



## REVIEW OF THE LATE LUCY CRAWFORD CASE

### INFORMATION & BACKGROUND

This Review into the care and progress of Lucy's condition was conducted by Dr Anderson, Clinical Director, Women & Children's Directorate and Mr Fee, Director of Acute Hospital Services.

This Review was initiated because of the sudden and unexpected outcome of Lucy's condition and was in keeping with the Trust's developing arrangements for the Review of such cases as part of its Clinical and Social Governance arrangements.

Lucy's death and the circumstances around her stay at the Erne Hospital was notified to Dr Kelly, Medical Director on Friday 14 April 2000 by Dr O'Donohoe, Consultant Paediatrician.

The Review involved an examination of Lucy's casenotes, receiving and reviewing comments/reports from those involved in Lucy's care and an examination of the casenotes and a discussion with Dr Quinn, Consultant Paediatrician, Altnagelvin Hospital. The Review has also considered comments from Sr Traynor, Mrs Martin, Infection Control Nurse and Post Mortem Report.

### PURPOSE OF REVIEW

The main purpose of the review was to trace the progression of Lucy's illness from her admission to the Erne Hospital and her treatments/interventions in order to try and establish whether:

- a) There is any connection between our activities and actions, and the progression and outcome of Lucy's condition
- b) Whether or not there was any omission in our actions and treatments which may have influenced the progression and outcome of Lucy's condition
- c) Whether or not there are any features of our contribution to care in this case which may suggest the need for change in our approach to the care of patients within the Paediatric Department or wider hospital generally

### FINDINGS

Lucy Crawford was admitted to the Children's Ward, Erne Hospital on 12 April 2000 at approximately 7.30pm having been referred by her General Practitioner. The history given was one of 2 days fever, vomiting and passing smelly urine. The General Practitioner's impression was that Lucy was possibly suffering from a urinary tract infection. The patient was examined by Dr Malik, Senior House Officer, Paediatrics, who made a provisional diagnosis of viral illness. She was admitted for investigation and administration of IV fluids. Lucy was considered to be no more or less ill than many children admitted to this department. Neither the postmortem result or the independent medical report on Lucy Crawford, provided by Dr Quinn, can give an absolute explanation as to why Lucy's condition deteriorated rapidly, why she had an event described as a seizure at around 2.55am on 13 April 2000, or why cerebral oedema was present on examination at postmortem.

### ISSUES ARISING

#### 1 Level of Fluid Intake

Lucy was given a mixture of oral fluids and intravenous infusion of solution 18 between her admission, at around 7.30pm on 12 April 2000, and the event that happened around 2.55am on 13 April 2000. Dr Quinn is of the view that the intravenous solution used and the total volume of fluid intake, when spread over the 7 ½ hour period, would be within the accepted range and has expressed his surprise if those volumes of fluid could have produced gross cerebral oedema causing coning.

There was no written prescription to define the intended volume. There was some confusion between the Consultant, Senior House Officer and Nurses concerned in relation to the intended volume of fluid to be given intravenously. There is a discrepancy in the running total of the intravenous infusion of solution 18 for the last 2 hours. There is no record of the actual volume of normal saline given when commenced on a free flowing basis.

## 2 Level of Description of Event

Retrospective notes have been made by nursing and medical staff in respect of the event which happened at around 2.55am on 13 April 2000. In all of these descriptions and the subsequent postmortem report the event is described as a seizure. With the exception of Nurse McCaffrey's report, little detailed descriptions of the event are recorded and no account appears to be in existence of the mother's description who was present and discovered Lucy in this state.

## 3 Reporting Incident

While a procedure for reporting and the initiation of an investigation into Clinical Instances/Untoward Events was not in existence universally, at the time of Lucy's admission to the Erne Hospital, Dr O'Donohoe proactively reported the unexpected outcome of Lucy's condition to Dr Kelly, Medical Director.

## 4 Communications

The main communication issue identified within this review was the confusion between all those concerned in relation to the intended prescribed dosage of intravenous fluids. The record shows that Dr O'Donohoe's intention or recollection was that Lucy should have 100mls bolus of fluids in the first hour and 30mls hourly thereafter. While the Nursing staff held a clear view that the expressed intention was to give 100mls hourly until Lucy passed urine. Furthermore this was considered by the Nursing staff interviewed to be a standard approach in such circumstances. This clearly demonstrates the need for standard protocols for treating such patients and the need, in keeping with required practice, to have a clearly written prescription.

## 5 Documentation

The main issues identified here are the need for clearly documented prescriptions for intravenous fluids, the accurate documentation of the fluid administration, and the need to document patients or parents descriptions of unusual clinical events, such as the seizure, describing the detail which may be required at a later date.

## 6 Care of Family

Mrs Doherty, Health Visitor, and Dr O'Donohoe were proactive in offering support to the family and given the opportunity to explain where possible the reasons for the change in Lucy's condition and support them in their bereavement.

## 7 Team Support

All team members involved in Lucy's care were shocked and traumatised by the unexpected deterioration in her condition. A team briefing consisting of all disciplines did not take place. Such a process may help support those concerned and reduce the fear of attempts to apportion blame between team members.

## 8 Linkage with the Regional Centre

A number of issues arose in respect of our link with Regional Services in this case. These included the arrangements to support the transfer of such patients, the need for greater communication between the local hospital and the regional hospital in respect of feedback which is to be given to parents in such instances and the significant time delay in getting access to the final postmortem report.

The Review Team have made a number of recommendations including a proposal for a further meeting with the Crawford Family along with relevant Clinical Staff so that the Review can be shared. We would hope that the Family would avail of a meeting.

amended  
Copy sent to  
Dr Anderson.  
31/7/00  
sb

Sent to  
Dr Anderson.  
10/7/00.

## REPORT

Sequence of  
events page

This copy had been taken for Dr O'Donoghue's legal advice. missing

## THE REVIEW OF LUCY CRAWFORD'S CASE

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My home not been used as yet

I gave the list of correspondence to Mr Good Brainer for his use.

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Mr Eugene Fee, Director of Acute Hospital Services  
5 July 2000



### MEMORANDUM

TO: Mr T Anderson, Clinical Director for Women & Children's Directorate

FROM: Mr E Fee, Director of Acute Hospital Services

REF: EF/sb

DATE: 5 July 2000

SUBJECT: Lucy Crawford

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Trevor, during your period of Annual Leave, Dr Kelly and myself met with Dr Quinn and we also had the opportunity of reviewing the final autopsy report on the late Lucy Crawford.

I have drafted, for your information and use, a report in relation to our review of this case. Please feel free to amend in any way you feel appropriate. I have not had the opportunity to read the draft report when typed.

I know Dr Kelly met with Dr O'Donohoe, on Wednesday 28 June 2000, to give him feedback on our meeting with Dr Quinn. We would suggest that beyond the completion of this report a meeting should be arranged again with the family to give further feedback. This meeting would probably best be attended by yourself, Dr O'Donohoe and Sister Traynor.

I understand that the family, in addition to the meeting held with Dr O'Donohoe, also met with Dr Hanrahan, the Paediatrician in Belfast, and that the final autopsy report was shared with them by Dr O'Hara and Mr Stanley Millar, Western Health and Social Services Council. This meeting, I understand, was held on 16 June 2000.

**EUGENE FEE**  
**DIRECTOR OF ACUTE HOSPITAL SERVICES**

Acute Hospital Services

DRAFT

Re: Lucy Crawford (deceased)

On Friday 14 April 2000 Dr O'Donohoe, Consultant Paediatrician, advised Dr Kelly, Medical Director that 17 month old Lucy, who was admitted to the Children's Ward, Erne Hospital on Wednesday, 12 April 2000, evening, had deteriorated rapidly early on 13 April morning had been transferred to the Royal Belfast Hospital for Sick Children's Intensive Unit and was, at the stage of his report to Dr Kelly, declared brain dead.

Dr Kelly advised Mr Mills, Chief Executive and Mr Fee, Director of Acute Hospital Services by telephone and requested that Mr Fee consider establishing a review of Lucy's care at the Erne Hospital.

Mr Fee spoke to Dr Anderson, Clinical Director, Women and Children's Directorate, at 1.00pm and it was agreed that they would jointly co-ordinate this review.

It was confirmed on Monday 17 April 2000 that Lucy Crawford had died in hospital, in Belfast and the funeral was held Sunday 19 April 2000. Between Monday/Tuesday 17/18 April Dr Anderson and Mr Fee met with Dr O'Donohoe, Dr Malik, Sister Edmunson, S/N McManus, E/N McCaffrey and S/N McNeill to offer them support and to advise them of our intent to conduct a review.

On Wednesday 19 April Dr Anderson and Mr Fee met to review the case notes and agreed the following Action Plan:-

- 1) That staff listed above and Dr Auterson, Consultant Anaesthetist, would be asked to provide a factual account of the sequence of events from their perspective.
- 2) That the case notes/copy of case notes would be made available for reference to those concerned. Dr Anderson agreed to get a copy of the case notes made and have both the copy and the original retained in Mrs Millar's office for the immediate future.
- 3) Dr Anderson is to speak to Dr O'Donohoe and request that he share with staff concerned, in confidence, the verbal report of the cause of death received.

- 4) Mr Fee is to seek an appropriate method of advising Lucy's parents that we will arrange an opportunity to share with them information on the nature of Lucy's illness, the treatment given, and the cause of death, addressing where possible, any questions they have, when we have established the necessary information and facts

Mr Fee will speak to Ms Murphy, Health Visitor Manager, to establish what support is being given to the family and if it is possible to make this offer through the Health Visiting Service.

- 5) Mr Fee is to establish, from the Infection Control Service, the nature of ROTA Virus infection.
- 6) It was agreed that Dr Anderson and Mr Fee would need an external expert Paediatric opinion on the management of Lucy's care. Mr Fee is to test the source of such an opinion with Mr Mills.
- 7) Dr O'Donohoe and the staff concerned are to be encouraged to consider creating the opportunity to talk through the issues and emotions surrounding this case. Mr Fee and /or Dr Anderson could facilitate such a discussion.
- 8) Mr Fee and Dr Anderson gave consideration to whether or not the work arrangements require modification for any of the staff involved. In the absence of an expert opinion on the likely significance of the care given having contributed to the deterioration of Lucy's condition and the unlikely event of a reoccurrence of a similar outcome of a child presenting with this type of condition it was decided that no alteration to the work arrangements for those concerned would be appropriate at this stage.

Mr Mills advised Dr McConnell, Western Health & Social Services Board, of Lucy's condition on Friday 14 April 2000 and Mr Fee advised Dr Hamilton, Western Health & Social Services Board of her death and the Press interest on Monday 17 April 2000.

Typed on 21 April 2000



ERNE HOSPITAL  
ENNISKILLEN, CO. FERMANAGH BT74 6AY

**WOMEN AND CHILDRENS SERVICES**

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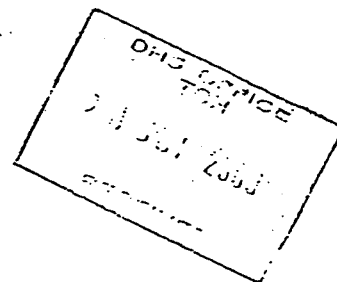
Telephone: [REDACTED] - Direct Dial: [REDACTED]

Fax No: [REDACTED] - E-mail Address: [REDACTED]

17 July 2000

Mr E Fee  
Director of Acute Hospital Services  
Tyrone County Hospital  
OMAGH  
Co. Tyrone

Dear Mr Fee



RE: REVIEW OF LUCY CRAWFORD CASE

Having read through the Review including all of the reports received, I do not have the final report of the Post Mortem and therefore have not seen it. The overall impression gained from reading through all of the reports is of a child who came in with what was thought to be a viral infection or a urinary tract infection. This child was thought to be no sicker than the average patient coming in to the ward and it seems to have come as a major surprise to everyone when there was a sudden deterioration noted at a few minutes before 3 o'clock in the morning. From which point onwards the child never showed any evidence of improvement until eventually determined brain dead.

I found that the report by Dr Quinn, whilst being helpful in the sense that it ruled out any obvious mis-management on the part of our medical/nursing staff at the hospital, was also evidence of the fact that there was no clearly obvious explanation for the child's sudden deterioration.

Certain lessons can be learned from the information that we do have available and the most obvious of these is:

- (1) the need for prescribed orders to be clearly documented and signed by the prescriber; and
- (2) the importance for standard protocols to be readily available in the ward against which treatment can be compared.

There was also a mistake in the calculation of the ongoing cumulative fluid which the patient received. This would be understandable if it had occurred after the emergency at 3 o'clock but in fact the inaccuracies precede precede that emergency. There is no obvious indication as to suggest that the nursing staff were under excessive pressure by an excessive workload up to that point. If they were then the staffing of the ward would need to be addressed.

er recommendations would be:

- (1) That all team members involved in the care of the child on the night in question would probably benefit from a joint meeting and discussion of this report/findings; and
- (2) That it would be appropriate for another meeting with the family to appraise them of all of the knowledge and opinions that we have at this point. Whilst we are not in a position to give them definite answers we may at least be able to demonstrate our openness and show to them the measures that have been taken to analyse the care of Lucys admission.

Thanking you.

Yours sincerely



Dr T Anderson, M.B., F.R.C.O.G.  
Clinical Director

## REPORT RE: THE REVIEW OF LUCY CRAWFORD'S CASE

### BACKGROUND

On Friday 14 April 2000 Dr O'Donohoe, Consultant Paediatrician advised Dr Kelly, Medical Director, that 17 month old Lucy Crawford had been admitted to the Children's Ward, Erne Hospital on Wednesday 12 April 2000. She was admitted at around 7.30pm and had deteriorated rapidly early on 13 April 2000 morning. This deterioration in Lucy's condition led to emergency resuscitation within the Paediatric Department, a transfer to the High Dependency Unit, Erne Hospital, and a subsequent transfer to the Royal Belfast Hospital for Sick Children's Intensive Care Unit, where she died.

In light of the unexpected development and outcome of Lucy's condition it was agreed that a review would be established in keeping with the developing arrangements for Review of Clinical Instances/Unoward Events. This review has been conducted by Dr Anderson, Clinical Director, Women & Children's Directorate and Mr Fee, Director of Acute Hospital Services with an input from Dr Kelly, Medical Director. External assistance and advice was made available by Dr Quinn, Consultant Paediatrician, Altnagelvin Hospital.

### PURPOSE OF REVIEW

The main purpose of the review was to trace the progression of Lucy's illness from her admission to the Erne Hospital and her treatments/interventions in order to try and establish whether:

- a) There is any connection between our activities and actions, and the progression and outcome of Lucy's condition
- b) Whether or not there was any omission in our actions and treatments which may have influenced the progression and outcome of Lucy's condition
- c) Whether or not there are any features of our contribution to care in this case which may suggest the need for change in our approach to the care of patients within the Paediatric Department or wider hospital generally

### *PROCESS OF REVIEW*

1. The case notes were reviewed
2. All staff within Sperrin Lakeland Trust who had an involvement in Lucy's care were asked to provide a written comment/response of their contribution to Lucy's care
3. Some separate discussions were held with Sister Traynor (appendix 11) and Mrs Martin, Infection Control Nurse
4. Dr Quinn, Consultant Paediatrician, Altnagelvin Hospital, was asked to give his opinion on 3 specific issues. A copy of the patient's notes were made available to Dr Quinn
5. The outcome of the postmortem was considered
6. A meeting was held between Dr Kelly, Dr Quinn and Mr Fee on Wednesday 21 June 2000 to share with him the result of the autopsy and seek his comment and a formal response on the issues raised. Dr Quinn's report dated 22 June 2000 is included as appendix 1.

### *FINDINGS*

Lucy Crawford was admitted to the Children's Ward, Erne Hospital on 12 April 2000 at approximately 7.30pm having been referred by her General Practitioner. The history given was one of 2 days fever, vomiting and passing smelly urine. The General Practitioner's impression was that Lucy was possibly suffering from a urinary tract infection. The patient was examined by Dr Malik, Senior House Officer, Paediatrics, who made a provisional diagnosis of viral illness. She was admitted for investigation and administration of IV fluids. Lucy was considered to be no more or less ill than many children admitted to this department. Neither the postmortem result or the independent medical report on Lucy Crawford, provided by Dr Quinn, can give an absolute explanation as to why Lucy's condition deteriorated rapidly, why she had an event described as a seizure at around 2.55am on 13 April 2000, or why cerebral oedema was present on examination at postmortem.

## *ISSUES ARISING*

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### 3 Reporting Incident

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## 9 Recommendations

- a) the need for prescribed orders to be clearly documented and signed by the prescriber
- b) the importance for standard protocols to be readily available in the ward against which treatment can be compared
- c) that all team members involved in the care of the child, on the night in question, would probably benefit from a joint meeting and discussion of this report/findings; and
- d) that it would be appropriate for another meeting with the family to appraise them of all of the knowledge and opinions that we have at this point. Whilst we are not in a position to give them definite answers we may at least be able to demonstrate our openness and show to them the measures that have been taken to analyse the care of Lucy's admission.

31 July 2000