SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

BRIEFING REGARDING THE LATE LUCY CRAWFORD

Lucy was referred for admission to the Children's Ward, Erne Hospital by the on-call General Practitioner, Dr Kirby, with a history of fever, vomiting and drowsiness on 12 April 2000 at 7.30pm.

She was commenced on IV Fluids at approximately 11.00pm/ Lucy was moved to a side ward later, following a bout of diarrhoea. At about 2.55am on 13 April 2000 Lucy's mother alerted staff to her observations that Lucy appeared to be having a fit.

Medical staff, at the Erne Hospital, were involved in an attempt to stabilise Lucy. She was transferred to the ICU/HDU at the Erne Hospital while transfer was arranged to the Paediatric Intensive Unit at Royal Belfast Hospital for Sick Children. Lucy's transfer was managed by a Consultant Anaesthetist and an ICU Nurse from the Erne Hospital. Lucy left the Erne Hospital at around 6.30am, arriving at Belfast after 8.00am on 13 April 2000.

Following a period of care, at the Royal Hospital, Lucy was extubated at 1.00pm on 14 April 2000 and died at around 1.15pm on the same day.

Following Lucy's death, Dr O'Donohoe, Consultant Paediatrician, advised Dr Kelly, Medical Director, Sperrin Lakeland Trust, ~~who in turn~~ advised Mr Mills, Chief Executive and Mr Fee, Director of Acute Hospital Services, requesting that Mr Fee establish a review of Lucy's care at the Erne Hospital. Later on 14 April 2000 Mr Fee agreed to jointly co-ordinate this review with Dr Anderson, Clinical Director of Women & Children's Services. The review included a case note review; ~~and~~ review of written comment from staff involved in Lucy's care; discussions with other relevant staff; an opinion on specific matters from Dr Quinn, Consultant Paediatrician, Altnagelvin Trust, ~~considering the outcome of the hospital post mortem and a discussion with Dr Quinn~~. Dr Quinn ~~opinion~~ in his report expressed the opinion that the fluids used in the treatment of Lucy had not adversely contributed to ~~her~~ her condition. Additionally the hospital post mortem did not indicate any difficulty with the fluids used.

A report on this review was finalised on 31 July 2000.

The Trust concluded that there had been communication difficulties which had resulted in poor recording of the prescribed volume of fluid. Clinical care had not been found to be sub standard.

Dr O'Donohoe had met with the family during May 2000. There was ~~a number of~~ correspondence between the Trust, the Crawford family and the Chair of the Western Health & Social Services Council. In the correspondence the Trust had encouraged the family to participate in a further meeting with Trust staff so that the findings of the review, based on the information available, at that time, could be shared. These offers were declined.

On 10 January 2001, Mr MacCrossan wrote to Mrs Crawford, on behalf of Mr Mills, Chief Executive, enclosing a report prepared by Mr Fee, Director of Acute Hospital Services in relation to Lucy's care, again encouraging the family to participate in a meeting to discuss the facts, as known.

This was followed up with a further offer of a meeting in a letter from Mr Mills to Mrs Crawford on 30 March 2001. To date no such meeting has been accepted by the family.

At this stage staff from the Trust have participated in 2 days of the Coroner's Inquest, conducted by Mr Leckey, and await the conclusions of the Inquest to see what additional lessons can be learned from Lucy's tragic death beyond those identified in Dr Anderson's & Mr Fee's review.

The family subsequently instigated legal proceedings, which ~~resulted in litigation~~ resulted in an out of court settlement in December 2003. An aspect of the settlement was an acceptance by the Trust of its culpability in the matter. During the course of the legal proceedings the Trust became aware that the Coroner had indicated his intention to open a fresh case for an inquest (Prior to this the death certificate had been signed by the coroners office) Additionally the inquest of Rachel Erguson resulted in questions being asked by the CMO regarding the causes of the use of the paediatric fluids used. This practice was changed with the Trust in 2001.