SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

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 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.

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