Young, Christine

From: Mulhern, Kevin
Sent: 08 April 2004 10:37
To: Campbell, Dr Henrietta; Carson, Ian; McCarthy, Miriam; Gowdy, Clive; Shannon, Colm
Subject: Impartial Reporter story: 08.04.04 - Lucy Crawford

For Information

Lucy: Minister backs Coroner

The Health Minister has issued a statement accepting the Coroner's findings on the death of 17-month-old, Lucy Crawford. The little girl from [redacted] died four years ago. But it wasn't until February this year that an inquest found that "fundamental errors" at the Erne Hospital led to her death. Health Minister, Angela Smyth told the Impartial Reporter this week that she "fully accepts the Coroner's verdict" and she expressed sympathy with Mae and Neville Crawford, from Letterbreen. However, vital questions remain and it seems that answers are being wrought bit by bit from those in authority. The Minister's spokesman said she was "not available" for a one-to-one interview, and a list of questions we forwarded to her were far from fully dealt with in her statement. The Sperrin Lakeland Trust has now slammed the door firmly shut in the face of our inquiries. In this newspaper last week, the Chief Executive of the Sperrin Lakeland Trust, Mr Hugh Mills finally admitted that the Trust was responsible for Lucy's death. He wrote to the Crawfords last week requesting a meeting, and sent them a copy of the report by Dr. Murray Quinn, part of the Trust's internal review. This report was received by the Trust in June 2000, but was kept from the family despite a number of requests to release it to them. Following the interview with Mr. Mills last week, it was released to the family, a few days before the fourth anniversary of Lucy's death. Several parts of it are giving the Crawfords major cause for concern. In his covering letter, Mr Mills refers to it being "based on medical knowledge at the time." This continues to prompt the Crawfords to ask if Mr. Mills fully accepts the Coroner's findings or not. Most alarmingly, the Quinn report says: "I find it difficult to be totally certain as to what occurred to Lucy in and around 3a.m., or indeed what the ultimate cause of her cerebral oedema was." This week, we sent a list of questions to the Trust as a follow-up to the release of the Quinn report. Despite the fact that there is substantially little different to the circumstances of our interview of lastweek, this week the Trust officers say it would be "inappropriate to comment." The Trust statement says in full: "The Sperrin Lakeland Health and Social Care Trust wishes to restate that changes in clinical practice were introduced in 2001 ahead of regional guidelines on fluid replacement therapy issued by the Chief Medical Officer. "In response to your list of queries, can we assure you that the Trust is co-operating with the referral of the inquest findings by the Coroner to the General Medical Council and Chief Medical Officer. A further offer has been made to Mr. and Mrs. Crawford to meet with Trust officers. "As the examination by the above bodies is ongoing and the Trust is reviewing the lessons learned from its handling of the case, the Trust do not consider it appropriate to comment further at this time." The Trust has reverted to type, refusing to give answers about Lucy Crawford. As far as the Minister is concerned, we also sent a list of questions to her concerning the case. Her statement, in full, reads: "I would like to express my deepest sympathy to the parents and family of Lucy Crawford. "I am satisfied that the cause of Lucy's death has been properly and comprehensively investigated and I fully accept the coroner's verdict on the cause of death. In his deliberations the coroner did not see a need to refer the case to the Director of Public Prosecution. He did, however, refer inquest papers to the General Medical Council, which is responsible for the registration of medical practitioners, and I await the findings of the General Medical Council in due course. "Dr. Henrietta Campbell, the Chief Medical Officer, issued guidance on the prevention of hyponatraemia in 2002. This guidance provides very practical advice for doctors and nurses who manage the care of children in hospital. "It has been commended by both local clinicians, and by expert witnesses who gave evidence at Lucy's inquest. Following the inquest into Lucy's death the Coroner wrote to the Chief Medical Officer asking her to consider if any changes are required to the current guidance. In response, Dr. Campbell has engaged 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. "Under Clinical Governance arrangements introduced last year, my Department is strengthening the systems for quality assurance within Trusts. "Specifically, work is underway to improve the mechanism for reporting andinvestigating untoward incidents and to ensure the maintenance of good medical record keeping. This latter area was found to be seriously lacking in Lucy Crawford's case and a major lesson learned from this tragic case was the importance of accurate record keeping. "The lessons learned since Lucy's death and the action taken to inform health professionals should prevent a similar tragedy from occurring in the future. "My Department will continue to work to ensure that all patients receive high quality care throughout the health service." Although at least the Minister is making a personal statement on the issue, many vital questions remain unanswered. The fact is, they need to be answered before full confidence can be restored in the Sperrin Lakeland Trust and its management of health services in this area.