



Trust to review Lucy case, again

The Sperrin Lakeland Trust says it has set up a steering group to review how it handled the case of Lucy Crawford, the 17-month-old baby who died as a result of mistakes at the Erne Hospital in April 2000.

Immediately after Lucy's death, the Trust held an internal review which has largely been discredited as nothing more than a whitewash.

As news of the latest review was released, the Impartial Reporter has learned that the General Medical Council has received a complaint alleging serious professional misconduct against the doctor in charge of Lucy's case, Dr. Jarleth O'Donaghue.

The pressure is clearly on the Sperrin Lakeland Trust to come up with answers; but there must already be serious doubts about how they can be trusted to investigate themselves again – having failed so clearly to do so in 2000.

And in a further twist, the Chief Medical Officer in Northern Ireland has confirmed that she was NOT informed about Lucy Crawford's death until 2003, the year AFTER she issued new guidelines on the dangers of hyponatraemia.

Lucy, the 17-month-old daughter of Neville and Mae Crawford, died in April 2000 as a result of "fundamental errors" at the Erne Hospital. An inquest this year found that Lucy died from hyponatraemia, brought on by the hospital's disastrous management of her drip.

Since the inquest revealed this in February, debate has raged not only about how this could have happened, but how Lucy's death was swept under the carpet in the Trust's investigation. The whole issue of accountability within the health service is under intense scrutiny.

The chairman of the Trust, Mr Harry Mullan, this week confirmed plans to undertake an analysis of aspects of the Trust's handling of the Lucy Crawford case. Mr Mullan said "Immediately following the inquest into Lucy's death, we stated we would be reflecting on the Coroner's conclusions. In the course of this reflection on how we, as an organisation, handled this tragic case, we recognised some flaws and areas where improvement was needed."

The Trust's move will be viewed as something of an admission that their original internal review failed to get at the truth, among other "flaws".

The terms of reference for the steering group have not been worked out yet; but questions will remain. Inevitably, how can the Trust investigate itself this time?

Setting out the draft terms of reference of the "root cause analysis", Mr Mullan emphasised the commitment of the Trust and its officers to reflect on how improvements could be made. "Our primary goal is to learn lessons and improve our practice. Additionally, where we identify process issues which have wider implications, we will want to inform the appropriate authorities," said Mr Mullan.

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Mrs Jenny Irvine, non-executive director for the Trust, will be chairing the

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steering group. She will be joined by Dr Diana Cody, the Trust's medical director and there will be representation on the group from the Western Health and Social Services Board. The first task for the steering group will be to agree the terms of reference for the work to be undertaken.

The steering group will be supported by a representative of the NHS Modernisation Agency Clinical Governance Support Team. A specialist independent consultancy firm will manage the use of the "root cause analysis" approach, and develop a report to the steering group on findings and recommendations. The steering group may also commission external opinion and advice.

It is anticipated that the exercise will take 4-6 months to complete, culminating in a report and recommendations from the steering group to the Trust's Clinical and Social Care Governance Committee for approval.

The Chief Medical Officer, Dr. Henrietta Campbell, is responsible for ensuring lessons are learned for the benefit of the population here, but in an interview with the Impartial Reporter, Dr. Campbell fails to allay fears on that score.

Among the points which emerge from Dr. Campbell's interview are:

The Royal Victoria Hospital in Belfast didn't fully realise the implications of how Lucy died.

New guidelines introduced in 2002 did not take into account the circumstances of her death.

Dr. Campbell fails to withdraw her belief that there could have been something "idiosyncratic" about Lucy which led to her death; this despite expert evidence to the contrary given at the inquest.

The CMO says it is "not her job" to investigate untoward deaths, and she has not "looked at" how the Sperrin Lakeland Trust investigated Lucy's death.

She believes the General Medical Council will consider the investigation. In fact, she is wrong; the GMC will only consider the allegations against individual doctors and NOT how the subsequent investigation was carried out.

In fact, the GMC does not have the powers to look at systems employed by a hospital trust or the quality of its investigation into an incident. They hold doctors' registrations, as in order to practice in the UK doctors have to be on the register, and the GMC examines allegations of serious professional misconduct.

The Impartial Reporter understands such a charge has been levelled against Dr. Jarlath O'Donaghue, rather than the quality of the investigation into the incident carried out by the Trust."

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