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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/Untoward Events. This review has been conducted by Dr Anderson, Clinical Director, Women & Chilren'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 progession 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 5.30pm 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 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, 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

Her 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.

9 Recommendations

Trevor, perhaps, after you have scanned this report so far you, could draw together some recommendations.

6 July 2000