters he considers relevant to the death of Lucy Crawford and also of Raychel Ferguson and Adam Strain.

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BACKGROUND NOTE TO PQ4023/04

1. In April 2000, Lucy Crawford, a 17-month-old child, died following admission to the Erne Hospital and subsequent transfer to the Royal Belfast Hospital for Sick Children. The cause of death as recorded on the death certificate issued shortly after her death was "Cerebral oedema, Gastroenteritis, dehydration". Subsequently a Coroner's inquest into her death, completed on 19 February 2004, concluded that Lucy died from:
(a) Cerebral oedema, (b) acute dilutional hyponatraemia, (c) excess dilute fluid.

2. Hyponatraemia (a low sodium level in the blood) is known to be a risk in any child receiving prescribed fluids. It is potentially extremely serious, with a rapid fall in sodium leading to cerebral oedema, seizures and possible death. Hyponatraemia most often reflects a failure to excrete water. Stress, pain, nausea and vomiting are all potent stimulators of a hormone, ADH, that inhibits water excretion. Therefore a sick child, if given excess fluids, may not be able to excrete water adequately. The retention of water may, in severe cases, lead to cerebral oedema (swelling of the brain) and ultimately death.

3. Lucy Crawford was admitted to the Erne Hospital on the evening of 12 April 2000 with poor oral intake, fever and vomiting. At that time a presumptive diagnosis of a viral infection was made. She was dehydrated and required intravenous fluids, which were commenced about 10.30pm. At about 3.00am on 13 April Lucy collapsed, and was transferred to RBHSC at 6.00am, but in a moribund state. She was pronounced dead at 13.15pm on 14 April.

4. Lucy's death was reported to the coroner's office. Advice was sought from the State Pathologist's Department regarding the need for a coroner's post-mortem examination. Following discussion between the state pathologist and a consultant paediatrician at the RBHSC, it was agreed that a corner's post-mortem was not required and a death certificate could be issued. A Hospital post-mortem was conducted.

5. The Sperrin Lakeland Trust conducted an internal review into Lucy's death, concluding that neither the post-mortem nor an independent medical report provided could fully explain Lucy's deterioration. Specifically the review commented that the fluids Lucy received were, in both type and amount, within the accepted range, but cited poor record keeping as leading to confusion over prescribed fluids.

6. It was only in February 2003 following the inquest into Raychel Ferguson's death that the coroner was alerted to the similarities between Lucy Crawford's case and that of Raychel Ferguson a nine-year-old who had died from hyponatraemia. Subsequently an inquest was opened into Lucy's death and an inquest held in February 2004.

7. Following the inquest on Lucy Crawford, attention was drawn to the death of another child, Adam Strain, whose cause of death was similar. Adam died in November 1995, following renal transplant surgery. His autopsy confirmed cerebral oedema due to dilutional hyponatraemia and impaired cerebral perfusion as cause of death.

8. To summarise, the sequence of events were as follows:

November 1995	Adam Strain died.
April 2000	Lucy died
June 2001	Raychel Ferguson died.
	Death reported to coroner.
March 2002	CMO issued guidance on prevention of hyponatraemia.
February 2003	Inquest into Raychel Ferguson's death.
March 2003	Links between Raychel's and Lucy's death identified.
February 2004	Inquest into Lucy's death.

9. Detail of the conduct of the consultant paediatrician involved in Lucy's management has been referred to the General Medical Council, which will, through its normal procedures, consider the case and whether there are grounds for disciplinary action.

10. In 2000, at the time of Lucy's death, the statutory Duty of Quality on HPSS providers had not been introduced. The Trust did however take steps to investigate the reason for Lucy's death. A case review was conducted and a paediatrician from Altnagelvin Hospital was invited to act as a medical assessor.

11. The UTV Insight Programme broadcast on Thursday 21 October raised a number of allegations about the treatment of Lucy Crawford and the subsequent investigation into her death. These included specific references to the actions of individual doctors, the management of Sperrin Lakeland Trust and the Department's Chief Medical Officer (CMO).

12. In light of the allegations contained in the 'Insight' programme you announced an independent investigation into the issues raised by it on 1 November.

13. The Inquiry has been set up under the Health and Personal Social Services (Northern Ireland) Order 1972. John O'Hara, QC is chair of the Inquiry and a secretariat has been appointed. You announced the terms of reference for the Inquiry on 18 November.

14. The issue concerning an assessment of the explanation provided by the CMO to the parents of Lucy Crawford is a matter for Mr O'Hara.

Reply prepared by

Ruth Fisher
Eastern Board Unit
Secondary Care Directorate
Tel [redacted]

Andrew Browne
Eastern Board Unit
Secondary Care Directorate
Tel [redacted]

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