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From: "roreilly" <roreilly[redacted]>

To: "Des Doherty" <desmond.doherty[redacted]>

Subject: When Hospitals Kill transcript

Date: Thu, 2 Dec 2004 15:15:18 -0000

Hi Des,

Here's the script for Insight: When Hospitals Kill. I'll need to dig out the script for the original programme about Raychel, Insight: Vital Signs and I'll bat it over to you before the end of the day.

My contact numbers are:
:: [redacted] (direct line)
:: [redacted] (mobile)
:: [redacted] (home)

Many thanks again, Des. Keep in touch,

Ruth

Ruth O'Reilly
Producer, Insight

Attachment

Master_Script_for_publication.doc
.doc file

RF - FAMILY

Programme title: When Hospitals Kill
Production number: 04/0711
Transmission date: October 21 2004
Running time: 47:56 (7:16; 16:50; 17:30; 6:20)
Reporter: Trevor Birney
Producer: Ruth O'Reilly

Opening titles

Mae Crawford
I rang the out of hours doctor ... and the doctor there said, she looked at her and said she would need a drip and to bring her on up to the hospital.

Mae Crawford
She wasn't that ill. She had gastroenteritis.

Mae Crawford
It was just panic.

Mae Crawford
She was dead. She was hooked up to machines and everything but there was no life.

Mae Crawford
I feel these people are above the law.

WHEN HOSPITALS KILL

Reporter
In the past eight years, three children have needlessly died in hospitals here.
The reason they died is not complicated.
It was the fatal administration of this fluid that caused the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson.
This is a story of medical incompetence, tragedy and cover-up.
And yet our Chief Medical Officer says it was the unusual reaction of the victims that was the blame.

Dr Henrietta Campbell/Chief Medical Officer/ The Issue March 25 2004
...the rarity in these two events was the abnormal reaction ...

Dr Dewi Evans/Consultant Paediatrician
Oh, this statement is wrong.

Reporter:
Ignorance is one thing.
Tonight, Insight goes further.
We present evidence of how a hospital trust covered up that it caused the death of a child and lied to that child's grieving parents.
It's a cover-up which forced this doctor out of his job when he tried to blow the whistle.
A cover-up which has left nurses resorting to sending anonymous letters after another suspect death.
Tonight we confront those who colluded in the cover-up.

Dr Murray Quinn/Consultant Paediatrician
Dr Quinn: **They've got their answers.** (shrugs)
Reporter: **They don't. They say they don't.**
Dr Quinn: **Well, they've got their answers.**

Reporter
We examine concerns around the role of the Chief Medical Officer in this affair.
And we show how the health service's emphasis on protecting its own far outweighs its regard for the bereaved - or even the courts.

<u>THE DEATH OF LUCY CRAWFORD</u>

Mae Crawford
We all enjoyed looking after her, the four of us and had a great time with her.
Someday I hope we will be able to look back on those memories and think what a great pleasure she gave to us all.

Reporter
Medically, there was very little wrong with Lucy Crawford when she was admitted to the Erne Hospital in Enniskillen.
Like many other babies, she'd picked up a tummy bug, which had caused vomiting and diarrhoea.
A GP suggested her parents take her to the hospital so that she could be re-hydrated through a drip. In an interview for UTV six months ago, Lucy's mother explained how her daughter had died.

RF - FAMILY

26

Mae Crawford
So we accepted that and that's what we did, we brought her up and we were there about half past seven. The doctor tried to get the drip in and he couldn't ... Then doctor O'Donohoe arrived and he give her some Dioralyte, a drink. She drank that and the drip wasn't set up until 11 o'clock.
At about quarter past 12 she vomited and I was quite worried, and I said, "What, why is she being sick and she's sleeping?" And the nurse just dismissed it and said, No, she will be fine, not to be worrying," and she left. Then about quarter past two ... I had to go and find a nurse because there was no one about and she came down and she said didn't know what it was ...
And about 3 o'clock I was just sitting watching Lucy on the edge of the bed and she was still sleeping and she very still, and the next thing she give 3 loud breaths and her body went rigid and she .....(pause) (whispers) **I just can't ...**
(normal volume) **I lifted Lucy up and I, her body was rigid and heavy and I couldn't open her mouth ...so I put her down, I had rang the bell at this stage, and no one came. So I put her down and went out and look up the ward and there was no nurses, and I just shouted for help. Eventually a nurse came and she stood at the door and said, "Oh my God." So then the next thing another nurse arrived with equipment and then it was just panic.**

Reporter
Without giving them any indication of what had gone wrong in the first place, the Crawfords were informed that their daughter had been stabilised - the first of many lies told by the Erne Hospital.

Mae Crawford
We went in to see Lucy and she was just, she was dead, she was hooked up to machines and everything, but there was no life.

Reporter
Lucy was transferred to Belfast's Royal Hospital for Sick Children.
But when she left the Erne Hospital, she was brain dead.
There was nothing the Royal could do and at quarter-past-one on Friday, April 14th, 2000, her life support machine was turned off.

END OF PART ONE

PART TWO

Reporter
Lucy Crawford was a toddler with a tummy bug who went into Enniskillen's Erne Hospital to get rehydrated on a drip. Suddenly she was dead.

Mae Crawford
Lucy brought so much joy into our lives, and whenever she died, the life just left us all.

Reporter
So why did Lucy Crawford die?
Well, it's very simple. And we know that from these: Lucy Crawford's medical notes. These tell us that the Erne Hospital gave Lucy the wrong fluid and far too much of it. This caused her brain to swell up or to "cone", which means the brain is being pushed down through the hole at the bottom of the skull. This stopped Lucy's breathing and ultimately killed her.
Insight has spoken to one of the leading experts in this field, a doctor who was the expert witness for the Coroner John Leckey in these cases.

Dr Ted Sumner/Consultant Paediatric Anaesthetist
Intravenous fluids can be dangerous if they are given too great or too low a volume or if it's the wrong sort of fluid. And it's particularly if there are abnormal losses from, say, vomiting and diarrhoea where the sodium chloride is being lost, saline is being lost effectively. So that if that isn't replaced by saline, then the sodium in the blood becomes diluted and then that's when the problem of dilutional hyponatraemia occurs and the subsequent brain swelling.

Reporter
The hospital knew full well that the fluids were to blame – and Insight's investigation proves they realised it at the time of Lucy's sudden collapse. Blood tests showed a critical drop in Luch's sodium levels - low sodum IS hyponatraemia. The solution in the drip was also switched around this time to conventional saline and poured into her little body free-flowing. It was another huge mistake.

Dr. Ted Sumner
In my view they would have realised that she had hyponatraemia and therefore they would need to correct that by giving saline. But sadly I think it was already too late because the coning process was well under way and it is often irreversible by that stage. But also they gave far, far too much, I mean half a litre for over one hour to an nine kilo child was far, far too much and would just exacerbate the situation by that stage.

Reporter
Within hours of Lucy's collapse the management at the Erne Hospital had been told.
But rather than simply telling the devastated Crawfords what had gone wrong, the hospital authorities began closing ranks.

<u>THE COVER UP</u>

Mae Crawford
Us having to try and get answers it has put a strain on the household.

Reporter
Because Lucy died at the Royal, paediatricians there were responsible for certifying her death. The fact that she had died as a result of the fluids she'd been given should have come to light at this stage. But it didn't – and what happened exposes a glaring loophole which according to one lawyer who specialises in this area, exists in Northern Ireland to this day.

Professor Tony McGleenan/Barrister
The critical issue is the death certification process because we need to see what's on a death certificate to see what the cause of death was. Now the death certification process has been closely scrutinized following the Shipman case and recommendations have been made that that has to be overhauled. Because there's too much pressure on an individual doctor to certify the cause of death and there's too much scope for concealment of a cause of death.

Reporter
Dr Donncha Hanrahan is a consultant paediatric neurologist at the Royal. It was Dr Hanrahan who told the Coroner of Lucy's death. And he informed the Coroner that Lucy had died of gastroenteritis, dehydration and brain swelling. Yet this diagnosis was patently wrong. Lucy hadn't died of a tummy bug or gastroenteritis. It wasn't the dehydration that had caused her brain to swell up and kill her. The brain swelling, or cerebral oedema, had been caused by hyponatraemia. The hyponatraemia had been caused by the Erne Hospital giving Lucy this fluid, which was the wrong fluid and the hospital also gave her too much of it.

Dr Ted Sumner
Reporter: **Lucy did not die of gastroenteritis.**
Dr Sumner: **No. She died of dilutional hyponatraemia which caused brain swelling and this coning process damage to the brain stem. Of course she did have gastroenteritis which necessitated the intravenous fluids that ultimately killed her.**

Reporter
Insight has established that on the day of Lucy's admission to the Royal, Dr Hanrahan knew that her condition had been caused by the fluid she'd received; that the Erne was to blame. Yet 24 hours later, he failed to tell the Coroner any of this, leaving the Coroner believing she'd died of natural causes.
For some reason Dr Hanrahan misled the Coroner. This caused the Coroner to rule out an official post-mortem and a public inquest. It also meant that the Crawfords were given an incorrect death certificate.
But the story doesn't end there. Once the dealings with the Coroner were over, the Royal conducted a post-mortem of its own … and didn't tell the Coroner about it. To this day the Royal has neither explained Dr Hanrahan's seriously deficient diagnosis of Lucy's death nor why the hospital carried out the post mortem. What's more is that the post-mortem actually shows they had the answer: Lucy's clinical history, written by Dr Hanrahan's own registrar, Dr Caroline Stewart, states:

Actor's voice
Dehydration and hyponatraemia, acute coning and brain stem death.

Reporter
Yet this information wasn't passed to the Coroner. And the law requires anyone, including a doctor, with any relevant information about a death to ensure the Coroner is told.
Over the past six months Insight has sought answers from the Royal. We have sent e-mails and telephoned. We spoke to Dr Hanrahan directly. But no explanation was forthcoming as to why the most important element of Lucy's diagnosis was not given to the Coroner. We were left with no other option but to seek answers from Dr Hanrahan in person. We began by asking him about the doctor who prescribed the lethal fluids at the Erne Hospital, Dr Jarlath O'Donohoe. Why had he not told the Coroner what Jarlath O'Donohoe had done?

Dr Donncha Hanrahan/Consultant Paediatric Neurologist
Reporter: **Were you covering up for Dr O'Donohoe?**
Dr Hanrahan: **No, no, no.**
Reporter: **Were you covering up for him?**
Dr Hanrahan: **No, of course not.**
Reporter: **Well, why did you not mention the presence of hyponatraemia when you spoke to the Coroner?**
Dr Hanrahan: **I've nothing further to say to you. Can I leave it at that? Thank-you very much.**
Reporter: **Can you not explain to me why?Are you not interested in answering these questions?**
Dr Hanrahan: **Not to you. …**

Reporter: **Why did you mislead the Coroner?**
Dr Hanrahan: **I didn't mislead the Coroner and I can't say anything else at the moment to you. OK? …**

Reporter: **Dr Caroline Stewart, and others were aware of the presence of hyponatraemia …**
Dr Hanrahan: **Mm, hm** …
Reporter: **… you were aware of that at the time of Lucy's death. …**
Dr Hanrahan: **Yeah …**
Reporter: … **why did you not tell that to the coroner when you spoke to him?**
Dr Hanrahan: **Em, I would need to check up my facts on this.**

Reporter
Since this encounter Dr Hanrahan has not come forward with any explanation. Earlier this year Dr Hanrahan stated on the record for the first time that Lucy had died as a result of the fluids she had received. That was when he asked by the Coroner at Lucy's inquest. He didn't tell the Crawfords when they met him two months after their daughter had died. Instead, he directed them back to the Erne Hospital.

Mae Crawford
We asked the Erne hospital to speak to Dr O'Donohoe who had set up the drip. And we met him one day and he arrived without Lucy's notes. He said he couldn't understand, he didn't know what happened and he could not understand it.

Reporter
Jarlath O'Donohoe was the most senior doctor in charge of Lucy. He had prescribed the fluids which had killed the little girl but, when he met the Crawfords, he lied. He fully understood what had caused Lucy's death. The management at the Sperrin Lakeland Trust, which runs the Erne Hospital, also knew. But by the time of the O'Donohoe meeting, the cover-up at the Trust was well under way.

Professor Tony McGleenan
The fullest investigation which a hospital will carry out internally is the internal Chief Executive's review which may or may not involve an external report being commissioned. But beyond that, essentially, there's no external accountability involved there.

Reporter
This is Hugh Mills, he's the Chief Executive at the Sperrin Lakeland Trust and the man ultimately responsible for the cover-up of Lucy Crawford's death. He says that on the day Lucy died he instigated a review of her death.
Hugh Mills' review failed in almost every aspect to identify what had gone wrong.
In his findings, he states that "neither the post mortem nor the independent medical report on Lucy Crawford can give an absolute explanation as to why Lucy's condition deteriorated rapidly". So the review's findings were inconclusive.
This has puzzled both Dr Sumner and the paediatrician who provided an expert report for the Crawford family.

Dr Dewi Evans/Consultant Paediatrician
I prepared this report in February 2001 which was less than a year after she died. Now, if I had enough information to come to a definitive cause for death, then that information should have been available to the hospital trust, if they'd bothered to get an opinion from an appropriate expert in the field.

Dr Ted Sumner
It's quite patently clear from the notes that the volumes of fluid given were too great and that they were the wrong sort of fluid to replace abnormal losses.

Reporter:
This is the man who provided the trust with an expert view of the case. Dr Murray Quinn is a consultant paediatrician at Altnagelvin Hospital in Londonderry. He used to hold clinics at the Enniskillen hospital every week.

Dr Dewi Evans
Reporter: **To ask someone from a hospital within the same board area to carry out a review is hardly independent.**
Dr Evans: **I wouldn't, yes. I don't think I would ask someone from my own area. You know: it's Northern Ireland/South Wales, similar population. Everybody knows everybody else.**

Reporter
Dr Quinn reported:

Actor's voice
"I find it difficult to be totally certain as to what occurred to Lucy in and around 3am or indeed what the ultimate cause of her cerebral oedema was."

Reporter
The experts who have examined Lucy's medical notes say it's EASY to be absolutely certain as to what occurred in and around 3am. Dr Quinn's report has now been roundly discredited for a number of reasons. Firstly, he wasn't independent. Secondly, Dr Quinn failed to comment, even, on the sudden drop in Lucy's sodium levels. And remember: low sodium equals hyponatraemia. Thirdly, Dr Quinn assessed Lucy's fluid intake very differently to any other paediatrician who has looked at the notes. They all focused on the four hours that Lucy was on the drip from 11pm through to 3am when she collapsed. This showed a lethally high rate of fluid administration. Instead, Dr Quinn calculated Lucy's intake over seven hours, which on paper substantially reduced the rate of fluid that Lucy had received. Altnagelvin Trust repeatedly told Insight that Dr Quinn's report was nothing to do with it. We attempted to speak directly to Dr Quinn on several occasions. But he instructed staff to tell us that he was not taking our calls. So, again, we felt it only appropriate that Dr Quinn be given a further opportunity to explain his report.

Dr Murray Quinn/Consultant Paediatrician
Dr Quinn: **What are you doing here?**
Reporter: **Dr Quinn. My name is Trevor Birney. I'm from UTV, sir.**
Dr Quinn: **I just wonder why you have the camera going.**

Reporter
Dr Quinn admits that he was not sufficiently independent ...

Dr Quinn: **I said that what they should do when I did the case report was – the case review, the notes review, was that they should get an independent person from outside our board to give an opinion.**

Reporter
He denies that it's a report at all.

Dr Quinn: **This is not a medical report.**
Reporter: **It is. It says `medical report' right there.**
Dr Quinn: **No. This is a case note review.**
Reporter: **Well, it says `medical report', sir.**
Dr Quinn: **That's not what it is.**
Reporter: **OK. So it's ... that's wrong. That's not ... So you got that wrong as well?**
Dr Quinn: **No, no, no. It's a case notes review.**
Reporter: **Well, why did you not say `case notes review?'**
Dr Quinn: **It doesn't matter what's written there.**

Reporter
Dr Quinn still doesn't seem convinced about the cause of Lucy's death – or the dangers of fluids ...

Reporter: **Whenever you give a child 400 ml of the wrong fluid over a four-hour period, she will suffer from hyponatraemia and cerebral oedema. You don't even understand that.**
Dr Quinn: **Oh, actually, I do.**
Reporter: **Well why did you not put that in your report?**
Dr Quinn: **Because it's not a report.**
Reporter: **Do you not accept that she died of hyponatraemia?**
Dr Quinn: **That's what the coroner said.**
Reporter: **Do you accept that?**
Dr Quinn: **It may be. I mean, there are a lot of explanations ..:**

Reporter
But then he has a firmer opinion about what's best for the Crawford family ..

Dr Quinn: **I'm very sorry that Lucy Crawford died and I hope that her parents will be allowed to grieve in private, not in public. Thank you.**
Reporter: **But do you think they deserve the truth?**
Dr Quinn: **Thank you.**
Reporter: **Do you think they deserve the truth of what happened?**
Dr Quinn: **They've been through the formal complaints procedure. They're been through a court case were I understand they got financial compensation for, for whatever reason. They've been through … and there's been another television programme. There've been paper reports, none of which … the Coroner's court. So they've got the anwers** (shrugs)
Reporter: **They don't. They say they don't.**
Dr Quinn: **Well, they've got the answers.**

Reporter
Finally Dr Quinn blames Sperrin Lakeland Trust for the report that carries his name ..

Dr Quinn: **… I was sweet-talked into writing a summary which is not the complete amount of discussion that I had at that time, so anyone who makes a …**
Reporter: **You were sweet-talked?**
Dr Quinn: **… if I were …**
Reporter: **You were sweet-talked?**
Dr Quinn: **… if I were … if I were …**
Reporter: **Sweet-talked by whom?**

Reporter
By providing such a flawed report, Dr Quinn allowed Sperrin Lakeland Trust to deny that it was responsible for Lucy's death.

Dr. Dewi Evans
I think he failed to recognise the significance of giving too much fluid which was too dilute, although the evidence was there, from the differences in the blood tests carried out on Lucy when she came into hospital and the blood tests carried out a few hours later. So the evidence was there …
Reporter: **So in your opinion not only did the hospital fail Lucy on the night of her treatment but they also failed in the investigation to discover what had occurred.**
Dr Evans: Well, the hospital trust had a duty of care to investigate thoroughly. Once they had one report that failed to come up with the answers, and I don't criticise that, then they should have got themselves more reports.

Reporter:
It's clear that the Sperrin Lakeland trust failed in its duty to properly investigate Lucy's death; in fact its review ensured that no lessons would be learned about the dangers of intravenous fluids, leaving the door open for further deaths. The only mild rebuke contained in the review is around poor communications and record-keeping.
The Crawfords weren't even aware that this review had been carried out until they lodged a formal complaint against the trust six months after Lucy's death. It was handled by this woman, Bridget O'Rawe. Her job at the trust is two-fold: she deals with complaints but she also protects the trust's corporate identity – a clear conflict of interests. The Crawfords' complaint produced more lies. Bridget O'Rawe promised the family a full investigation which the trust never carried out.
Both the review and the complaints process ought to have given the Crawford family the truth, however unpalatable: that the Erne hospital had killed little Lucy, albeit accidentally. Instead they became a vehicle for the cover-up, a cover-up that had been easy to perpetrate.

END OF PART TWO

PART THREE

Reporter
Lucy Crawford was killed by a lethal dose of fluid at her local hospital but a year on her parents were battling a cover-up.

<u>THE WHISTLE BLOWER</u>

Reporter:
On the day of Lucy Crawford's death, a nurse at the Erne Hospital in Enniskillen made a startling comment to a paediatrician about what had happened.

Reconstruction
"Nurse": **She was dead anyway, but they took her to the Royal to save their own skins.**

Reporter
This started a chain of events that would end the pediatrician's career in the Enniskillen hospital and force him to leave the job he loved and the town his family called home.
This is the doctor the nurse made the comment to.
His name is Dr. Muhammad Asghar.
Dr. Asghar refused to take part in this programme.
But Insight has discovered that after hearing the remark, Dr. Asghar examined Lucy Crawford's notes and realised immediately that she had been killed by the fluids.
Later on the ward, he spotted a colleague, Dr. Amer Ullah Malik, was upset. Dr Malik had assisted the Consultant Dr O'Donohoe on the night of Lucy's admission. He told Dr Asghar that he'd just had a meeting with Dr O'Donohoe.
From evidence obtained by Insight, we've reconstructed the conversation that ensued.

Reconstruction
"Dr Asghar": **Is there something wrong?**
"Dr Malik": **Jarlath O'Donohoe has just had me in his office to talk over what happened. He said I could add to the notes if I wanted to.**
"Dr Asghar": **Don't add to the notes. If you want my advice, don't do that. There's a good explanation for your notes ...**
"Dr Malik": **I said I wouldn't. But then he asked me if I had my own medical protection insurance. And he said to me: "I can put the blame on you, but I'm not going to do that." What am I supposed to do.**

Reporter
Dr Asghar was horrified. What he did next was in accordance with protocol set down by the doctor's governing body, the General Medical Council. He set out all his evidence put it in an envelope and hand-delivered it to the Sperrin and Lakeland Chief Executive, Hugh Mills, the same Mr Mills who had produced the internal review of Lucy's case that amounted to little more than a whitewash.
For six months the Trust did nothing. But in late autumn, Dr Asghar warned them he would report Dr. O'Donohoe directly to the GMC unless they acted.
So, in December, 2000 - eight months after Lucy's death, the Trust turned to the Royal College of Paediatrics and Child Health. It provided them with the names of two experts who examined the allegations. However it was another process cloaked in utter secrecy.

Dr Sheila Shribman/Royal College of Paediatricians
Reporter: **What can you tell us about the investigations that were carried out by the College at the Erne Hospital in Enniskillen?**
Dr Shribman: **Well, my understanding is that we did provide names of experts, but, of course as I explained earlier, the work is confidential and the report or reports are provided to the Trusts so the hospital would be the people to approach if you needed further information.**

Reporter
The trust refused to give Dr. Asghar a copy of the findings of this investigation and it won't tell us what was in it. But what we DO know is that none of this information – neither Dr Asghar's concerns, nor the Royal College report – ever made their way to the Coroner. And, don't forget, the trust is legally bound to hand over all relevant material to the coroner for his investigation. But it never saw the light of day. There's no shortage of evidence pointing to the fact that Lucy Crawford was killed by her local hospital. But all this was happening while Lucy's parents were at home with a death certificate saying she had died of natural causes – of gastroenteritis – and the trust was lying to them, telling them that they didn't know what had killed Lucy.

Mae Crawford
We felt we had to go to a solicitor, which we didn't want to do because we're just ordinary people and all we wanted was our answers. What happened to our little girl?

Professor Tony McGleenan
You may have a civil action in the High Court looking at a fatality but it will not necessarily give you the answers which you need to find out about why the death occurred. If it is a very controversial case, then there may be an incentive on the trust to settle the case without having a factual investigation. In other words, we'll never find out why the death occurred.

Reporter
And that's exactly what happened to the Crawfords. In the Autumn of 2002 they received a small settlement although there was no admission of liability by the trust. But the Crawfords didn't experience the litigation process at its worst.

ADAM STRAIN

Reporter
Lucy Crawford was not the first child to have died of hyponatraemia in Northern Ireland. In 1995, a full five years before Lucy's death, Adam Strain was killed in exactly the same way while undergoing a transplant operation at the Royal. To this day his mother cannot talk publicly about it. She met and married her husband after Adam's death.

Jay Slavin
Debra can't conduct the interview because after the inquest and following the litigation that happened afterwards, Debra was legally gagged by the Royal Hospital and therefore can't talk publicly about it.

Reporter
The Royal had silenced Adam's family and Northern Ireland's premier teaching hospital did nothing to educate fellow medics about the lessons of the four year-old's death. This culture of silence only served to ensure that another two children would die of a wholly preventable condition.

Jay Slavin
I think it boils down to the fact of the hospital trying to hide their mistakes and the reputation of doctors, trying to protect them from any further litigation or the public eye.

THE POLICY-MAKERS

Reporter
Lucy Crawford's death had been successfully concealed at trust level. Then another catastrophe. Fourteen months after Lucy's death, nine year-old Raychel Ferguson died of hyponatraemia in Altnagelvin Hospital following a routine operation to remove her appendix. Like Lucy, she was taken to the Royal and pronounced dead there. But this time the coroner for Greater Belfast, John Leckey, was told the truth and alarm bells started ringing loudly. The Chief Medical Officer, Dr Henrietta Campbell, set up a working group of paediatricians from all over Northern Ireland to examine the issue of hyponatraemia. But Raychel's family are angry that both Adam and Lucy had died and yet no-one within the health service had issued any warnings.

Ray & Marie Ferguson
If they had have brought it to light a bit sooner, Raychel would still be here today. Well, I believe Raychel should have been here anyway, even without bringing it up to date. If they had have brought it sooner, Raychel should have been here. Definitely.

Reporter
The Department of Health has done nothing to bring the trusts which have killed to account. Indeed its approach has protected them and clouded the whole issue. Don't forget: the coroner was given misleading information by a member of the medical profession about what had killed Lucy Crawford. Yet Dr Campbell blamed the Coroner.

Dr Henrietta Campbell/BBC Newsline 6:30/March 2004
On looking back at the issues, I think if we'd had an early inquest into Lucy's death, then it might have been that Raychel's death might never have happened. We have to recognise that.

Reporter
So what the Chief Medical Officer appears to say there is that the fatal flaw in the system is not with the paediatrician at the Royal misleading the Coroner, but with the Coroner himself.

Now the Coroner, John Leckey, didn't know the real cause of Lucy's death until last year. But did Dr Campbell know before him? She has been wholly inconsistent on this point.

Dr Henrietta Campbell/The Issue, March 18 2004
We learnt about this untoward event, Lucy's death, when Raychel died.

Reporter
So that was June 2001. But Dr Campbell has since revised her position. Now she says it was March last year that she learned about Lucy's death.

Now this man is Dr John Jenkins and he is Dr Campbell's adviser on the issue of fluid management. He was a leading figure on the working group set up by Henrietta Campbell on the issue of hyponatraemia.

Dr John Jenkins/Consultant Paediatrician
It was recognised that after two children had died in Northern Ireland in conditions with hyponatraemia that we needed to look at this. And the Department of Health, Dr Campbell, our Chief Medical Officer set up a working group which met first in September 2001 ...
Reporter: **Who were those two children, for the record?**
Dr Jenkins: **The two children were Lucy Crawford and Raychel Ferguson.**

Reporter
But the Chief Medical Officer says she didn't learn about Lucy's death until 2003. Yet here we have one of her senior advisors saying that she told HIM about it in eptember 2001, a full two years before the Coroner would learn about Lucy's death.
Dr Campbell's understanding of hyponatraemia provides another get-out for the medical profession: she blames the physiological reaction of the victims.

Dr Henrietta Campbell/The Issue, March 25 2004
The rarity in these two events was the abnormal reaction which is seen in a very few children.

Dr Dewi Evans
Reporter: **Is this statement right or wrong?**
Dr Evans: **Oh, this statement is wrong.**
Reporter: **Would it therefore worry you that it was made by the Chief Medical Officer for Northern Ireland?**
Dr Evans: **Well, yes it would. Clearly the Chief Medical Officer may not be a practising clinician and may have no experience of children's medicine at all. But it is incorrect.**

Dr Ted Sumner
Any child would have reacted in the same way in the same circumstances. That children are at risk who are losing abnormal volumes of saline by vomiting or diarrohea who are given low sodium-containing solutions intravenously will react in exactly the same way as Raychel and Lucy did.

Reporter
And there's now some concern about just how well doctors here are acquainted with the dangers of hyponatraemia and managing children's fluids. According to the Chief Medical Officer, doctors here couldn't have been aware about the dangers of hyponatraemia prior to Lucy's death.

Dr Henrietta Campbell/The Issue, March 25, 2004
In the light of what was known in the medical community throughout the whole of the UK in the year 2000 when poor Lucy died, there were very few people who would have known what was going wrong ...

Reporter
A 30-second internet search and a trip to the Medical Library and we discovered this: an article detailing exactly what happened to Adam, Lucy and Raychel, "Hyponatraemia and death or permanent brain damage in healthy children". It was published in that most mainstream of medical journals, the British Medical Journal in 1992. Now, that's a full three years before the death of Adam Strain; eight years before Lucy Crawford died and nine years before Raychel Ferguson died in Altnagelvin Hospital. Yet the medical establishment here say they knew nothing about it.

Jay Slavin
Debra sought some solace from the fact that Adam's death might have actually helped other children in the future from becoming the same fate. Unfortunately, as we all know now, that hasn't been the case. Very let down that that solace we had is gone.

Ray & Marie Ferguson
They said it was a rare thing. They had never seen it before. But then when we went to Raychel's inquest we learned that what happened to Raychel: every first year medical student is taught this. I found that very, I just couldn't believe: if they were taught it, then they just weren't listening.

Reporter
Dr Ted Sumner has provided expert evidence for the Coroner, John Leckey, in four cases now. He was last here in May this year for the inquest into the death of 15 year-old Conor Mitchell who died at Craigavon Area Hospital last year. Now the inquest didn't find that Conor died as a result of the fluids. But Dr Sumner was so concerned about how Conor's fluids were managed that he wrote to the Department of Child Health at the Queen's University of Belfast and to the senior lecturer there, Dr John Jenkins.

Dr Ted Sumner
I'd been to Northern Ireland four times to inquests and as an expert witness to help Mr Leckey establish the cause of death in these four cases and I thought that enough was enough and I resigned from that situation. But I thought that before I did it, I really thought that I had to get closure on this. And I expressed, formally, my anxiety that there were problems over those years of ignorance of fluid management and that I wanted my unease to be known, and that processes were in place that would improve the level of knowledge and stop these things happening again.

Reporter
The medical fraternity has minimised the dangers of fluid management in all sorts of ways. It's defended the use of the solution which killed Adam Strain, Lucy Crawford and Raychel Ferguson as absolutely standard in hospitals here at the time of their deaths. It has claimed that it was an abnormal reaction to the fluid that caused the children to develop hyponatraemia. But all this has only diverted attention away from the bottom line of this condition: that it is caused by hospitals. Even in Raychel Ferguson's case, where the cause of her death was immediately identified, it was months before her parents realised what that meant – and even then they didn't hear it from the hospital.

Ray and Marie Ferguson
I know at the time when we were waiting on the results to come back of what happened to Raychel, I was in contact with the Coroner a few times. And this day in particular when I phoned him I asked him, 'Did Raychel die of natural causes?' And he said, 'No'. So I said this, 'So, you're telling me that Raychel would have been still here today if she hadn't have went to the hospital?' He more or less said, 'Yes'.

Reporter:
The Coroner for Greater Belfast, John Leckey, only realized that Lucy Crawford hadn't died of natural causes three years after her death. When he did so, he contacted the Attorney General in London and sought special leave to open an inquest. He only did that after being contacted by this man, Stanley Millar. Stanley Millar acted for the Crawford family when they lodged a complaint against Sperrin Lakeland Trust over the treatment of their daughter.
It was the evidence coming out of Raychel Ferguson's inquest which prompted Stanley Millar to write to the Coroner. It was a year before Lucy's inquest took place and, when it did, few people emerged with any credit. The coroner found that the little girl's death was a direct consequence of the hospital's fluid regime. He ordered changes to Lucy's death certificate, to show the real cause of death and he referred the case to the GMC. But a disturbing theme of both the Lucy Crawford and the Raychel Ferguson cases was that, when an it came to the inquest, the doctors responsible for the two children's care refused to go into the witness box.

Mae Crawford
We were all cross-examined, including myself by the Sperrin Lakeland barrister. On the Thursday morning the coroner said that Dr O'Donohoe, who was in charge of Lucy's care, had decided not to give evidence. We were devastated that he had decided not to, because this was forum where we were going to get all our answers as we thought.

Reporter
Every step along the way of what happened in Lucy's case demonstrates just how easy it is for a death in a hospital to be covered up. One Belfast barrister has been examining the human rights implications

Prof Tony McGleenan
The requirement imposed on the State whenever there has been a fatality in which they have been involved is to hold a prompt, public, effective and independent investigation and it must adequately involve the next-of-kin in that process …
Q) So is the public interest level not being met at the moment?
A) Well, currently we don't have a systematic means of looking at all these fatalities. It doesn't exist. We have a random process which is dependent on the initiative of family members making complaints. It's depending on the good faith of junior members of the hospital staff raising issues which are, perhaps, uncomfortable. But there is no automatic requirement for a hospital fatality to be thoroughly and effectively investigated.

END OF PART THREE

PART FOUR

Reporter
Four-and-a-half years after her death, Lucy Crawford's parents say they still have not been told the full truth about why she died. After the publicity following Lucy's inquest in February, they personally felt the backlash in the local newspaper when it carried an admission from Hugh Mills. One letter to the paper from a consultant at the Erne Hospital shows where his priorities lie.

Actor's voice
The Belfast coroner apparently felt he had a point to make ... In short it was a set-up ... At this point we should all be pulling together to get proper sustainable health services in the shape of a new hospital for the Sperrin Lakeland Region. The message for The Impartial Reporter is clear - back off.

Reporter
The man who ultimately carries responsibility for the cover-up of Lucy Crawford's death turned down Insight's request for an interview. So we turned up at the trust's annual public meeting to give him the chance to explain himself.

Hugh Mills
Reporter: **Mr Mills. Trevor Birney from UTV, sir. Mr Mills, I just want to ask you a couple of questions. First of all, why did you cover up the death of Lucy Crawford?**
Hugh Mills: **The death of Lucy Crawford was a very tragic event, particularly for the Crawford family and indeed for our staff..**
Reporter: **So why did you cover it up?**
Hugh Mills: **This, ah ..**
Reporter: **Why did you cover it up?**
Hugh Mills: **This event happened four-and-a-half years ago ...**
Reporter: **This is your review, sir. Is that your review there?**
Hugh Mills: **...and we have undertaken significant changes in practices at the Erne Hospital. Am ..**
Reporter: **Why did you? Could you answer the question for me?**
Hugh Mills: **Improvements have been made in the Erne hospital since then. Now we know that the outcome of the Coroner's inquest has been referred to the General Medical Council and also the trust has established a review of the circumstances and I would not want to make any further comment ...**
Reporter: **Well, could I ask you ...**
Hugh Mills: **... until the outcome of those events has taken place. I have no further comment to make ...**
Reporter: **Why did you ... Is this your review?**
Hugh Mills: **The outcome of those events. I have no further comment to make.**
Reporter: **What about Dr Asghar, Mr Mills? Dr Asghar's concerns that he raised with you in June 2000? Why did you do nothing about those?**
Hugh Mills: **I have no further comment to make. ...**

Reporter: **Mr Mills, could you also answer, why did you not refer the Royal College of Paediatrics' report to the Coroner?**
Hugh Mills: **I have no further comment to make. …**

Reporter: **How did you fail to get at the truth?**
Hugh Mills: **I'm not taking any further questions, Trevor.**
Reporter: **Well, answer me, just answer me the question.**
Hugh Mills: **I am not taking any further questions.**
Reporter: **Do you stand over the veracity of this document?** (Mr Mills turns away and waves his hand) **You don't stand over it?**
Hugh Mills (walking up the hall): **I've no further comment.**
(Mills glances back and continues walking)

Reporter
The cover-up by the Sperrin Lakeland Trust ensured that no-one was made accountable for the death of Lucy Crawford.
Dr O'Donohoe, the doctor in charge of Lucy's care at the Erne Hospital, has now been referred to the GMC's Professional Conduct Committee. This investigation into his fitness is only taking place because the coroner referred the case to the GMC.
In the meantime, Dr O'Donohoe is still working as usual on the children's wards at the Erne Hospital.
However Dr Asghar, the one doctor who accurately diagnosed what happened to Lucy Crawford and tried to pursue the matter is gone. His relationship with his bosses deteriorated from the time of Lucy's death and he left the Enniskillen last year to start a new life in England.
There are worrying signs that the lessons may not have been learned at the Erne Hospital after Lucy's death. Insight has been told of the subsequent death of a child which clearly alarmed staff at the hospital. An inquest is pending and the parents have asked us not to identify the child concerned before the cause of death has been established for certain. At the time the hospital told them it was due to natural causes. Then two anonymous letters arrived, telling them something very different. One was clearly from a nurse who claimed she'd lose her job if her identity was discovered. Insight also understands that Dr Muhammad Asghar passed on his concerns about the case to his superiors.

The three families who have suffered all say that their greatest difficulty here has been the complete refusal of the hospitals concerned to acknowledge what they have done, leaving them feeling like pariahs. Nothing can bring their children back. But the parents feel that if the medical authorities handled the cases more openly and treated them with more respect, they may be better placed to move on.

Ray & Marie Ferguson
Our life is upside down, spent at the cemetery most of the time. And then you have the other three boys. It's just constant pain, that just is what it's like. And there is no way that we want any other family to go through what we had to go through.

Jay Slavin

I think it's prolonged the grieving process and fact that there's been no proper closure. Debra hasn't .. it's always in the back of her mind, she fought as hard as she could against the Royal Hospital. Unfortunately you're fighting a multi-million pound trust. And an individual simply can't do it without some backing.
I know there's not a day goes by when Debra doesn't think about Adam and the girl still cries herself to sleep at night. Even if we had another child she wouldn't feel the same.

Mae Crawford

It's all this brushing under the carpet at the Sperrin Lakeland Trust in Enniskillen here and have caused us on top of our grief; dealing with the death of our little girl and we had to cope with all this as well which has just been a terrible time.

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