

Marie Dunne - Commun. Mgr

From: Marie Dunne - Commun. Mgr Sent: 22 October 2004 10:12

To: Stella Burnside - Chief Executive; Geoff Nesbitt - Anaesthetists; Irene Duddy - Dir of

Nursing; Theresa Brown - Risk Management

Subject: FW: impartial reporter story

Importance: High

Hi - I just opened this.

Marie

----Original Message----

From: Baxter, Clare [mailto:Clare.Baxter(

Sent: 21 October 2004 17:49

To: Marie Dunne - Commun. Mgr; Hall Janet (E-mail); Jo McGinley (E-mail)

Subject: FW: impartial reporter story

Hi all, here's a story which appeared yesterday in the Impartial Reporter janet I'm sure you've already seen it!). We have been asked by UTV for an interview with the Minister and will be preparing a statement on Friday morning. Will be in touch tomorrow.

Clare

> death of Lucy Crawford.

> The paediatrician, who now lives and works in the south of England, says > he came on duty the morning after Lucy had been transferred to the Royal > Victoria Hospital in April 2000, and soon realised what had gone wrong.

> It emerged this year that mistakes at the Erne before she was transferred in the middle of the night caused Lucy's death.

> But a former doctor now claims that from the very day that Lucy died, the > Enniskillen hospital knew what had gone wrong and immediately began a > cover-up.

> Tonight, UTV will broadcast an "Insight" special, called "When Hospitals > Kill", an hour-long special investigation into the deaths of at least > three children in Northern Ireland from hyponatraemia.

> The Impartial Reporter understands that part of the programme will feature > the story of the doctor who says he was forced out.

> The Impartial Reporter has also interviewed this doctor on two occasions; > once at his Enniskillen home, surrounded by boxes packed with the family's > possessions awaiting their move, and also at the hospital where he now > works in the south of England.

> "We did not want to move, we loved it in Enniskillen," he said. "But it > was very traumatic for me. I was forced to move out."

> The doctor agreed to speak to the Impartial Reporter on the basis that we > did not identify him.

> He said he came on duty on children's ward the morning Lucy died. The

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> staff were upset and talking about the incident.
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 > But what really alarmed the doctor was when one nurse said: "She was dead
 > anyway, but they sent her to the Royal to save their own skins."
 > The doctor examined Lucy's notes and said he realised immediately that the
 > drip was to blame. What had killed Lucy was the amount of fluid and the
 > rate at which it was pumped into her body. The doctor recognised this on
 > the day, and his opinion was vindicated at this year's inquest.
 > Later the doctor met a junior colleague (a fellow-countryman from
 > Pakistan) who had helped treat Lucy, and was now upset as he felt he was
 > being bullied into joining the cover-up.
 > The doctor told us he detailed all his concerns in a letter, which he
 > handed to Mr Hugh Mills, Chief Executive of the Sperrin Lakeland Trust in
 > June 2000.
 > The doctor believes his attempts to blow the whistle ultimately cost him
 > his job at the Erne. He claims he was soon cold-shouldered by colleagues
 > and eventually asked for an investigation into internal relationships,
 > which was facilitated by the Royal College of Surgeons.
 > The report they produced was given to the Trust, but never shared with the
 > doctor who made the complaint.
> He continued to work at the Erne, but says he found it intolerable; he
> suffered depression and lack of sleep, and eventually decided to move his
 > family to England.
> We have asked Mr Mills, through the Trust, what happened to the letter he
> was given in June 2000, and why the Royal College report was not shared.
> The Trust replied with the following statement:
> "The Trust takes seriously all concerns raised by staff. Those identified
> by Dr ***** were fully addressed, with the advice and guidance of the
> Royal College of Paediatricians, and feedback provided."
> However, it would seem that the serious concerns he expressed in June 2000
> did not form any part of the internal investigation by the Trust, which
> relied instead on a now-discredited report from another paediatrician from
> the Western Board area.
> Tonight's programme, "When Hospitals Kill" studies the case of three
> children in Northern Ireland who died from hyponatraemia, the term for the
  swelling of the brain cause by mismanagement of fluid.
> A boy called Adam Strain died at the Royal in 1996, but his mother
> received compensation on condition that she was gagged from talking about
> the case. Four years later, Lucy died from the same condition, but at
> first the cause of her death was wrongly given as gastroenteritis.
> The following year, 2001, another girl, Raychel Ferguson, died at the
> Althagelvin Hospital in Derry.
> Last night UTV broadcast a trail which said they would expose a
> "cover-up".
> At the inquests of all three children, expert evidence was given by Dr
> Edward Sumner, consultant paediatric anaesthetist at the renowned Great
> Ormond Street Hospital in London.
> The Impartial Reporter has also met Dr Sumner, and he told us he believed
> that none of the three children should have died.
> A common theme from the parents of all three children is that they would
> have been comforted if lessons had been learned from their tragedy to
> avoid further deaths.
> The Impartial Reporter has also learned that the death of another child,
> AFTER Lucy Crawford's is being investigated after a member of the hospital
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> staff sent the family an anonymous letter. > It also seems that even after at least these three deaths, leading health > figures in Northern Ireland have not fully grasped the implications of the > hyponatraemia. -> The Chief Medical Officer, Dr Henrietta Campbell commented earlier this > year that "the rarity in these two events was the abnormal reaction which > is seen in very few children." > > However, this is in complete contradic tion of the finding of the Coroner > for Greater Belfast, John Leckey, when he conducted the inquests into the > deaths of the children. Incoming Mail Disclaimer Althagelvin Hospital HSS Trust may monitor the content of emails sent and received via its network for the purposes of ensuring compliance with its policies and procedures. Ext. For support please contact I.T. Department; Email IT