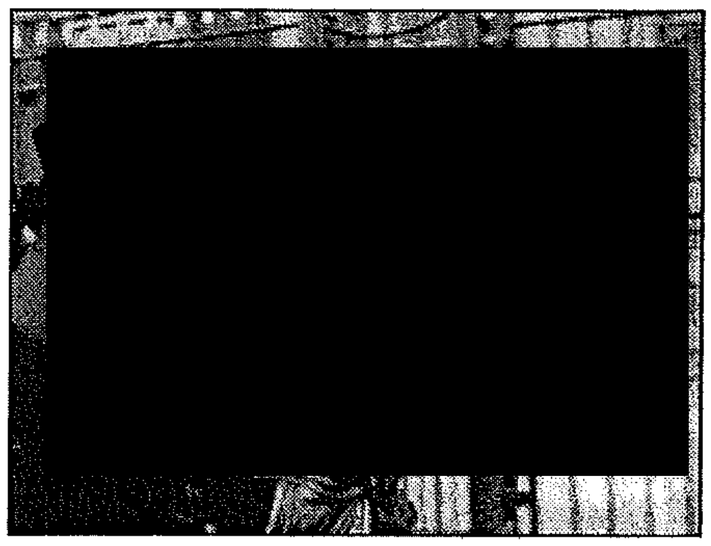
Parents shocked by doctor's silence over baby's death

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 Station Road, Letterbreen, 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.

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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."

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