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Series of errors led to Lucy's death

By Michael Breslin <mailto:m.breslin[redacted]>

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 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'.