PR563 / 25 March 2004

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

STATEMENT REGARDING THE DEATH OF LUCY CRAWFORD

The death of Lucy is undoubtedly a tragedy for the Crawford family – nobody can underestimate the grief experienced from the loss of a child. As an organisation dedicated to caring for people, we regret our part in this tragedy.

Following the recent conclusion of the litigation process and the Coroners Inquest, we have issued a letter of apology to Mr and Mrs Crawford, expressing our regret for the failings in our service at the time of Lucy's death.

We understand the family's criticism of the limited contact – this is regrettably a consequence of legal processes. We regret that our earlier efforts to meet with Mr and Mrs Crawford during the period from Lucy's death to May 2001 were unsuccessful. At this time, we are constrained in participating in the UTV programme, as there is ongoing litigation and the Chief Medical Officer, the GMC and we are examining the findings of the Coroners Inquest.

Immediately following the Coroners Inquest, we issued two statements which set out our position.

Practice today at the Erne Hospital is different from the time of Lucy's death in April 2000 almost four years ago. These practice changes occurred following the Coroner highlighting the death in June 2001 of Raychel Ferguson. The Trust adopted new procedures on fluid replacement in 2001, ahead of the guidelines issued by Dr Etta Campbell, Chief Medical Officer, in 2002 and staff have been trained in these practices.

These changes in practice occurred in respect of documentation, patient observation, weighing infants and administration of intravenous (IV) fluids and include:

Documentation

- Nursing staff have received updated training on records and record keeping.
- Nursing records are subject to audit.
- Commenced a programme for the appointment of clinical pharmacists to improve prescribing and recording of medicines.

Observations

- Emergency Admissions Policy is now in place, which specifies minimal observation standards within the first 24 hours of admission and that the type of observation required is detailed.

Weighing

- Young children's weights are now double checked by a second person.

Fluids

- Solution 18 is not used as the first treatment.
- Department of Health wall chart 'Risk of Hyponatraemia" is prominently displayed in treatment rooms where IV fluids are erected.
- Children on IV fluids have electrolytes assessed 4-6 hourly as necessary.
- Medical casenotes include a section for fluid replacement calculations before any child is commenced on IV fluids.

These changes have been led by medical and nursing staff supported by managers at the Erne Hospital.

The Trust is carefully reflecting on the conclusions of the Coroner and assessing the implications arising from the Inquest in order to ensure that our Trust and others learn the lessons of this tragic case. These will be considered with medical and nursing staff and discussed with legal representatives. Furthermore, arrangements are being established to consider key learning points with the Chief medical Officer, Western

Health and Social Services Board and members of the Western Health and Social Services Council. The Trust would wish to ensure that any further lessons from this tragedy are shared with the wider HPSS at an early opportunity.

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