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SERIES OF ERRORS LED TO LUCY'S DEATH

Former users' watchdog boss says lessons must be learnt

BY MICHAEL BRESLIN

Stanley Millar, now retired as chief executive of the Western Health and Social Services Council, spoke to the 'Herald' this week about his part in alerting the Belfast Coroner to the death of Lucy Crawford.

Her death was the subject of a UTV documentary last week which claimed that the Sperrin Lakeland Trust had covered up the cause of her death and that the Coroner at her inquest had been misled.

As a result of Mr Millar's "whistle-blowing", John Lecky conducted an inquest, the findings of which formed the basis of last week's hard-hitting 'Insight' special: 'When Hospitals Kill'.

Mr Millar recalled that Lucy died in April 2000 and, about one month later, Mr and Mrs Crawford contacted him as chief officer of the WHSSC, the watchdog body for users of the health service: "They had three questions they asked me to try and get answers to - why did Lucy die, could her death have been prevented and was anybody responsible for Lucy's death.

"I worked with them and arranged a series of meetings. I went up with them and met the pathologist in the Royal who conducted the post mortem on Lucy on 16th June, 2000. The answers he came up with were pneumonia, dehydration, gastro-enteritis and cerebral oedema. We came away from that meeting still with no answers".

Thereafter, he contacted the Erne hospital, requesting a copy of Lucy's case notes and then the Sperrin Lakeland Trust to make a formal complaint. In neither case were satisfactory conclusions given and, in Millar's own words: "There was something there that just didn't add up".

Two years later and Mr Millar was contacted by the Ferguson family whose daughter, Raychel was admitted to Altnagelvin hospital, showing symptoms similar to Lucy - vomiting, diarrhoea, etc - and died there. He accompanied the Fergusons to Altnagelvin.

"I could see the similarities (to Lucy's case), but what was different in this case is that the doctors in Altnagelvin referred Raychel's case to the Coroner who subsequently ordered a post mortem which decided that her condition was hyponatraemia. The difference in the two cases is that the doctors in Derry alerted the Coroner. Lucy was transferred to the Royal but the doctors there did not make the Coroner aware of Lucy's condition.

"All that happened was that a hospital post mortem was conducted and a death certificate was issued and that was the end of the Crawford case. I was still carrying the burden of involvement in Lucy's case and I wrote to the Coroner for Greater Belfast, John Lecky on 27th February, 2003 and pointed out to him there did seem to be similarities.

"I also pointed out that if the Crawford case had been investigated properly, that Raychel Ferguson might still be alive".

Acting on his letter, Mr Lecky referred the Crawford to the Lord Chancellor who advised that an inquest take place.

It was at this inquest that an expert witness, Dr Edward Sumner identified the cause of death in both cases as hyponatraemia, the medical term for the swelling of the brain caused by mismanagement of fluid.

Stanley Millar told the 'Herald' that lessons had to be learnt from Lucy's tragic death. He said there was 'a catalogue of errors' right across the Province, what he called, 'a systems' failure' and he suggested seven areas of improvement - • better communication between doctors and nurses on the one side and the parents of child hospital patients

• better communication between the different doctors when a care episode has a tragic outcome

• better liaison between the doctors in the Erne and the Royal ('it's very easy for the doctors in Belfast to criticise the Erne')

• better liaison between the doctors and the Coroner's service

• a better arrangement for the transfer of case

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Huge turn-out for Irvinestown funeral

There was a huge turn-out on Saturday morning last for the funeral Mass in the Sacred Heart Church, Irvinestown of 21-year old Joanne McCusker, whose family home is at Church Street in the town, who was found dead along with her boyfriend, Brett Buckland (33) in a car in Glenfarne Forest, not far from Blacklion on Tuesday morning of last week.

Joanne is immediately survived by her parents, Pat Joe, a native of Dromore and Anne Marie and by her brother, Noel.

Mr Buckland's mother was present in the overflow congregation. The local parish priest, Fr Michael McGourty was assisted in the Mass by Canon Tom Breen, the parish priest of Domore.

Fr McGourty, who has been in Irvinestown for the past six years, spoke to the 'Herald' of the impact of the tragedy: "This was one of the most traumatic events in that time and one of the saddest funerals in Irvinestown for a long time. There was, of course, an extra dimension to it, the mysterious circumstances of their death".

Fr McGourty said he reminded the congregation that another family had been bereaved and that he included the Bucklands in the led prayers.

Joanne's family are well-known locally and in Dromore. Joanne's grandparents Joe and Ann Conway also reside in Irvinestown. Mr Conway was a well-known contractor, now retired. Following the Mass, burial took place in the adjoining cemetery.

Series of errors led to Lucy's death

Stanley Millar

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notes from one hospital to another ('so that the patient's condition is provided and the receiving hospital can make an assessment')

- a review of the whole way complaints are investigated by the Health Service
- and, the need for hospital staff to maintain a duty of care, particularly with grieving parents.

Mr Millar commented:

"This was a huge tragedy for the Crawford family, but it also was a huge tragedy for the Children's Ward in the Erne hospital. The one thing that needs to be done now is to begin to restore confidence. If a GP sends a child into the hospital and sets up a drip, it is very important that the parents of that child should have confidence in the care that is provided by the doctors and nurses in the Erne.

"The onus is on the Sperrin Lakeland Trust to restore that confidence and to build up a relationship between the staff in the hospital and the community it serves".

Mr Millar said last week's television programme raised many issues that needed to be investigated, and he went on: "The good thing, as far as everyone is concerned, is that the care for Lucy, at the time - and we're talking about almost five years ago - was exactly the same care she would have got in any other hospital in the Province. This is the way people were cared for with that condition at that time and the proof of that is that, two years later, Raychel Ferguson went into Altnagelvin and got the same treatment.

"There was a big cloud, I have no doubt, over the Erne hospital and, whilst there are issues still to be resolved, there were staff who took Lucy's death very badly. There were nurses in the ward that night who will never get over it. It is time to look at the way forward and what we have to do is make sure that this never happens again".

Trust holding enquiry

The Sperrin Lakeland Health and Social Care Trust has side-stepped the grave allegation, made in last week's UTV's 'Insight' programme, that it was guilty of a cover-up following the death, in April 2000 of 17-month old Lucy Crawford.

The little girl was transferred from the Erne to the Royal where she died but it wasn't until another little girl, with similar symptoms, died in Altnagelvin Hospital the following year that the then chief executive of the Western Health and Social Services Council, Stanley Millar alerted the Belfast Coroner, John Lecky to Lucy's case.

Mr Lecky accepted the evidence of an expert witness that both children died from a condition known as, 'hyponatraemia', the medical term for the swelling of the brain caused by mismanagemet of fluid.

The Coroner referred aspects of the case to the General Medical Council who, in turn, have called the clinician in charge of Lucy's case to a hearing.

In last week's hour-long documentary, three of the main 'players' were 'doorstepped' for a comment- the clinician in the Royal who, wrongly, gave the cause of Lucy's death; a paediatrician from the Western Health Board who drew up a report for the Trust and did not correctly give the cause of her death and, Hugh Mills, the chief executive of the Sperrin Trust.

All three, the programme explained, had declined or ignored an invitation to an interview.

Asked for a comment on the 'Insight' programme, the Trust issued the following statement: 'We can confirm that practice today at the Erne hospital is different from the time of Lucy Crawford's death in April, 2000, almost four years ago.

"The Trust adopted new procedures on fluid replacement in 2001, ahead of guidelines issued by Dr Etta Campbell, chief medical officer in 2002 and staff have been trained in these practices. Additionally, the Trust is on record in its determination to learn any further lessons from the tragic death of Lucy Crawford.

'The Trust did not participate in the programme, given the ongoing investigation by the General Medical Council and the establishment of a steering group which is taking forward a 'root cause analysis' examination of the circumstances surrounding Lucy Crawford's death and our handling of the investigative process'.

'Root cause analysis' as a practice that is increasingly used in the health care setting to examine events/processes/systems surrounding adverse incidents and near misses. The term originates from the aviation industry where it is used to determine the cause of aviation accidents.

The 'root cause analysis' arose out of a meeting in May this year of the Trust's Clinical and Social Care Governance Committee where the Trust chairman, Harry Mullan proposed the setting up of a steering group to oversee the process.

Mr Mullan said then he had written to Lucy's parents to share those plans with them and he remained hopeful that they might feel able to contribute to the process.

Addressing the committee at its meeting last month, the chairman of the steering group, Jenny Irvine, a non-executive (independent) member of the Trust Board, who sat with Dr Diana Cody, the Trust's medical director, reported that their group intended presenting their report and findings to the committee in March next year.

Mrs Irvine, who has a nursing background, said the steering committee had been set up to examine the circumstances of a tragic event, Lucy Crawford's death and she acknowledged the devastation experienced by Lucy's family.

A minute of the meeting released to the Press afterwards read: 'She (Mrs Irvine) reinforced her belief that no harm had been intended; however, harm had occurred and she expressed deep regret that a little girl had died as a consequence'.

Police urged to probe Trust

BY ADRIAN MULLAN

WEST Tyrone MLA Dr Kieran Deeny has called for the chief executive of the Sperrin Lakeland Trust, Hugh Mills, to be sacked and for police to investigate the health trust for "criminal negligence" following a TV show on the cover-up of a child's death at the Erne Hospital. The cover-up began as Dr Maurice Hayes was preparing a report which recommended the closure of acute services in the Tyrone County Hospital, Omagh, in favour of a new hospital in Enniskillen.

Following the hard-hitting 'Insight' television report on UTV into the cover-up, there was heated speculation on whether Mr Mills could survive this scandal.

This week, Dr Deeny also called for the scrapping of the Sperrin Lakeland Trust as a "health care entity". Moreover, he called for the removal of Henrietta Campbell, the North's Chief Medical Officer, following statements she made on the programme.

MLA demands sacking of chief executive after TV probe

The Insight investigation showed that the tragic death of 17 month-old Lucy Crawford from Letterbreen, Co. Fermanagh, was due to incompetence on the part of the Sperrin Lakeland Trust. After her death, the parents were lied to when they sought to get to the truth about what happened their little girl.

It now seems that the Sperrin Lakeland Trust's cover-up was motivated by the politics of the hospital debate. In August 2000, just four months after Lucy's death and about the time when the truth should have emerged, Stormont Health Minister Bairbre de Brún initiated the Hayes Review of hospital services. The review and the subsuquent debate and uncertainty in Omagh caused by the Enniskillen decision happened before the truth came out.

Last February, at the inquest into Lucy's death, Coroner John Leckey, found that "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 coroner established that the Sperrin Lakeland Trust lied to the family. The Crawford family was told that the outcome of its "independent" medical had not found that "... the care provided to Lucy was inadequate or of poor quality."

Protecting the reputation of the Erne at a critical time in the hospital review of acute services may account for the Trust's cover-up, it emerged this week. The UTV programme established that, after the tragedy, SLT bosses "sweet-talked" a paediatrician from Altnagelvin, Mr Murray Quinn, into writing a medical report suggesting that Lucy died of natural causes. In fact, her death was caused by hyponatraemia brought on by the Erne consultant Jarlath O'Donoghue using incorrect fluids and in the wrong amounts.

After Lucy's death the Trust and a cadre of medical practitioners tried to close ranks to cover up the blunder, even misleading the Northern Ireland Coroner as to the cause of Lucy's death.

A doctor working at the Erne at the time, who brought the details of the blunder to the personal attention of Hugh Mills, subsequently left his post because his life had been made so difficult by the management after he blew the whistle and threatened to report Dr O'Donoghue to the General Medical Council.

Sperrin Lakeland Trust was contacted with a number of questions about Lucy's death. A statement which did not answer or address the questions was issued by the Trust by way of reply.

Herald staff members Oonagh Moore, Nicola Maybin, Eileen Magee, Maurice K copies of the Tyrone Herald which will be available throughout the county on M

It's full steam ahe

BY MAURICE KENNEDY

FROM next Monday, November 1, a brand new newspaper will be hitting the shelves right across the county with the launch of the Tyrone Herald.

News, sport and features from right across the county will be part of the mix with a host of weekly articles on everything from property and motoring to fashion and personal finance. The new Monday newspaper will have a heavy sporting emphasis wit prehensive coverage and analys the big games. Among the colu writing for the Tyrone Herald Mattie McGleenan, Dessie Rya Ciaran McGarvey in GAA and Shiels covering local soccer.

It promises to be a historic d the newspaper industry in Co T with the arrival of the first ever tabloid serving the entire count Tyrone Herald is a sister paper

Firework attacks fresh calls for tota

BY ANNAMAY McNALLY

A SPATE of attacks and accidents throughout Tyrone have brought renewed calls for a total ban on fireworks. Supporters of a ban include a Coalisland woman whose daughter, Natasha McCausalnd, lost four fingers when she picked up a discarded firwork.

Anne McCausland, mother of Natasha who was eight years old when the incident occurred five years ago, said people will never learn to be careful with fireworks.

Natasha was treated at the Royal Victoria Hospital in Belfast and has spent the last five years undergoing surgery on her hand. Her mum told the Ulster Herald this week, "Every year Halloween comes and that brings back the memories. Still five years down the line and they are still about."

Anne said people knew about the injuries to her daughter and to others, but they had not

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Council severs all contact with Sperrin Lakeland Trust

By Adrian Mullan

TWO years ago Omagh District Council rejected a call by Cllrs McLaughlin and McGowan for a vote of 'no confidence' in the Sperrin Lakeland Trust: On Tuesday night there was a clamour as various councillors sought to bring similar motions.

This time, and in the wake of the devastating UTV Insight programme 'When Hospitals Kill', the Trust was finally cast adrift from any air of respectability it may have enjoyed from its relationship with the Council.

Whereas only four councillors backed a motion two years ago, the motion which called for the severing of all contact with the Trust, won the unanimous support of the Council.

Tabled by Cllr O'Doherty it called for the council to break all contacts with the Trust; called for the council to contact the WHSSB to ask them if they are happy about continuing to commission services from the Trust, and for the Council to contact Fermanagh District Council to ask if it still wants to continue its close working relationship with the Trust. An amendment tabled by Cllr McGowan urging the Minister to extend the inquiry to the status of Public Inquiry was appended to the motion by consent.

suspend

Cllr O'Doherty urged that the Minister be asked to suspend Trust Chief Executive Hugh Mills and the Trust's complaints manager, Brigid O'Rawe. 'How can anybody have anything to do with the Trust after what has taken place', asked Cllr O'Doherty.

Dr Deehan seconding the motion said she utterly condemned the Trust's attempt to cover-up the death of 17 month old Lucy Crawford. 'We as a council have, up to now, worked closely with SLT to allow us to put on pressure to maintain services in Tyrone County Hospital.' She said it was the responsibility of Hugh Mills, as chief executive, to ensure the safe delivery of services and that the attempt by the Trust to cover-up the death of a child was reprehensible. 'Those actions on the part of Hugh Mills are incompatible with him remaining in his post. Sperrin Lakeland Trust [Board] should have asked him to tender his resignation. We cannot work with a body that works in a way which threatens the lives of patients.'

Paddy McGowan said that it was a pity that the people who were 'wild to get in on the issue now' hadn't supported the original motion of no confidence. 'We were over-ruled because we were told that they were such nice people.' Cllr Bert Wilson said that, 'Everyone knew the Trust was taking us for a ride. We shouldn't have to ask them to step down. If they had any decency they

would step down themselves. They should all [the Trust Board of Management] be asked to step down.'

Johnny McLaughlin said that under the stewardship of Hugh Mills the Trust had been operating a 'hidden agenda'.

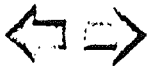
Oliver Gibson, observing that a meeting with the Health Minister was imminent, 'Let's use this splendid opportunity to ask what is she going to do.'
'Sperrin Lakeland Trust is very much the whipping boy in all of this', commented Cllr Shields 'We need to remember that SLT is only one of the bodies involved. The council should not be lead into making a scapegoat of one individual so that others get away in the smoke ... we must act responsibly.'
He continued, 'This council cannot get involved in scapegoating ... I accept that we should sever contact with SLT until the Inquiry is complete but we must be careful about lending weight to any prejudicial view of this.'

sympathy
Barry McElduff suggested that the council should express its sympathy to the families of the three children who died.

He said he had no hesitation in stating that he had no confidence in Hugh Mills as chief executive of the Trust. He stressed that the Minister must now be pressed as to guarantees that services would be maintained in the interim [until the new acute hospital is built]

Joe Byrne said he has asked Eddie McGrady MP to ask questions in the House of Commons to ask the NIO minister to outline the current situation regarding the state of acute services at Tyrone County Hospital. He will be asking if the Minister can confirm that the department of Health will continue to provide, maintain, and develop resources at TCH in order to keep it viable until the Acute Services Review plan has been implemented.
A motion, tabled by Reuben McKelvey, calling for the suspension of Mr Mills during the inquiry failed to find a seconder.

If you have an opinion on the story you just read then why not share it with us. Click the image above and have 'Your Say'.



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WHSSC calls for 'open' public inquiry

THE WESTERN Health and Social Services Council has said that any inquiry into the deaths of Derry girl Raychel Ferguson and Lucy Crawford must be "open and transparent."

Following the monthly meeting of the WHSSC the independent Watchdog Body's Chairman Paddy McGowan said they welcomed moves made by the Health Minister Angela Smith that an independent inquiry be set up.

He said: "We are deeply concerned about the medical and care issues raised in the UTV Insight programme and the very disturbing allegations that there was a 'cover-up'".

He added that both the Chief Officer Maggie Reilly and himself, met with Mr Hugh Mills, the Chief Executive of Sperrin Lakeland Trust, his Chairman Mr Harry Mullan and Dr. Diana Cody the current Acting Medical Director back in June 2004.

He continued: "We met to discuss the reasons why the Western Health and Social Services Council had declined the invitation to participate in the Trust's internal review of the events leading to the death of Lucy Crawford.

"Our main concerns and objections at that time centred around, what was in our opinion the very narrow focus of the review, the absence of independent medical expertise and the fact that there was a lack of openness and transparency in the review process.

"We clearly stated at that time that we would be more confident if the Trust and the Department had instigated a full and independent review of all of the issues relating to the death of Lucy Crawford and the subsequent handling of the parents right to know what had happened to their daughter.

Terrible effects

"These families live with an enduring burden of grief and powerlessness which neither time nor compensation could eradicate. We can only guess at the terrible effects that these untimely deaths have had on the families.

"This inquiry therefore must be open and transparent, it must be bound by a time frame which is reasonable in which to work and reach conclusions.

"It must be able to call on all of the key people involved in the care of the children and all others who had a responsibility to protect these and future children in the planning and delivery of care".

"To that end we call on the Minister to make this a full public independent inquiry and in light of the families' concerns we would further call upon the Minister to appoint an independent Chair from outside the jurisdiction."

Mr. McGowan said that the families had a right to be heard not only as witnesses but also in the shaping of this inquiry.

"They must be supported to participate in a way that is meaningful to them," he said.

"The outcome of this inquiry one can only hope will give some relief to the families in the knowledge that whilst nothing will ever return their children to them, that the lessons learnt and changes implemented will mean that no other family should ever have to go through this again."