SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

LATE LUCY CRAWFORD CASE

Briefing Note to WHSSC

Case Background:

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. Dr O'Donohoe carried out the introduction of the IV as the junior medical officer had been unable to do so. 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 Paediatrician 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.

Adverse Incident Review:

Following Lucy's death, Dr O'Donohoe, Consultant Paediatrician, advised Dr Kelly, Medical Director, Sperrin Lakeland Trust. Dr Kelly 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. - In 2000 the practice of adverse incident review involving an external opinion was relatively uncommon within N.I. This represented an evolving practice being led within the Trust, by the Medical Director under the Clinical & Social Care Governance arrangements. - Later the same day, 14 April 2000, Mr Fee agreed to jointly co-ordinate a review with Dr Anderson, Clinical Director of Women & Children's Services. The review included; a case note review; review of written comment from staff involved in Lucy's care; discussions with other relevant staff; an independent external opinion on specific clinical matters from Dr M Quinn, Consultant Paediatrician, Altnagelvin Trust. The Trust concluded that there had been communication difficulties and there was poor record keeping.

A report on this review was finalised on 31 July 2000. A range of actions were developed including a plan to meet with the Crawford family to share the outcome of the review. This has not yet happened at the point at which the family invoked the complaints procedure.

Dr O'Donohoe had also met with the family, at their request, during May 2000.

Complaints Process:

Contact was initiated via WHSSC in September 2000. In the period from September 2000 – March 2001 eight letters were issued by the Trust in correspondence with the family and the Council.

In these correspondence the Trust continued to encourage the family to participate in a meeting with Trust staff so that the findings of the internal review, based on the information available, at that time, could be shared. These offers were not availed of.

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

This was followed up with a further offer of a meeting in the letter from Mr Mills to the Crawford family on 30 March 2001. This was not availed of.

A criticism of the Trust has been the decision not to provide a copy of the external report of the independent consultant. At the time the decision was not to issue the report, but rather seek to meet face to face to discuss its content. This was a genuine attempt to avoid the potential misunderstanding or misreading of its content. A copy of the report has since been sent, via Solicitors, on 30/03/04.

Litigation:

The family instigated legal proceedings on 27/04/01 which concluded in an out of court settlement in December 2003. An aspect of the settlement was an acceptance by the Trust of its liability in the matter. During the course of the legal proceedings the Trust became aware of, and was then formally advised that the Coroner had indicated his intention to reopen Lucy's case for an inquest. (Prior to this the death certificate had been agreed with and signed by the Coroner's office). An important concept to bear in mind is that of the Bolam principle. This involves testing the standard of clinical practice at the time. Research publications in the BMJ in March 2001 highlighted the emerging trend in adverse outcomes for children treated with Solution 18. Additionally the death of Rachel Ferguson in 2001, at Altnagelvin Hospital, and subsequent inquest resulted in guidance being issued by the CMO regarding the cessation of the use of the particular fluids used. This practice has been changed within the Trust in 2001 as a result of the Medical Director recognizing similarities in the outcome of the two cases.

In the course of litigation the Trust received correspondence on behalf of Mrs Crawford via a Consultant at the Erne Hospital and her G.P. The Patient/Client Advocate made contact with the family G.P. to ensure effective support was in place. Based on legal advice the option of mediation, considered at the time, was not taken. Mrs Crawford was written to, advising of this. The letter of 28/03/03 indicated the Trusts wish to meet following conclusion of litigation. A further letter was sent on 30/03/04 reminding Mr & Mrs Crawford of this offer.

At the conclusion of the litigation, the Trust indicated its intention to issue an apology to the Crawford family. Legal advice, based on discussions with the family's legal representatives was not to do so at that time. A letter of apology was issued on 19/04/04 after the conclusion of the inquest.

Coroner's Inquest:

The Coroner's Inquest commenced on Tuesday 17 February and concluded on Thursday 19 February 2004. The Coroner, Mr John Lecky concluded that the cause of death was:

1a) Cerebral Oedema
b) Acute Dilutional Hyponatraemia
c) Excess Dilute Fluid
2) Gastroenteritis

He also stated that he would share all the papers with the Chief Medical Officer and write to her to highlight the need for practice to be reviewed. Furthermore he advised that he would also refer all papers to the General Medical Council. The Trust is co-operating with both the CMO and GMC in consideration of this case.

The Trust plans to reflect on the Coroner's findings to assess what additional lessons can be learned from Lucy's tragic death beyond those identified in the initial review and the introduction of practice changes in line with the Chief Medical Officer's guidance. It also intends to reflect on process and systems issues highlighted.

Media/Public Information:

Careful consideration was been given at all stages to the likelihood of press and public interest in this case. The approach has been to protect confidentiality, as appropriate, not to seek to publically counter the family's assertions, and to seek to inform/reassure public understanding of the issues particularly that appropriate changes in clinical practice had been introduced to services.

Chief Executive
20th April 2004