Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on TUESDAY the 17th day of FEBRUARY 2004, at inquest touching the death of LUCY CRAWFORD, before me MR. J L LECKEY Coroner for the District of GREATER BELFAST as follows to wit:-

The Deposition of MAE ELIZABETH CRAWFORD of [redacted] who being sworn upon her oath, saith

My daughter Lucy Crawford was born on 5th November 1998 at the Erne Hospital, Enniskillen. She was a healthy child.

On Tuesday 11th April 2000 Lucy had been left to our babyminder as normal while I went to work. At approximately 11.15am our babyminder rang me to work to tell me that Lucy had vomited. I left work at about midday and brought Lucy home. When I got home I telephoned our GP Dr. Graham and made an appointment for Lucy at 2.30pm. Lucy was sick twice on the journey to the Health Centre.

Dr. Graham examined Lucy and said that he couldn't see anything wrong and that there was nothing to worry about. I brought Lucy home again. She played a little with her toys. Although she refused milk at bedtime she slept all night.

On the morning of Wednesday 12th April 2000 I found Lucy standing up in her cot at about 7.45am. She seemed in reasonable form but we decided that Neville would stay home with Lucy. When I came home from work at approximately 1.00pm Lucy was lying on a Bean Bag in the sitting room. I checked Lucy's temperature and gave her a small drink. I gave Lucy some Calpol and she fell asleep. Later at approximately 3.15pm she took another small drink and sat on my knee.

At 6.00pm Lucy had a temperature of 100 degrees. I gave her another spoonful of Calpol and phoned the Out of Hours Service, Westdoc. I spoke with Dr. Kirby. She advised me to bring Lucy in. My husband, Neville left his work and met us at the Westdoc premises. Dr. Kirby examined Lucy at about 7.00pm and advised us to bring Lucy to Hospital, as she needed a drip. She assured us that there was nothing to worry about and that Lucy would be fine in the morning.

We arrived at the Erne Hospital at around 7.20pm where Lucy was admitted to the Children's Ward. We were shown to a cot but Lucy sat on my husband, Neville's knee.

Dr. Malik arrived and observed Lucy, while a nurse took Lucy's details, weighed her and attached a bag for a urine sample. We asked Dr. Malik to check her eyes. He shone a light into her eyes and said she was okay. At his request I carried Lucy into the treatment room. Dr. Malik commented that there was a lot of Gastroenteritis around. I told him that Lucy had no diarrhoea. He asked us who else in the house had gastroenteritis but I told him that no one had.

Dr. Malik put some anaesthetic cream on Lucy's hand and foot. I asked Neville to get Lucy a drink and he returned with some Juice. Nurse Swift took Lucy's temperature, which was 39.2°. Nurse Swift pricked Lucy's thumb for a sample. Meanwhile Dr. Malik looked for veins in Lucy's hands and foot. He tried unsuccessfully at least 11 times to connect into a vein. Nurse Swift and Dr. Malik did not seem alarmed. They chatted to each other about their weekend and Dr. Malik's trip to England. I voiced my concerns for Lucy because she was not crying and was floppy. I thought she was quite hot and asked for a thermometer to take her temperature again. It was still raised but Nurse Swift said she could not give her paracetamol until after the drip was inserted. Nurse Swift and Dr. Malik continued to talk among themselves. I indicated that I wanted bloods, etc. checked but I was told by Nurse Swift that it would be morning before any tests could be checked as the lab was closed. Eventually Dr. Malik muttered something to the effect that Lucy would have to go theatre to get the IV line inserted. He then left the room.

At approximately 8.50pm Dr. O'Donohoe arrived into the treatment room. He looked at Lucy and put on more anaesthetic cream. Dr. O'Donohoe left the room and returned a short time later with a bottle of glucose and a cup of juice. I gave Lucy the bottle and she drank all of it. Dr. O'Donohoe said that he would have to wait until the cream had taken effect. Neville then took Lucy and sat with her in the main waiting area of the Children's ward. On Dr. O'Donohoe's return, we brought Lucy back to the treatment room again. On his second attempt, Dr. O'Donohoe inserted a drip into Lucy's right hand. This was at approximately 10.30pm. Dr. O'Donohoe then left the ward.

Lucy was then given a paracetemol suppository and I carried her back to the cot, while Nurse Jones wheeled the drip counter and brought a cup of juice. Lucy was quiet and sleepy.

At about 11.00pm Lucy's older sister came in to the Children's Ward. I said to Lucy, "Look Lucy there's your sister". There was no response from Lucy, her eyes were staring as if she was looking through her, as if she did not know her big sister. We told a nurse about this but she said nothing. Dr. Malik arrived and we asked him to look at her eyes because they looked glassy. He shone his pen light into her eyes, said she was okay and walked away. This was the last time Lucy was seen by a Doctor until 3.00am.

Lucy closed her eyes and I thought she was sleeping. When Neville and my elder daughter left a nurse came over and said she was going to give me a bed opposite to rest in but that if they needed it during the night, I would have to rest in a chair. While she was doing this, Sister Edmundson came and spoke to me and then left. A Nurse came with a cup of tea for me and I sat on the edge of the bed and watched Lucy sleeping.

At about 12.15am on Thursday 13th April, 200 Lucy became a little restless. I sat her up and then she vomited. I took off her pyjama bottoms and cleaned her. I then walked up the ward to find a Nurse to ask for a clean sheet. Nurse Jones told me not to put pyjamas on Lucy. Lucy was sleeping.

At 2.15am Lucy had a bowel movement, which frightened me. It was runny, green and foul smelling. I rang the bell and Nurse McCaffrey came and helped me clean Lucy. I said to her "What on earth is that?" She said she didn't know and asked me if I had any nappies. Nurse McCaffrey was not alarmed. She took the nappy and its contents away and returned a few minutes later saying that Lucy was going to be moved into a side ward because of the risk of infection to the other patients in the ward. Lucy was sleeping again. Lucy and I were moved into a side ward at the end of the ward and left on our own. I was sitting watching her, she was quiet and sleeping.

Just before 3.00am, Lucy moaned a little and started to breath loudly for 3-4 breaths. 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 I could not. I rang the bell but no one came. I left the side ward and shouted up the ward.

Nurse McCaffrey appeared. She came to Lucy's door and shouted. I lifted Lucy but she did not respond to me. Nurse McManus and Nurse Jones came into the room with equipment and started to give Lucy oxygen. Nurse McCaffrey stood and did not know what to do. I asked what was wrong but no one answered me.

Dr. Malik then came into the room followed by Dr. O'Donohoe and Dr. Auterson. No-one told me what was happening. Neville and my elder daughter arrived. Dr. Auterson was trying to insert some equipment, a pipe or drain, but couldn't because he did not have the correct ones. Nurses were running to get what they didn't have on the trolleys, it seemed that they did not know what or recognise the name of the equipment that 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.

I sat outside the room with Neville, my elder daughter and my parents whom I had rung. There was a lot of commotion in and out of the room. Nurses were running with pieces of equipment, which had to be brought from other areas of the hospital. Sister Edmundson, who was on duty, arrived and I asked her what was happening. She said they were working with Lucy.

At 3.35am Sister Edmundson told us they were moving Lucy to the Intensive Care Ward. At no time did anyone approach us to tell us of Lucy's condition.

We sat around until 5.30am. A Nurse came and said they had stabilised Lucy and were sending her to the Royal Belfast Hospital for Sick Children for a scan. I said I wanted the scan to take place in Enniskillen but she told me that the Royal would be better able to treat Lucy. We went in to an office and asked Dr. Auterson and Dr. O'Donohoe how Lucy was. We asked that Lucy be airlifted to the Royal but we were told that this did not happen.

Dr. Auterson said Lucy would not be leaving the Erne Hospital, Enniskillen until 9.00am due to the fact there was no one to cover him. We were not happy about this and asked for him to ring another doctor who was on leave, but he said he could not

do this. Dr. Auterson was my Anaesthetist when Lucy was born by Caesarean Section 17 months earlier.

Dr. Auterson then made a phone call and we were then told that Dr. O'Donohoe would accompany Lucy in the ambulance to Belfast and they would be leaving shortly. Lucy, Dr. O'Donohoe and a nurse left in the ambulance at 6.40am. I was not allowed to travel with Lucy in the ambulance.

We travelled to the Royal in our own car. At about 10.00am the Doctors spoke to us frankly and compassionately. They explained that Lucy's condition was very serious. They did not give us any hope. They said that they could do nothing with a dead baby. Dr. Crean expressed his anger and frustration that Lucy's notes had still not come through from the Erne Hospital in Enniskillen. Unfortunately Lucy's condition did not improve through the day. At about 6.00pm Dr. Hanrahan explained they would carry out Brain Stem tests the next morning.

On Friday 14th April 2000 Dr. Hanrahan and Dr Chisakuta brought us in to their office after they had carried out the tests and told us they were negative. They advised us that they had no alternative but to take Lucy off the ventilator and she was taken off at about 1.00pm.

Dr. Hanrahan told us that we should seek answers from the Erne as to what had happened to Lucy.

My husband and I met Dr O'Donohoe in May 2000, one month after Lucy's death. We asked him various questions surrounding Lucy's death. He said 'he did not know' or 'did not understand it'. Dr O'Donohoe did not have Lucy's notes with him. He said he had given them to Dr Kelly to check. We were left feeling totally deflated and in the dark surrounding the circumstances in which Lucy died.

We then contacted the Western Health and Social Services Council and worked with Mr Stanley Millar, the Chief Officer at the time. We invoked the Sperrin Lakeland Health & Social Care Trust complaint procedure by letter dated 22nd September 2000. We were told by Mr Millar that we would be provided with a written explanation of what happened within twenty days. We received a letter dated 30th March 2001 from the Chief Executive of the Sperrin Lakeland Health & Social Care Trust stating that 'the outcome of our review has not suggested that the care provided to Lucy was inadequate or of poor quality'.

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 & Social Care Trust or any of its employees as to what did happen to Lucy or what caused her death.

We had high hopes that the complaint procedure would provide us with the answers. As a result of the unsatisfactory nature of the outcome we felt that we had no alternative to instruct our Solicitor, Mr Murnaghan, who has worked tirelessly for us three and half years.

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 & Social Care Trust have tried to brush Lucy's death under the carpet. We feel that doors have been firmly shut in our faces and swung open only to provide information when required as a result of legal action.

We feel our little girl, Lucy was totally let down by the Sperrin Lakeland Health & 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'.

Lucy's death has had a profound, debilitating and devastating affect on her sister, brother, father and myself. 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 & Social Care Trust wholly accountable and fully responsible for Lucy's death.

Whilst the ventilator and tubes were disconnected in the Royal Belfast Hospital for Sick Children on Friday 14th April, 2000, my little girl died in a side room in the children's ward of the Erne Hospital, Enniskillen on Wednesday 12th April, 2000.

We were never given the underlying cause of the cerebral edema.

Mr. Good: I felt Hurst Swift and Dr. Malik were not concentrating on Lucy. I later became aware that the Lab was open during the night. At time there were a number of people in the side-room where Lucy was. The nurses could not locate certain equipment and Dr. Anderson became very frustrated. At no stage did the nursing staff tell us what was going on. They were very busy.

Mr. Fee: After Lucy's death I attempted to find out what happened. I received the conclusions of the Review the Trust later carried out. A Mr. Quinn & Altnaglvin was asked to make an assessment. A copy of their report was not provided. We instructed Dr. Evans & Swanson to prepare a report

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day

of 20 , at inquest touching the death of

, before me

Coroner for the District of

as follows to wit:—

The Deposition of MAE ELIZABETH CRAWFORD

of *(Address)*

who being sworn upon h[illegible] oath, saith

He was our expert in relation to civil proceedings. No explanation of Lucy's death was ever provided. The civil proceedings were settled. M. Crawford.

P.T.O.

TAKEN before me this 17th day of February 2004

Coroner for the District of Greater Belfast

We were never given the underlying cause of the Cerebral Oedema.

Mr Good: I felt Nurse Swift and Dr.Malik were not concentrating on Lucy. I later became aware that the lab was open during the night. At times there were a number of people in the side-room where Lucy was. The nurses could not locate certain equipment and Dr Auterson became very frustrated. At no stage did the nursing staff tell us what was going on. They were very busy.

Mr Fee: After Lucy's death I attempted to find out what happened. I received the conclusions of the review the Trust later carried out. A Mr Quinn of Altnagelvin was asked to make an assessment. A copy of that report was not provided. We instructed Dr Evans of Swansea to prepare a report. He was an expert in relation to civil proceedings. No explanation of Lucy's death was ever provided. The civil proceedings were settled.