Lucy Crawford decd

The inquest last month came at the end of what has been a long and painful search for the truth by Lucy's parents. The Coroners finding was a vindication of the family's determination.

The family were disappointed that the Consultant in charge of Lucy's care, Dr. O'Donohoe, failed to give evidence at the inquest. Whilst this decision may have been based on legal advice they feel it was a bad decision.

They feel it was a bad decision for him. They also feel it was a bad decision for them.

The family had waited a long time to get answers. They themselves underwent the ordeal of giving evidence and being cross-examined by a barrister on behalf of the Trust. Dr. O'Donohoe's failure to do likewise deprived the family of an important opportunity to find out what happened to their daughter and why.

From the families perspective the central issues which Lucy's death has highlighted are as follows;

1. The nature of the fluid management regime.

   The family are concerned that the focus on the use of Solution 18 is an attempt to deflect attention from the real failings in the fluid management system.

   Each of the Doctors at the Inquest gave evidence that not alone was the wrong fluid prescribed but also that it was administered at the wrong rate.

   Dr. Campbell appears to have confined her comments last week to the fact that Solution 18 was in common use throughout NI at the time. This misses the point. The evidence at the Inquest was that Lucy would probably have survived even with this fluid, had it been administered at the correct rate.

   The Coroner found that Lucy had died from Cerebral Oedema caused by acute dilutional Hyponatraemia which in turn **was caused by the administration of excess dilute fluid**. Hyponatraemia may have been a complicated and obscure medical term that described the process that led to Lucy's death. The cause is remarkably obvious and simple. She was given too much fluid too quickly.

   Fluid management is a basic skill taught at medical school. It involves an estimation of likely fluid loss and the calculation of the fluid required to replace such losses and maintain fluid levels. Each patient is different and the plan for fluid administration must be formulated on a case-by-case basis. There was no evidence that any such calculation was undertaken for Lucy. She was only mildly dehydrated.

   Whilst the term hyponatraemia may not have been widely known prior to Lucy's death the basic principles of fluid management were. Had those principles been observed Lucy would be here today.

UTV

2. The review.

At the family's request the Trust initiated a review shortly after Lucy's death. The chief executive of the Trust then wrote to the family indicating that the review had not disclosed that the treatment provided to Lucy was inadequate or of poor quality

One might question the quality of the review process given the Coroners findings and the evidence of all three experts including the expert initially retained by the Trust.

Dr Campbell indicated last week that the Trust did not realise and could not have been expected to realise the implications of Lucy's case for the wider Health Service. Has Dr. Campbell been provided with a copy of the review and if not how can she make such a statement. If she has been provided with a copy of the review why have the family not seen it.

I would be surprised if Dr. Sumner would agree with these sentiments. All of the experts agreed that the fluid used was not appropriate to make up deficit fluids and all agreed that the rate of administration was wrong. No proper fluid prescription was recorded. It is difficult to see how these issues could not have had wider implications. It is also difficult to see how an 'independent' review failed to highlight these issues.

We have written to the Trust requesting sight of the [illegible] To date we have not been provided with a copy. We do not know if a written report was provided by Dr. Quinn or what information was provided to him. Clearly the fact that this review, which apparently cleared the Sperrin Trust of wrongdoing, was carried out by a Consultant from Altnagelvin has implications given the subsequent death of Raychel Ferguson in that hospital.

If confidence in the Trust is to be restored the full circumstances in which the review was carried out need to be examined. It is only then that the Trust will be able to claim that the lessons from Lucy's death have been learned.

3. The response of the Trust to the death;

The Trust appears to be incapable of dealing with the tragedy in a sensitive manner. A 17-month-old child died unnecessarily. To this day no one from the Trust has come to the parents and said we are sorry for the mistakes that led to your daughters death.

The Chief Executive of the Trust did write last week expressing regret for "the failings in our service at the time of Lucy's death." This is some way short of acknowledging the failures that the Coroner found led directly to Lucy's death.

The family know that no one set out to cause Lucy harm. However the attitude adopted by the Trust after Lucy's death has only served to increase the family's pain and suffering. The Trust's response lacked compassion and appears to have

been less than frank. The family can be forgiven for believing that the Trust have obstructed their search for the Truth and in their words have 'slammed doors in their faces'.

It has been said time and again after the Inquest that lessons have been learned. Dr Campbell's focus in interview on the type of fluid only leads one to doubt whether this is the case.

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