Fisher, Ruth

From: Browne, Andrew
Sent: 11 November 2004 14:18
To: Fisher, Ruth
Subject: FW: subs and PQs

-----Original Message-----
From: Carnew, Sholto
Sent: 11 November 2004 11:50
To: Browne, Andrew
Subject: FW: subs and PQs

Andrew - These are all the papers Minister has received on this. Minister has issued letters yesterday to the families involved agreeing to a meeting. This is going to take place on the 25 November in place of the Downe Hospital visit. I'm afriad this probably will now fall to your side also.
Apologies
Sholto

sub.242.2004.doc (26 KB) sub.179.2004.doc (442 KB) sub.179.2004.PDF (1 MB) sub.89.2003.pdf (1 MB) sub.412.04.doc (33 KB) 3296.doc (34 KB) 3297.doc (35 KB)

See document 036 and 037.

DHSSPS

074-023-096

From Dr M McCarthy
Senior Medical Officer

Date 18 May 2004

1 CMO
2 Mrs Angela Smith

INQUEST ON DEATH OF CONOR MITCHELL

Issue:	**An inquest on the death of Conor Mitchell, a 15 year old boy who died in hospital on 12 May 2003 is scheduled to commence on 24 May 2004**
Timing:	**Routine**
Presentational Issues:	**Given the high profile of recent inquests into the deaths of Lucy Crawford and Raychel Ferguson, this is likely to attract media attention.**
Recommendation:	**Minister notes that the inquest will be conducted next week by the Belfast Coroner.**

Background

Conor Mitchell a 15 year old boy died on 12 May 2003 following admission to Craigavon Area Hospital and subsequent transfer to Paediatric Intensive Care at the RBHSC.

1. Conor, a 15 year old boy with significant physical disability and a history of epilepsy, was admitted to Craigavon Area Hospital on 8th May 2003 with a 10 day history of general malaise and vomiting. At that time he was diagnosed as having a viral infection and treated with fluids and antibiotics.

2. Conor's condition deteriorated, he had a number of seizures and suffered a respiratory arrest. He was transferred to the Paediatric Intensive Care Unit at the Royal Belfast Hospital for Sick Children. His condition failed to improve and he died on 12 May.

3. The post-mortem following Conor's death concluded that the cause of death was cerebral oedema (swelling of the brain) but an underlying cause of was not identified.

Presentational Issues

4. It is likely that the media will be interested in this case and may try to link Conor's death with the deaths of Lucy Crawford and Raychel Ferguson who both died from hyponatraemia. Indeed, I understand that the Crawford and Ferguson families have been in contact with the Mitchell family.

5. Available information however suggests that Conor's death was <u>not</u> related to hyponatraemia.

Recommendation

6. Minister notes an inquest into the death of Conor Mitchell is scheduled to commence on 24 May and is likely to attract media attention.

DR M McCARTHY
Senior Medical Officer

Distribution:

Secretary
Dr Carson
Mr Hamilton
Dr Mitchell
Dr Mock
Mr Sullivan
Mr Shannon

EOR/179

MEMO

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MINISTERIAL SUBMISSION

From: Dr M McCarthy

Date: 6 April 2004

To:
1. CMO ✓ ste
2. Secretary 6/4/04.
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.**

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

ANNEX A

Form 22

CORONERS ACT (NORTHERN IRELAND) 1959

VERDICT ON INQUEST

On an inquest taken for our Sovereign Lady the Queen, at THE OLD TOWNHALL BUILDING, 80 VICTORIA STREET, BELFAST in the County Court Division of GREATER BELFAST on TUESDAY the 17TH to THURSDAY the 19TH of FEBRUARY 2004, before me MR J L LECKEY HM Coroner for the district of GREATER BELFAST touching the death of LUCY REBECCA CRAWFORD to inquire how, when and where the said LUCY REBECCA CRAWFORD came to her death, the following matters were found:

1. Name and surname of deceased: LUCY REBECCA CRAWFORD

2. Sex: FEMALE

3. Date of Death: 14 April 2000

4. Place of Death: ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

5. Usual Address: [redacted]

6. Marital Status: SINGLE

7. Date and Place of Birth: 5 November 1998 at

8. Occupation: DAUGHTER OF WILLIAM NEVILLE CRAWFORD, [redacted]

9. Maiden Surname: N/A

10. Cause of Death: 1(a) CEREBRAL OEDEMA (b) ACUTE DILUTIONAL HYPONATRAEMIA (c) EXCESS DILUTE FLUID 11 GASTROENTERITIS

Findings:

On 12th April 2000 the deceased, who was aged 17 months was admitted to the Erne Hospital, Enniskillen with a history of poor oral intake, fever and vomiting. The vomiting was sufficient to have caused a degree of dehydration and she required intravenous fluid replacement therapy. It was believed she was suffering from gastroenteritis. Her condition did not improve and she collapsed at about 3.00am on 13th April, developing thereafter decreased respiratory effort and fixed and dilated pupils. Whilst in a moribund state she was transferred by ambulance shortly after 6.00am to the Royal Belfast

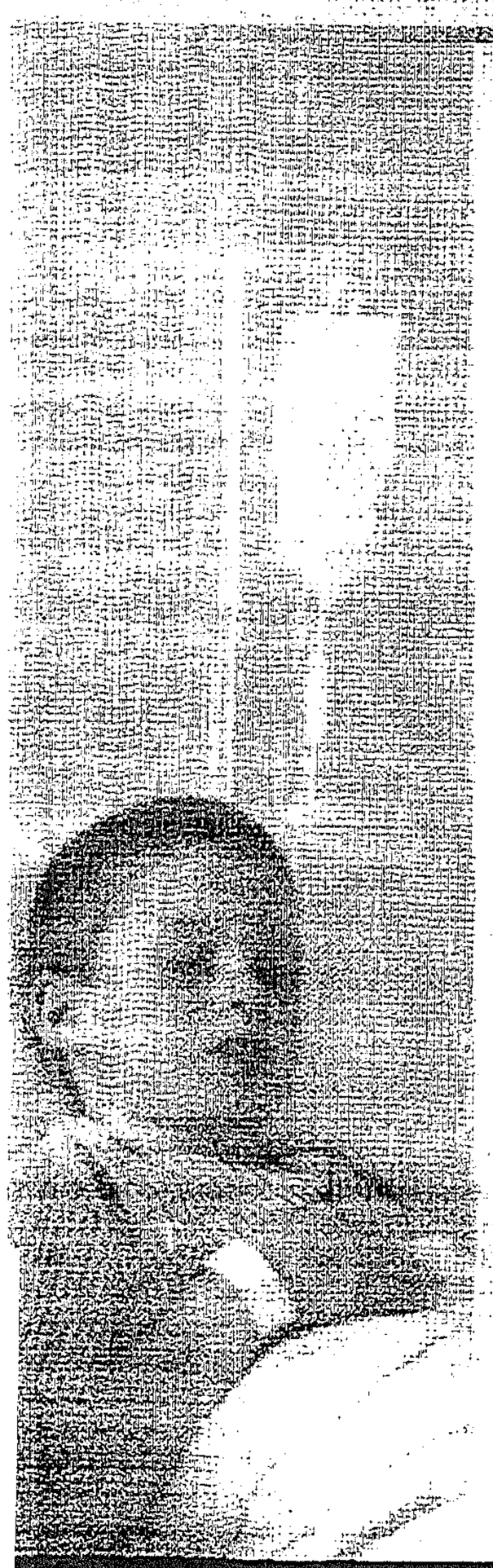
Hospital for Sick Children. Her condition remained unchanged and after two sets of brain-stem tests were performed showing no signs of life she was pronounced dead at 13.15 hours on 14th April. She had become dehydrated from the effects of vomiting and the development of diarrhoea whilst in the Erne Hospital and she had been given an excess volume of intravenous fluid to replace losses of electrolytes. The collapse which led to her death was a direct consequence of an inappropriate fluid replacement therapy in that the use of 0.18% saline to make up deficits from vomiting and diarrhoea was wrong, too much of it was given and there had been a failure to regulate the rate of infusion. This led to the development of dilutional hyponatraemia which in turn caused acute brain swelling and death. The errors in relation to the fluid replacement therapy were compounded by poor quality medical record keeping and confusion by the nursing staff as to the fluid regime prescribed.

Date: 19TH FEBRUARY 2004

Signed: [signature]

Coroner for GREATER BELFAST

CHILD AT RISK OF RECEIVING PRESCRIBED FLUIDS HYPONATRAEMIA



INTRODUCTION

- **Any child on IV fluids or oral rehydration is potentially at risk of hyponatraemia.**

- Hyponatraemia is potentially extremely serious, a rapid fall in sodium leading to cerebral oedema, seizures and death. Warning signs of hyponatraemia may be non-specific and include nausea, malaise and headache.

- Hyponatraemia most often reflects failure to excrete water. Stress, pain and nausea are all potent stimulators of anti-diuretic hormone (ADH), which inhibits water excretion.

- Complications of hyponatraemia most often occur due to the administration of excess or inappropriate fluid to a sick child, usually intravenously.

- Hyponatraemia may also occur in a child receiving excess or inappropriate oral rehydration fluids.

- Hyponatraemia can occur in a variety of clinical situations, even in a child who is not overtly "sick". Particular risks include:

  - Post-operative patients
  - CNS injuries
  - Bronchiolitis
  - Burns
  - Vomiting

BASELINE ASSESSMENT

Before starting IV fluids, the following must be measured and recorded:

- **Weight:** accurately in kg. [In a bed-bound child use best estimate.] Plot on centile chart or refer to normal range.

- **U&E:** take serum sodium into consideration.

FLUID REQUIREMENTS

Fluid needs should be assessed by a doctor competent in determining a child's fluid requirement. Accurate calculation is essential and includes:

Maintenance Fluid

- 100mls/kg for first 10kg body wt. plus
- 50mls/kg for the next 10kg, plus
- 20mls/kg for each kg thereafter, up to max of 70kg.

[This provides the total 24 hr calculation; divide by 24 to get the mls/hr].

Replacement Fluid

- Must always be considered and prescribed separately.
- Must reflect fluid loss in both volume and composition (lab analysis of the sodium content of fluid loss may be helpful).

CHOICE OF FLUID

- **Maintenance fluids** must in all instances be dictated by the anticipated sodium and potassium requirements. The glucose requirements, particularly of very young children, must also be met.

- **Replacement fluids** must reflect fluid lost. In most situations this implies a minimum sodium content of 130mmol/l.

- **When resuscitating** a child with clinical signs of shock, if a decision is made to administer a crystalloid, normal (0.9%) saline is an appropriate choice, while awaiting the serum sodium.

- The composition of oral rehydration fluids should also be carefully considered in light of the U&E analysis.

Hyponatraemia may occur in any child receiving any IV fluids or oral rehydration. Vigilance is needed for all children receiving fluids.

MONITOR

- **Clinical state:** including hydrational status. Pain, vomiting and general well-being should be documented.

- **Fluid balance:** must be assessed at least every 12 hours by an experienced member of clinical staff.

  Intake: All oral fluids (including medicines) must be recorded and IV intake reduced by equivalent amount.

  Output: Measure and record all losses (urine, vomiting, diarrhoea, etc.) as accurately as possible.

  If a child still needs prescribed fluids after 12 hours of starting, their requirements should be reassessed by a senior member of medical staff.

- **Biochemistry:** Blood sampling for U&E is essential at least once a day - more often if there are significant fluid losses or if clinical course is not as expected.

  The rate at which sodium falls is as important as the plasma level. A sodium that falls quickly may be accompanied by rapid fluid shifts with major clinical consequences.

  Consider using an indwelling heparinised cannula to facilitate repeat U&Es.

  Do not take samples from the same limb as the IV infusion.

  Capillary samples are adequate if venous sampling is not practical.

  Urine osmolarity/sodium: Very useful in hyponatraemia. Compare to plasma osmolarity and consult a senior Paediatrician or a Chemical Pathologist in interpreting results.

SEEK ADVICE

Advice and clinical input should be obtained from a senior member of medical staff, for example a Consultant Paediatrician, Consultant Anaesthetist or Consultant Chemical Pathologist.

- In the event of problems that cannot be resolved locally, help should be sought from Consultant Paediatricians/ Anaesthetists at the PICU, RBHSC.

The Department Of Health, Social Services And Public Safety. Guidance is also available on the Departmental website : www.dhsspsni.gov.uk

ANNEX B.

ANNEX C

DRAFT

MINISTERIAL STATEMENT

I would like to express my deepest sympathy to the parents and family of Lucy Crawford 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. 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.

Sor/39/02

MINISTERIAL SUBMISSION

From: Dr M McCarthy

cc: Dr I Carson
Mr P Simpson
Mr J Hamilton
Mr K Mulhern

Date: February 2003

1. CMO ✓ 20.2.03
2. Des Browne

INQUEST VERDICT ON RAYCHEL FERGUSON

Issue: **The recent inquest on Raychel Ferguson, a 9 year old who died following surgery in Altnagelvin Hospital on 10 June 2001.**

Timing: **Urgent.**

Presentational: **Minister may be asked to comment on the case when he visits Altnagelvin Hospital on Thursday 20th February.**

Recommendation: **That Minister notes information relating to the case and agrees lines to take.**

Background

1. Raychel Ferguson, a 9 year old girl died on 10 June 2001 following an appendicectomy in Altnagelvin Hospital. The inquest on her death was held on 5th February 2003 and the findings concluded that she died from cerebral oedema caused by hyponatraemia (depleted sodium levels).

2. Raychel was admitted to Altnagelvin Hospital on 7 June 2001, complaining of abdominal pain. Appendicitis was diagnosed and she underwent appendicectomy the same day. Initially post-operative recovery proceeded normally. However the following day she vomited and complained of a headache. On the 9th June she suffered a series of seizures and was transferred to the Paediatric Intensive Care Unit at RBHSC where she died on the 10th June.

3. The post-mortem examination established that she died from cerebral oedema caused by hyponatraemia. The verdict at the inquest concluded that the hyponatraemia was caused by inadequate electrolyte (salt) replacement in the face of vomiting and water retention.

4. Hyponatraemia is rare but potentially extremely serious, a rapid fall in sodium leading to seizures and death. Warning signs are often non-specific and include nausea, headaches and malaise.

5. Hyponatraemia often reflects water retention and is a particular risk in patients who have just had surgery or who are vomiting, when a hormone may be released that causes the body to retain water.

Summary of Issues

6. Issues likely to arise focus on:

- **The Case**: Now that the inquest has concluded, Rachael's family may pursue legal proceedings.

- **The implications for disseminating information to health professions:** Following Raychel's death, the Chief Medicial Officer established a group to draw up guidance for hospital medical and nursing staff working with children. The guidance aims to raise the awareness of hyponatraemia and provide clear and practical advice on steps required to prevent hyponatraemia. Guidance was completed in February 2002 and disseminated to Trusts. A copy of the guidance is attached (Annex A).

- **Quality of Care:** A statutory duty of Quality will soon apply across the HPPS. New arrangements including the establishment of a Health and Social Services Regulation and Improvement Authority will be put in place to monitor practice against agreed Standards.

Handling and Timing Issues

7. There has been a considerable amount of media interest in this case. The Belfast Telegraph reported on the inquest proceedings. UTV is currently recording, material including an interview with the Chief Medical Officer, for an *Insight* programme due to be televised within the next few weeks. It is possible that Minister will be asked to comment on the case and its implications when he visits Altnagelvin Hospital on Thursday 20 February. Lines to take are attached (Annex B).

Recommendation

8. I recommend that you agree the lines to take.

M.McCarthy

DR MIRIAM McCARTHY

Senior Medical Officer

CHILD AT RISK OF HYPONATRAEMIA

INTRODUCTION

- **Any child on IV fluids or oral rehydration is potentially at risk of hyponatraemia.**
- Hyponatraemia is potentially extremely serious, a rapid fall in sodium leading to cerebral oedema, seizures and death. Warning signs of hyponatraemia may be non-specific and include nausea, malaise and headache.
- Hyponatraemia most often reflects failure to excrete water. Stress, pain and nausea are all potent stimulators of anti-diuretic hormone (ADH), which inhibits water excretion.
- Complications of hyponatraemia most often occur due to the administration of excess or inappropriate fluid to a sick child, usually intravenously.
- Hyponatraemia may also occur in a child receiving excess or inappropriate oral rehydration fluids.
- Hyponatraemia can occur in a variety of clinical situations, even in a child who is not overtly "sick". Particular risks include:
  - Post-operative patients
  - CNS injuries
  - Bronchiolitis
  - Burns
  - Vomiting

BASELINE ASSESSMENT

Before starting IV fluids, the following must be measured and recorded:

- **Weight:** accurately in kg. [In a bed-bound child use best estimate.] Plot on centile chart or refer to normal range.
- **U&E:** take serum sodium into consideration.

FLUID REQUIREMENTS

Fluid needs should be assessed by a doctor competent in determining a child's fluid requirement. Accurate calculation is essential and includes:

Maintenance Fluid

- 100mls/kg for first 10kg body wt; plus
- 50mls/kg for the next 10kg, plus
- 20mls/kg for each kg thereafter, up to max of 70kg.

[This provides the total 24 hr calculation; divide by 24 to get the mls/hr].

Replacement Fluid

- Must always be considered and prescribed separately.
- Must reflect fluid loss in both volume and composition. (lab analysis of the sodium content of fluid loss may be helpful).

CHOICE OF FLUID

- **Maintenance fluids** must in all instances be dictated by the anticipated sodium and potassium requirements. The glucose requirements, particularly of very young children, must also be met.
- **Replacement fluids** must reflect fluid lost. In most situations this implies a minimum sodium content of 130mmol/l.
- **When resuscitating** a child with clinical signs of shock, if a decision is made to administer a crystalloid, normal (0.9%) saline is an appropriate choice, while awaiting the serum sodium.
- The composition of oral rehydration fluids should also be carefully considered in light of the U&E analysis.

Hyponatraemia may occur in any child receiving any IV fluids or oral rehydration. Vigilance is needed for all children receiving fluids.

MONITOR

- **Clinical status** including hydrational status, Pain, vomiting and general well-being should be documented.
- **Fluid balance:** must be assessed at least every 12 hours by an experienced member of clinical staff.

Intake: All oral fluids (including medicines) must be recorded and IV intake reduced by equivalent amount.

Output: Measure and record all losses (urine, vomiting, diarrhoea, etc.) as accurately as possible.

If a child still needs prescribed fluids after 12 hours of starting, their requirements should be reassessed by a senior member of medical staff.

- **Biochemistry:** Blood sampling for U&E is essential at least once a day - more often if there are significant fluid losses or if clinical course is not as expected.

The rate at which sodium falls is as important as the plasma level. A sodium that falls quickly may be accompanied by rapid fluid shifts with major clinical consequences.

Consider using an indwelling heparinised cannula to facilitate repeat U&Es.

Do not take samples from the same limb as the IV infusion.

Capillary samples are adequate if venous sampling is not practical.

Urine osmolarity/sodium: Very useful in hyponatraemia. Compare to plasma osmolarity and consult a senior Paediatrician or a Chemical Pathologist in interpreting results.

SEEK ADVICE

Advice and clinical input should be obtained from a senior member of medical staff, for example a Consultant Paediatrician, Consultant Anaesthetist or Consultant Chemical Pathologist.

- In the event of problems that cannot be resolved locally, help should be sought from Consultant Paediatricians/ Anaesthetists at the PICU, RBHSC.

The Department Of Health, Social Services And Public Safety. Guidance is also available on the Departmental website : www.dhsspsni.gov.uk

ANNEX A

074-023-1114

ANNEX B

LINES TO TAKE

My sympathy goes to the parents and family of Raychel following the death of their daughter.

I am concerned about this incident and want to make sure that the lessons we learn from this unfortunate event will prevent a similar case occurring in the future.

Guidance has already been issued to doctors and nurses involved in treating children in hospitals. This guidance raises awareness of hyponatraemia, a rare but potentially serious problem, and provides clear and practical advice on how to prevent it.

We must ensure the very highest quality standards in our Health Services. New arrangements to support the Duty of Quality will soon be in place. These will include the establishment of a Standards and Guidelines Unit within the DHSS&PS, and an independent HSS Regulation and Improvement Authority.

Sub/179/2004

From: Colm Shannon

Principal Information Officer

Date: 16 September 2004

To: 1. Secretary

2. Minister

RENEWED MEDIA INTEREST INTO DEATH OF LUCY CRAWFORD

Issue:	To update Minister on the latest developments in the Lucy Crawford and Raychel Ferguson case
Timing:	Urgent
Presentational Issues:	The death of Lucy Crawford continues to attract considerable media interest from the Impartial Reporter and UTV. UTV is now believed to be preparing a new programme on the case and is likely to approach the Minister for an interview.
Recommendation:	That the Minister agrees the lines to take.

Background

1. Minister is aware of the Lucy Crawford and Raychel Ferguson cases and the high level of interest that continues to be shown by both UTV and the 'Impartial Reporter' newspaper. A detailed briefing (Sub/179/2004) was prepared for the Minister in June for her interview with Denzil McDaniel, Editor of the Impartial Reporter.

2. UTV now appears to be preparing to broadcast an 'Insight' programme on the Lucy Crawford case which is expected to be shown in October. They recently asked the Royal Victoria Hospital for permission to film the outside of their building. It is also believed they have footage of senior members of the Sperrin Lakeland Trust which will be used in the forthcoming programme.

3. There may be a possibility that Minister might be 'doorstepped' by UTV and asked about the Lucy Crawford case. In preparation for such an event, lines to take are included in this submission.

4. 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, Hugh Mills and the doctor involved in the case, Dr O'Donohoe. The General Medical Council is expected to hold a preliminary inquiry over allegations of professional misconduct against Dr O'Donohoe around 22nd or 23rd September.

Issue

5. The Minister was approached by UTV in June to do an interview on the Lucy Crawford case. This bid was declined because of Ministerial commitments. No further approach has been received from UTV, however, any further bid would need to be considered in the context of the issues being addressed by the programme.

6. The attached lines are recommended for use in any doorstep situation. We will also alert information staff in other press offices to be aware of UTV's interest.

Recommendation

7. That the Minister notes the latest developments in this case and agrees the lines to take below.

COLM SHANNON

Principal Information Officer

cc Mr Gowdy
CMO
Colm Shannon

Tab B

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 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.