Young, Christine

From: Mulhern, Kevin
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To: Gowdy, Clive; Campbell, Dr Henrietta; Burne, Alison; Shannon, Colm
Subject: FW: Impartial reporter Crawford stories

Impartial Reporter stories February to March 2004

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Mother goes public to find truth about Lucy's death

The mother of a baby who died as a result of errors at the Erne Hospital has given her first interview about her family's four-year battle to get answers from the hospital authorities.

Since her 17-month-old baby Lucy died on April 14, 2000, Mae Crawford and her family have not only had to deal with their loss but have had the added burden of meeting a wall of silence when they asked what went wrong.

In a moving interview with Fearghal McKinney, to be shown on "The Issue" on Ulster Television tonight (Thursday), Mae, from [redacted] speaks about the little girl she lost, and her concern that the Sperrin Lakeland Trust has not been held accountable.

As much as what she says, the fact that such a usually private woman felt compelled to give the interview at all is remarkable in itself. But it is clear she has taken the extraordinary step in a bid to get answers.

Mae told The Impartial Reporter: "We have been through so much and didn't want to talk publicly before. This has been inside me for four years, and I thought the inquest was my opportunity to get it out."

However, the family was "astounded" when the consultant paediatrician in charge of Lucy's care at the Erne, Dr. Jarleth O'Donaghue, refused to give evidence at Lucy's inquest.

"But Dr. O'Donaghue didn't speak and we haven't got the answers from the Trust. We have been treated terribly," complained Mae.

In UTV promotional material for tonight's programme, Mae says: "There were no answers coming forth so then we felt we had to go to a solicitor which we didn't want to do. We're just ordinary people and all we wanted was answers to what happened to our little girl. It has been a long road and the Sperrin Lakeland Trust has brushed Lucy's death under the carpet for so long.

"They don't want to be accountable for her death but they have to be accountable. They are accountable," she insists.

The mother also speaks about the little girl she lost.

"Lucy was very bright, a very busy little girl and brought so much into our lives. When we lost her, it has just been terrible since then," says Mae, who with her husband, Neville, has two older children.

"We all enjoyed looking after her, the four of us, and we had a great time with her. Some day we hope to be able to look back on those memories and think what a great pleasure she gave to us all.

"It was a busy house. It changed the house and our family very much. She brought so much joy and she was such a special, special little girl. We will never forget the joy that she brought into our lives," says Mae.

The interview is to be shown on "The Issue" at 11 pm on Ulster Television tonight. The programme will also feature an interview with the Chief Medical Officer for Northern Ireland, Dr. Henrietta Campbell.

Lucy was suffering from diarrhoea and vomiting and was dehydrated when she was admitted to the Erne in April 2000. At her inquest at the end of last month Belfast coroner John Leckey found that she died because she was given too much of the wrong type of fluid and there was a failure to regulate the rate of infusion.

"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," he stated.

His findings were forwarded to the Chief Medical Officer for Northern Ireland, Dr. Henrietta Campbell. She has now admitted that Lucy's death and that of a nine-year-old girl in Derry in similar circumstances could have been avoided.

"The deaths of Lucy Crawford and Raychel Ferguson are a terrible tragedy. Nothing can bring comfort following the death of one's child," stated Dr. Campbell.

"From the evidence now accumulating in the medical literature it would appear that the deaths of Lucy and Raychel were preventable. Since March 2002, we have had guidelines in place which should prevent any such tragedy in the future. I have asked to be assured that these guidelines are being implemented and carefully monitored," she added.

The Sperrin Lakeland Trust has also said that changes have been made at the Erne.

"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," it stated.

The Trust will be carefully reflecting on the conclusions of the coroner and ensure that our Trust and others learn the lessons of this tragic case," it added.

The coroner also forwarded his findings to the General Medical Council which monitors professional standards and investigates complaints against doctors.

Yesterday(Wednesday) the GMC confirmed: "We have received the coroner's report and will be looking to see what action, if any, needs to be taken."

The GMC is best known to the public through handling complaints or other information which casts doubt on a doctor's fitness to practise. Initially it will look at the coroner's report to see if the case falls within its remit.

The GMC can take action: when a doctor has been convicted of a criminal offence; when there is an allegation of serious professional misconduct; when a doctor's professional performance may be seriously deficient; or when a doctor with health problems continues to practise whilst unfit.

If the case falls within this remit then within three months the Council's Preliminary Proceedings Committee will meet to decide if it should be forwarded to one of three other committees for consideration. The process can take up to a year.

Hospital's 'fundamental errors' led to baby death

A 17-month-old baby admitted to the Erne Hospital with an upset stomach and dehydration died because of "fundamental errors" in the drip treatment she was given to replace the fluids she had lost through vomiting and diarrhoea. Lucy Crawford, from [redacted] was given a "totally inappropriate" drip and the wrong dosage. Staff failed to notice the "alarm bells" as her sodium levels fell rapidly and she developed a condition known as hyponatraemia. She died from swelling of the brain. No-one knows how many children have died as a result of hyponatraemia. At Lucy's inquest this week questions were raised about the number of "other similar uncovered deaths across the UK" and in particular about whether an earlier examination of the circumstances of Lucy's death could have saved the life of nine-year-old Raychel Ferguson. She died 14 months later at Altnagelvin Hospital in Derry. The coroner, Mr. John Leckey, called upon an expert, Dr. Edward Sumner, a consultant paediatric anaesthetist, to investigate Raychel's death. He also asked Dr. Sumner to produce an independent report on Lucy's death. Dr. Sumner gave evidence that he had carefully examined the medical and nursing notes from the Erne. In his opinion Lucy died from acute swelling of the brain. He said it was difficult to know how dehydrated she was when she was admitted to the Erne but on balance he thought she was mildly dehydrated, perhaps less than five per cent. Dr. Sumner said it was "good practice" to record fluid levels to get a formal view of the level of dehydration. In Lucy's case this was only done afterwards. "What is absolutely mandatory is to write a full prescription saying what fluid is to be given and at what rates. This was not done," he stated. He said the prescription

should be recorded on the patient's chart so that staff have clear and specific instructions. He said Dr. O'Donohoe thought Lucy was getting 30 mililitres a hour when she was in fact getting 100 mililitres. He described the type of drip solution given to her as "totally inappropriate" to replace the fluid she had lost and maintain her levels. "I think Lucy effectively died in the Erne Hospital and I think the cause of death was acute cerebral oedema," he told the coroner. In Dr. Sumner's opinion the underlying cause was hyponatraemia arising from the intravenous fluid treatment. He said acute gastroenteritis must have been a contributing factor. Dr. Sumner said that, apart from a few small differences, his findings were in agreement with those of three other doctors who examined the case. He was asked if he was aware of other children having died as a result of poor fluid management. He replied: "I know several other cases where this was a very likely part of the mortality." The court heard that the death of Raychel Ferguson, 14 months after Lucy, led to the drawing up of a protocol to remind doctors and medical staff of the potential risk of hyponatraemia to children on drips. He agreed with a suggestion from Mr. Brian Fee, a barrister representing the Crawford family, that the wrong fluid was given at the wrong rate. "I think they were both fundamental errors," he stated. Mr. Fee asked if the combination of these two fundamental errors put Lucy on a course for catastrophe, and that catastrophic event occurred while she was still at the Erne Hospital. "Yes," replied Dr. Sumner. Mr. Fee suggested that at 3am a third "fundamental error" was made when Lucy's drip was changed to a normal saline solution and it was allowed to flow freely. Dr. Sumner said free flowing drips should not be given to children. "That should never be allowed to happen," he stated. In his opinion it only exacerbated the situation. Dr. Peter Crean, a consultant paediatric anaesthetist at the Royal Belfast Hospital for Sick Children, gave evidence that Lucy was admitted from the Erne in the early hours of Thursday, April 13, 2000, and died the following day. The coroner asked if Lucy was a "very, very ill wee girl" when she arrived at the Royal and what the prognosis was. Dr. Crean replied: "I felt there was really no chance." He said that when she was admitted to the Erne her sodium reading was 137 which was within normal limits but by 3am had dropped to "a low" 127. His cause for concern was the rate at which it had dropped. "It would certainly raise alarm bells," he stated. Before leaving the Erne her pupils were dilated and unresponsive. "That indicated some form of catastrophic event in the brain. I certainly feel the situation was not retrievable at that time," he stated. He pointed out that there was often little warning that something adverse was happening to a child and that their condition can deteriorate very rapidly. "Managing young children like this can be very difficult," he stressed. "I think if Lucy's fluids had been managed in a different way maybe the outcome would have been different," said Dr. Crean. Mr. Fee, instructed by Mr. Kevin Murnaghan, expressed the gratitude of the Crawford family to Dr. Crean and the medical staff at the Royal for the "professional and compassionate way" they were dealt with. Mr. Fee suggested that the wrong fluid was given to Lucy. Dr. Crean said it was wrong in that it was difficult to use one fluid generally. In order to reduce the risk of hyponatraemia fluids should be tailored to meet the needs of the individual patient and their progress should be monitored. He suggested the use of two fluids, one to replace losses and the other to maintain levels, would have been appropriate. Mr. Fee suggested she was given the wrong dosage. Dr. Crean replied: "I would have managed things differently and I would agree that it was an inappropriate fluid. It was wrong to use No. 18 for both maintenance and replacement." The inquest continues.

Parents shocked by doctor's silence over baby's death

The parents of a 17-month-old baby girl who died because of errors in her treatment at the Erne Hospital have expressed astonishment that the doctor in charge of their daughter's care refused to give evidence at her inquest.

Neville and Mae Crawford, from [redacted] had hoped Dr. Jarleth O'Donaghue, a consultant paediatrician at the Erne, would have provided answers about the death of their daughter Lucy. She was admitted to the Children's Ward with gastro-enteritis and was put on a drip to replace the fluid she had lost through vomiting and diarrhoea. The coroner, Mr. John Leckey, found that Lucy died because she was given an excessive amount of fluid, causing her brain to swell, resulting in her death.

The coroner said the collapse which led to her death was "a direct consequence of an inappropriate fluid replacement therapy" in that the wrong fluid was used, she was given too much of it and at the wrong rate of infusion.

"This led to the development of dilutional hyponatraemia which in turn caused acute brain swelling and death," he stated.

"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," the coroner added.

In a statement issued through their solicitor, Mr. Kevin Murnaghan, the Crawfords thanked the coroner for his thorough investigation of the circumstances of Lucy's death.

Mr. Murnaghan said: "After being told by Sperrin Lakeland Trust that the care provided to Lucy was not inadequate or poor quality they now know that she died as a direct consequence of the treatment she received during a few hours in the Trust's care at the Erne Hospital in Enniskillen. In spite of this fact and the finding of the coroner they have still not

received an acknowledgement from the Trust that it was responsible for Lucy's death.

"They are astonished that Dr. O'Donaghue, who was in charge of Lucy's care, refused to come forward, give evidence and answer questions at the inquest today," said Mr. Murnaghan.

"Mr. and Mrs. Crawford's pain at the loss of their daughter is compounded by the knowledge that her death was unnecessary and could easily have been avoided," he stated.

Reacting to the inquest finding the Trust stated: "This is undoubtedly a tragedy for the Crawford family - nobody can under-estimate the grief experienced from the loss of a child. As an organisation dedicated to caring for people, we regret our part in this tragedy.

"Practice today at the Erne Hospital is different from the time of Lucy's death in April 2000, almost four years ago," it stated.

It said changes were introduced following the inquest on Raychel Ferguson who died in similar circumstances over a year after Lucy, in June 2001.

"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," it stated.

"The Trust will be carefully reflecting on the conclusions of the coroner and ensure that our Trust and others learn the lessons of this tragic case," it added.

Dr. O'Donaghue was to have been the final witness at Lucy's inquest but his legal representative sought an adjournment so that she could take instructions from him as he had his professional reputation to consider.

Mr. Brian Fee, the barrister representing Mr. and Mrs. Crawford, opposed the application, pointing out that Dr. O'Donaghue had the Sperrin Lakeland Trust's legal representative available to him in court. He said the inquest had been an "on-going nightmare" for the Crawford family and the prospect of even a short adjournment would be a wholly repugnant prospect. The coroner accepted what Mr. Fee said about it having been a lengthy ordeal for the Crawford family and agreed that for him to grant an adjournment would not be fair to them.

"It's not in the interests of justice that the matter be adjourned," he added.

He pointed out that under the rules of a coroner's court no witness is obliged to answer any question which appears to prejudice him or her.

Dr. O'Donaghue's legal representative said her advice would be for him not to give evidence.

After announcing his findings in the case the coroner asked the legal representatives if there was any person or body they felt he should write to in order to prevent further deaths of a similar nature.

Mr. Fee submitted that there was clear evidence that Lucy received "fairly abysmal" care at the Erne Hospital. This was very much compounded by the failure of the Sperrin Lakeland Trust to recognise that mistakes were made and lessons had to be learned to prevent the recurrence of such tragedies.

He pointed out that a year after Lucy's death the Trust wrote to Mr. and Mrs. Crawford stating that an independent review indicated there was no evidence of a lack of quality of care in Lucy's case. That was difficult to understand, given the evidence presented at her inquest.

The coroner agreed. He expressed concern at how the Trust's review came to a conclusion which was at such variance to the expert medical evidence.

Mr. Fee said that over the four years since Lucy's death her family had persistently tried to get an answer to a relatively simple question: What caused Lucy's death?

They had been given no satisfactory answer whatsoever. He said a civil court action taken by Mr. and Mrs. Crawford had been another opportunity to ascertain if the Trust had learned the lesson and taken steps to ensure this would not happen again. Almost four years later the Trust decided not to contest liability. That was a "long way short" of saying Lucy died for the reasons outlined by the coroner. The first admission by anyone employed by the Trust was the candid evidence of Dr. Tom Auterson, the consultant anaesthetist at the Erne, who was called in to try and resuscitate Lucy when she stopped breathing.

Dr. Auterson had agreed that her treatment was "not up to standard" and that "too much fluid was given."

Mr. Fee suggested that the case might be of assistance to the Chief Medical Officer on the basis that, the more information available, the better equipped to ensure such things do not happen again.

He said the Crawfords did not want any other parents to go through what they have gone through. Their interest in this was not born out of any sense of vindictiveness or revenge but of a desire to ensure that the mistakes which led to Lucy's death are not repeated.

He suggested it might also be an appropriate case to refer to the General Medical Council. He said they were not making any pre-judgements but felt the Council might be interested in the case and in ensuring it does not happen again.

Mr. Fee said the third possibility was that the papers could be referred to the Department of Public Prosecution. However, Mr. and Mrs. Crawford were entirely happy to leave that decision to the coroner. They had no desire for the vindictive pursuit on anyone or for revenge.

In conclusion he said the Crawford family were strongly of the view that the findings should be sent to the Chief Medical Officer and the General Medical Council.

The coroner agreed. He said that while the "much praised protocol" on hyponatraemia, highlighting the potential dangers to children on drips, had been widely circulated, the Chief Medical Officer might glean some additional material from Lucy's case.

He said he did not propose to send the inquest papers to the DPP.

In his concluding remarks the coroner said he was indebted to Mr. Stanley Millar, chief officer of the Western Health and Social Services Council, for drawing the circumstances of Lucy's death to his attention. Had it not been for Mr. Millar's intervention he did not believe there would have been a proper investigation of her death. He hoped the inquest would go a long way to answer the questions of Mr. and Mrs. Crawford.

The coroner expressed his gratitude to the witnesses from the Erne Hospital who gave evidence, in particular Dr. Auterson. "I hope very much no other child will die in the same circumstances as Lucy," he stated.

He said he hoped the protocol on hyponatraemia would remain prominently displayed in hospitals and be an on-going subject of discussion among medical staff.

Extending his sympathy to Mr. and Mrs. Crawford at the end of the inquest, the coroner stated: "I'm sure the last three days have been a harrowing ordeal."

Mum blames hospital Trust for baby's death

A mother whose 17-month-old baby girl died after medical staff at the Erne Hospital made "fundamental errors" in her treatment has blamed the Sperrin Lakeland Health and Social Care Trust for her daughter's death. Mrs. Mae Crawford, from [redacted] also accuses the Trust of attempting to "brush Lucy's death under the carpet." Baby Lucy Crawford had gastroenteritis, an acute viral infection of the stomach and intestine, which caused her to vomit and gave her diarrhoea. As a result she became dehydrated. It was when she was admitted to the Erne and put on a drip to replace the fluids she had lost that fatal mistakes were made. Staff failed to properly manage her fluid level and she died from the resulting swelling of her brain. The court heard that "fundamental errors" lead to her death. The wrong type of drip fluid was used and the wrong dose was given. Staff also failed to follow "good practice" in that they failed to keep records including the "absolutely mandatory" writing down of clear and specific instructions as to what drip was to be used and at what rate. Lessons were not learned. Just over a year later a nine-year-old girl died in the Altnagelvin Hospital in Derry. As a result of her death a protocol was issued advising medical staff of the potential risks to children on drips, pointing out that the consequences can be extremely serious. Mrs. Crawford gave evidence that Lucy was born at the Erne on November 5, 1998. On Tuesday, April 11, 2000, she became ill and vomited. She was taken to see her GP, Dr. Graham, at Enniskillen Health Centre. He examined her and said he could see nothing wrong and there was nothing to worry about. However, the following evening Lucy was running a temperature so her parents took her to the Westdoc Out of Hours surgery on the Tempo Road in Enniskillen where she was examined by Dr. Aisling Kirby, from Derrylin. Dr. Kirby advised them to take Lucy to the Erne as she was low on fluid and needed a drip. She assured them there was nothing to worry about. Lucy was admitted to the Children's Ward around 7.20pm and was examined by Dr. Malik. He mentioned that there was a lot of gastroenteritis around. He looked for veins in Lucy's hands and foot and tried unsuccessfully 11 times to get an intravenous line inserted. Mrs. Crawford said she expressed concerns because Lucy was not responding. She asked for blood tests to be carried out but was told by Staff Nurse Brid Swift that the laboratory was closed and it would be morning before any tests would be checked. Dr. O'Donohoe arrived and inserted a drip into Lucy's right hand. It was approximately 10.30pm. Around 11pm Lucy was still not responding and was staring blankly. Her

mother asked Dr. Malik to check her eyes. He shone a pen light into them and said she was OK. "That was the last time Lucy was seen by a doctor until 3am," stated Mrs. Crawford. Around 12.15am Lucy became a little restless and was sick. Mrs. Crawford cleaned her up and she fell asleep. At 2.15am Lucy had a bowel movement which "frightened" her mother. It was runny, green and foul smelling. Nurse Teresa McCaffrey said they would move her into a side ward because of the risk of infection to other patients. Just before 3am Lucy moaned and started to breathe loudly. "Her body twitched, her eyes were flickering, her body rigid and I noticed that her hands were clenching backwards and tight fisted. I called her by name and tried to open her hands but could not. I rang the bell but no-one came. I left the side ward and shouted up the ward," explained Mrs. Crawford. "I lifted Lucy but she did not respond to me," she added. Dr. Malik, Dr. O'Donohoe and a Dr. Auterson, a consultant anaesthetist, came into the room. They did not seem to have the necessary equipment to hand to treat Lucy. Nurses ran to get the equipment but did not seem to know what Dr. Auterson was looking for. "Dr. Auterson was obviously frustrated and said he needed a smaller line. He then, in no uncertain terms, told me to get out of the room," said Mrs. Crawford. At 3.35am Sister Edmundson told them they were moving Lucy to the Intensive Care Ward. Around 5.30am a nurse came and told them Lucy was being transferred to the Royal Belfast Hospital for Sick Children in Belfast. They asked if their daughter could be air-lifted to the Royal but were told this did not happen. Around 6.40am Dr. O'Donohoe and a nurse left with Lucy in an ambulance for Belfast. Mrs. Crawford was not allowed to travel with her. She and her husband went in their own car. At 10am the doctors at the Royal spoke to them and said Lucy's condition was very serious. "They did not give us any hope. They said that they could do nothing with a dead baby," stated Mrs. Crawford. She said Dr. Peter Crean expressed "anger and frustration" that Lucy's notes had still not arrived from Enniskillen. The following day, Friday, April 14, they were told that brain stem tests had proved negative and there was no alternative but to take Lucy off the ventilator. She was taken off the ventilator at 1pm. Mrs. Crawford said they met with Dr. O'Donohoe a month later but he was unable to answer their questions about Lucy's death. They then complained to the Sperrin Lakeland Health and Social Care Trust. They subsequently received a letter from the Trust stating that "the outcome of our review has not suggested that the care provided to Lucy was inadequate or of poor quality." Mrs. Crawford continued: "Looking back we feel we were not listened to and side-lined in every way. It always seemed that everyone was avoiding the most important issue: What happened to Lucy? As of today we still have not received an explanation from the Sperrin Lakeland Health and Social Care Trust or any of its employees as to what did happen to Lucy or what caused her death. "We are all human, mistakes are made, apologies are given and appropriate measures are put in place to ensure such events never recur. Instead we feel the Sperrin Lakeland Health and Social Care Trust have tried to brush Lucy's death under the carpet. "We feel our little girl, Lucy, was totally let down by the Sperrin Lakeland Health and Social Care Trust. Lucy had been placed in their care and they were responsible for her. We feel that the acts and omissions of the Trust caused Lucy's death. We feel that the acts and omissions of the Trust since Lucy's death have caused us greater pain and suffering. The Trust has not been able to deal appropriately with the consequences of Lucy's death. In this instance what is supposed to be the 'caring profession' have in my book become the 'uncaring' profession," she added. She said Lucy's death had had a "profound, debilitating and devastating effect" on the family. "Lucy was a very special little girl and important member of our family. We miss her terribly. "I wish it to be made known that I hold the Sperrin Lakeland Health and Social Care Trust wholly accountable and fully responsible for Lucy's death," stated Mrs. Crawford.