McCarthy, Miriam

From: McCarthy, Miriam
Sent: 10 May 2004 09:15
To: 'j.jenkins@[redacted]'; Carson, Ian; Shannon, Colm; Mulhern, Kevin
Subject: FW: Lucy Crawford Letter

Importance: High

John/ Ian,

Ammended letter following our meeting last Friday- I have made a few additional changes

Miriam

-----Original Message-----
From: Mulhern, Kevin
Sent: 07 May 2004 17:31
To: McCarthy, Miriam; McCann, Noel
Subject: Lucy Crawford Letter
Importance: High

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Miriam

Can you please pass to Dr Jenkins and if possible can we clear on Monday. You may also wish Dr Carson to see this.

Noel

Can you please check second para and add in a timeline if possible at the end of it.

Happy to discuss

Kevin

Thank you for your letter of 8 April. Unfortunately, I found your response disappointing and the use of language questioning the veracity of the Chief Medical Officer's comments most regrettable. I can assure you that both Dr Campbell and the Department stand over the previous statements made and I think it would be helpful if I put the record straight on a number of issues and misconceptions within your letter.

Firstly, in relation to untoward events, it has been accepted by the Department that a formal system to report untoward deaths within hospitals was not in place at the time of Lucy Crawford's death. Much, however, has changed since 2000, particularly in the area of quality and accountability where more rigorous systems are now in place. For example, in April 2003 the Duty of Quality was introduced, within which Chief Executives of Trusts are formally accountable for matters relating to the quality of clinical care within their organisations. Also within the Quality agenda, the Department has been actively developing a system for reporting critical incidents and a system to ensure the maintenance of good medical record keeping. Developments within Northern Ireland are roughly parallel with what is happening in the rest of the UK. Indeed, within the UK it is only within the last few years that the National Patient Safety Agency has been established and we are working closely with them to take forward the issue of patient safety.

Developing a new system to identify 'untoward' incidents cannot be achieved overnight. In Northern Ireland there are about 15,000 each year, the majority of which occur in hospital. Approximately 3,500 of all deaths each year are reported to the coroner. Within this context any new system needs to be appropriate, workable and capable of identifying those incidents that require further scrutiny.

I would like to take this opportunity to re-emphasise Dr Campbell's role. As the Chief Medical Officer to the Department and the Minister she is responsible for providing professional advice on health and medical issues. She also has specific responsibility for improving the health of the population in her role as the senior public health professional within Northern Ireland. Dr Campbell is not accountable for the

activities within individual Trusts. It is within the context of her responsibility to protect the health of population that, following the tragic death of Raychel Ferguson, she convened a working group to develop guidance on the prevention of hyponatraemia, published in 2002. Northern Ireland was the first part of the UK to issue this guidance in 2002 and it provides very practical advice for doctors and nurses who manage the care of children in hospital. It has been commended by local clinicians, by the Belfast coroner, and by Dr Sumner who praised the guidelines when giving evidence into Raychel Ferguson's death.

Furthermore, Dr Campbell has recently initiated two further steps to ensure that the guidance remains up to date and in use. Firstly, she has sought assurances from Trust Chief Executives that the guidance has been implemented. Secondly, she has asked 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 and any emerging evidence on hyponatraemia since the publication of the guidance in 2002.

Our understanding of the purpose of the request to interview Dr Campbell was that she would be allowed the opportunity to outline the significant developments that had been made to help prevent future cases of hyponatraemia. It was unfortunate that your presenter did not give Dr Campbell the opportunity to put across the lessons that have been learned and the work undertaken since the tragic deaths of Lucy Crawford and Raychel Ferguson. This would have provided the balance to reassure the public of the important steps that have been taken since their deaths.

You suggested that the CMO comments contradicted those of the coroner. I can categorically say that this was not the case. Dr Campbell was trying to provide some background on hyponatraemia and set the context within which Lucy Crawford's death may be viewed. Although she attempted to highlight the rare occurrence of hyponatraemia, the widespread and accepted use of the fluid Lucy received, and the individuality of a sick child's response to fluid, the aggressive style of interviewing and Fearghal's frequent interruptions did not allow her to present important

information which would have been helpful to viewers. When CMO was speaking about hyponatraemia in general, it would appear that Fearghal McKinney misinterpreted her comments as relating specifically to Lucy Crawford's case, hence the perception that Dr Campbell's comments were inconsistent with those of the coroner. This was not the case and CMO fully accepts the coroner's verdict.

I would also stress that, contrary to your opinion regarding doctors' understanding of fluid management in children, 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 Archives of Disease in Children, a highly recognised paediatric journal, highlights the debate on this matter among experts and the many complexities surrounding fluid management in general and hyponatraemia in particular. Regrettably, within such a complex area, problems do on occasion arise as emphasised by the death of a child from hyponatraemia in a major UK hospital as recently as 2003, presenting with a similar clinical condition to that of Lucy Crawford. By last year, the guidance issued by Dr Campbell was already well established in Trusts across Northern Ireland. To question the veracity of Dr Campbell's comments is a simplistic approach to what is a complex and ongoing debate.

In regard to the reporting of the case I wish to correct you. The CMO became aware of the Lucy Crawford case after being written to by the Coroner. I accept that Mr Stanley Miller had alerted the Coroner to the case. Nonetheless this does not alter the fact that CMO was made aware of Lucy's death when the coroner brought it to her attention after considering Stanley's comments and re-examining appropriate documents

In relation to your comments about the briefing of Kevin Mulhern I want to emphasise that the Department's relationship with the media is one I take very seriously. In a current affairs programme it is our role to provide information and comments that will

be helpful in improving viewers' knowledge and understanding of health issues. In my view the contemporaneous notes you say UTV made of the conversation between Trevor Birney and Kevin Mulhern are selective to say the least. They do not refer to Trevor's comments that they would not be holding the CMO accountable or laying blame at her door. Kevin did explain the role of the CMO and how the new guidelines had been put in place.

In summary, our understanding remains that Dr Campbell was invited onto your programme to discuss how lessons had been learned from the past and how new systems and procedures were being introduced and developed. The tone, style and approach of the interviewer did not provide the opportunity for the CMO to outline the significant progress that has taken place since the tragic deaths of Lucy and Raychel.

I think that we will continue to differ on this subject but would conclude by saying we must ensure the very highest quality standards in our health services and this Department will continue to work to ensure that all patients receive high quality care throughout the health service.

Thank you for your letter of 8 April. Unfortunately, I found your response disappointing and the use of language questioning the veracity of the Chief Medical Officer's comments most regrettable. I can assure you that both Dr Campbell and the Department stand over the previous statements made and I think it would be helpful if I put the record straight on a number of issues and misconceptions within your letter.

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