STANLEY MILLAR 16-06-04

When did you become aware of the death of Lucy Crawford?

I first became aware in May 2000 about three weeks after Lucy's death when Mr & Mrs Crawford came to see me in my capacity as Chief Officer of the Western Health and Social Services Council popularly known as the Watchdog body which monitors the provision of health and social care in the area of the Western Board. They came to me with three which I thought were very basic questions why did Lucy die, could her death have been prevented and thirdly was someone responsible or could someone be held accountable for her death.

At what stage what exactly were the Crawford's looking for you to do.

Well I think the Crawford's obviously like most people don't know how to access the complaints system which is available in the Health Service and like most complaints systems it's not until someone actually has a need that they start and realize that there is a process there but evitably they need help and I thought that it was my role as Chief Officer of the Council to give them that advice and help.

And obviously they were even at that stage three weeks after the death of Lucy they were concerned about what exactly happened at the hospital on the night she'd been admitted.

Well they were very distressed and obviously they had huge concerns and huge anxieties over this little girl's death and I felt I was in a position where I could help them to get answers to those questions and in doing so it meant evoking the Health Service complaints procedure but before we went to that stage we agreed that we would follow a process we would try and find out as much information as we possibly could and remember one .....in pursuit is I went up with Mr & Mrs Crawford to the Pathology Department of the Royal Victoria Hospital we met the Pathologist who performed Lucy's

post mortem examination and we sat down and spent quite some time with him in trying to get answers to the questions but the reality was the answers were not there.

What exactly occurred in that meeting what were the Crawford's asking and what was the Pathologist telling them.

Well Mr & Mrs Crawford and with my support were wanting an answer to the simple question what was the cause of Lucy's death and there were a number of issues raised there was the issue of swelling of the brain there was pneumonia there was gastroenteritis but hyponatraemia which subsequently I believe was one of the causes of death it was never mentioned.

The Pathologist never mentioned hyponatraemia in that meeting.

No it wasn't mentioned and obviously being led people they were not familiar with medical terminology and they accepted that the main cause of her death was gastroenteritis, pneumonia and swelling of the brain.

Now if I could just take you back a stage at one point the Crawford's had visited the hospital in an intent to get some answers from the actual doctor involved what did you know of that meeting and were you involved at all in that.

No I was not involved at that stage this was an initiative I believe between the Crawford's and the Consultant in charge of Lucy I'm not you know familiar obviously I don't know what took place my involvement was more to try and get information we did request as people have a right to a copy of her medical notes both from her GP and from the Erin Hospital and the Royal Belfast Sick Children's Hospital we pursued those notes and really they weren't any help either so there were a lot of frustrations that were building up questions remained unanswered and I became quite perplexed because it seemed that a death of that nature a little girl 18 months full of life went into hospital as very common a lot of children do being dehydrated after a bout of vomiting and diarrhea went into

hospital for a drip to be set up she was assured that next morning she would be okay and yet during the night she simply collapsed and to all intents and purposes passed away.

Why did you not evoke the complaints procedure immediately being contacted by the Crawford's why did you feel an informal approach was necessary.

Well I think its better to ascertain the facts and try and get some understanding as to the nature of the complaint and the nature of the complaints process it that I can not complain for the parents the parents had to make that complaint themselves but I thought it was much better to try and get some understanding so that we knew the basis to complain and that we were able to make that decision as to being precise about the complaint. A complaint subsequently was made and it was about the quality of care that this little girl received but at the same time there were other issues that struck my mind as being very usual this little girl did not have a Coroners postmortem a hospital postmortem was agreed with the consent of the parents whereas I would have felt it would be normal that the Coroner would have been involved right from the very start.

And what was your understanding why he wasn't involved.

Well the Coroners normally involved on the basis of advice and information that he would receive from the doctors in charge of out patients that is the normal process that occurs but for whatever reason in this case it was deemed that a Coroner's postmortem was not necessary.

Now during the informal process you've said yourself there that the process went on from April through to September until the formal complaint was lodged you said it was an attempt to try and get information on which to build what the complaint was actually about what information did you get from the Erin Hospital from the Sperrin Lakeland Trust about what had occurred there on the night of the 12th and 13th of April.

The information we received was based on the medical case notes and they normally would be a very comprehensive record of what took place and from my limited medical knowledge it was obviously that there was something very untoward here happened.

Did you get any information apart from the notes from the Sperrin Lakeland Trust
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No I didn't seek any information directly because that normally would be part of the complaint process once the complaints system is evoked its up to the Trust concerned to investigate the matter the Council is not in a position to investigate that is one of the concerns about the whole complaints process that its self investigation and self reporting.

Now you've said that you got the case notes but you went with the family to the Royal Victoria Hospital in order to meet with the Pathologist there yet at the there was no informal contact at all with the Sperrin Lakeland Trust or with the Hospital about what exactly had occurred there.

Well there was once the complaints process was evoked there was a communication process between the family and the Trust now that proved to be inconclusive because what was established was that the Trust undertook a review of the case an internal review but the Crawford family were not involved in that review much to their disappointment and the findings of that review were not made public.

So from April through to September until the formal complaint was lodged you had absolutely no contact at all formally or informally with the hospital about what had occurred.

No I had no contact I understand the Trust did try to establish contact with Mr & Mrs Crawford but for there own reasons they felt that they were not able to enter into a dialogue.

In September then a formal complaint was lodged and you facilitated that what do you normally expect to happen in that situation and what did happen.

Well there are guidelines and time scales laid down with the complaints whereby the complainant would expect to receive an initial response of the complaint and then within a period of four weeks the complainant would expect that there would be a comprehensive response to that and that a review would be undertaken that would be the normal process and it's a stage process that would be the first stage.

Did the Crawford's get a reply within twenty days.

I am not aware that they did I think the complaint was acknowledged but they never received the detailed response that normally one would expect in a complaint.

Why not.

Well that's a question that obviously the Trust has to answer I'm not in a position to answer that.

Did they give you any reasons why they weren't able to answer the complaint.

No, I'm not aware of any reasons I think the Trust were very keen to establish a dialogue with the parents but the Crawford's declined that on the basis that they felt that the Trust was withholding information in the review that they had undertaken the internal review.

But the Crawford's weren't even aware of the internal review at that situation at that time in the autumn of 2000 six months after the death of their daughter they were completely unaware that any review had taken place.

Yes there are issues here that I think the Trust has to investigate because I would have thought that it would have been reasonable that that report should have been shared with the parents as a matter of fact I think the best practice would be that the complainant

parents should always be part of a review even if its an internal review I think that they had something to contribute to that review but they did not have the opportunity.

So one of the guidelines laid down a Trust should be giving answers to complainants within twenty days of receiving the complaint but in this case even though it was the death of a child we're talking about here a seventeen month old child the Trust didn't even believe that it should honor its own guidelines they ignored them effectively.

Yes, there appear to be difficulties there that remain to this day and that is that whole issue of communication between the bereaved parents and the Trust and I know that this was a matter of quite some concern.

So what occurred after that that was in the September in the October Brigid O'Rawe from the Sperrin Lakeland Trust wrote to the family and said that a full investigation would be carried out that was the first letter that came back after the formal complaint that you had lodged with the family yet at that stage we now know that a full investigation in fact the only investigation by the Sperrin Lakeland Trust into the death of Lucy Crawford had already been carried out and committed to paper.

Yes to my as far as I'm aware there was that one review that was conducted quite soon after Lucy's death in the mean time what was interesting was I encountered a similar case in …….. Hospital which also lay within the area of the Western Health and Social Service Council and that girl had there were similarities in her case her care her treatment and unfortunately similar outcome in so far as she also lost her life that case subsequently went a Coroners inquest which was interesting but I had a huge frustration and a huge burden to carry because I was not able to get answers to the Crawford's for the issues that they raised however there came a breakthrough whenever I had an opportunity in ……to obtain a briefing on the cause of the second little girls death and the similarities rung a bell I was struck by the comparison of the two cases and subsequently then I felt it

approach to write to the Coroner for Greater Belfast Mr John Leckey and draw his attention to the similarities and to Mr Leckey's credit he did respond to me and did suggest that he would follow up on my concerns and the outcome of that then was where he conducted to his credit a very comprehensive investigation which lead eventually to a Coroners inquest.

Just go back though Rachel Ferguson's death didn't occur until June 2001 that means that the Sperrin Lakeland Trust and given that Lucy had died fourteen months previous the Erin Hospital and the Sperrin Lakeland Trust if they had properly investigated the death of Lucy Crawford and if they had properly answered the complaint that was filed by the Crawford's Raychel Ferguson may yet be alive.

Well one can draw that conclusion you know that could be the case certainly I would like to think that medical staff would have been alerted about Lucy's death not only in the Erin Hospital but right across the Province so that other hospitals would have been aware for a similar child to be admitted to hospital that the alarm bells would have rung.

But that didn't happen.

That did not happen. Sadly that did not happen and we you know we have seen the outcomes there and sadly.

Where does the blame in your mind lay for that.

Well there are a lot of issues that I think need to be resolved you know the Health Service is very poor communication and there is a need for much improved communication not least whenever a child loses its life I think that its important where that information is shared between the medical profession that when there is a sad outcome of an episode of care that that should be shared right across the medical profession and that's how people will learn I think there's also a greater need for better communication between

Consultants who have a responsibility for the care of a patient and the Coroner service so that in the event of something untoward arising the Coroner service is made aware immediately and that they can start an investigative process starting off with a Coroners postmortem and the third issue that I think needs to be learned and that is much better communication between the parents of children and the health care professionals that care for them because no one knows a child better than the parents of that child.

Just going back slightly the complaint was lodged by the Crawford's in September and Brigid O'Rawe acknowledged it on the 2nd October and promised a full investigation what was the outcome of that complaint.

I'm not aware that the investigation was completed in the normal course of events one would have felt there would have been an initial response there would have been the investigation and that would have been completed within weeks rather than months in the event of the complainants being unhappy with the outcome it would have went then to an independent review organized by the Western Board but that process unfortunately did not follow through.

What happened. What happened with the complaint in your mind.

Well I think that's something that Sperrin Lakeland Trust has.to answer.

But you never got an answer to any of the complaints basically.

There was no conclusive response to the complaint that the family raised.

Then we had the death of Raychel Ferguson subsequently the inquest into her death which happened in 2003 just tell me specifically when you were sitting at home hearing I take it or reading about and listening to the reports of the inquest what exactly set off the alarm bells in your mind that made you link the death of Raychel Ferguson to the death of Lucy Crawford.

Well obviously when one is involved in a case like this particularly the death of a child you know its something that one has to carry and I felt a considerable burden in carrying this complaint and in working with the parents you know I got to know them very well it was almost as if I had got to know Lucy as well so that those questions that were being asked and remained unanswered and it was only whenever the Raychel Ferguson case came that it really clicked in my mind almost immediately that there were comparisons that there were similarities that were almost uncanny and that well there was the fact that the child both children went into hospital were dehydrated a drip had been set up and within a short period they had collapsed it was as simple as that.

But in Raychel's case in fact she had gone into hospital for an appendix operation she never became dehydrated really and it was only as a result of the fluids and the mixture of fluids and her vomiting afterwards that caused her what exactly going back made you write to the Coroner what exactly was the alarm bell what went off in your head given that the Sperrin Lakeland Trust hasn't answered any of the concerns.

Well it was a hope that possibly the Coroner could provide answers that I wasn't able to provide but there was an uncanny similarity in the two cases not least they were both you know young girls and you know beyond that just was an issue that was unresolved in my mind but for some reason it clicked once I heard the outcomes of the Raychel Ferguson inquest.

And yet this was even though all you were going on really because you haven't got any information from the Sperrin Lakeland Trust all you were going on was simply the medical notes in Lucy's case.

That's right.

The relatives didn't know at that stage there was anything to do with her fluids.

No it was a sense that well in reading the case notes you know through and through and almost learning them off by heart it was obvious there was an issue there that had to be resolved the infusion of what's popularly known as a drip.

Even in lay mans terms looking at the case notes it was quite obvious there was a problem with the drip.

Well there was an issue there that I couldn't resolve and had to be answered it was just the comparison of the two cases and the way the little girls collapsed and died.

And what was it when you read the case notes about the fluids that struck you that made you think there was an issue there what was it that you read what did you see.

Well it was just the fact that these girls went into hospital with a minor condition one with vomiting, diarrhea and another one with appendicitis and in both cases a drip was set up and a relatively short time after the drip was set up they collapsed and unfortunately died.

Lucy's case when you looked at the case notes as you said you looked at the case notes and it was quite clear that there was an issue of the infusion of the fluids in the drip what was it in those case notes that struck you that made you aware there was a problem with the drip.

Well it was just it was the treatment rather than the detail you know I wouldn't pretend to have any great medical knowledge but there was something that just didn't add up.

From the case notes.

From the case notes and from the experience of Lucy's mother who stayed with her all the time she was in hospital.

So you had pieced together in your own head that there was quite obviously a problem with the fluids and the amount of fluids that Lucy had been given.

Well it was the only reason that I could conclude that there was something untoward because I don't think they were given a lot of medication.

It must have been quite a was it a hard decision was it a big decision to write to the Coroner to give him what you knew that the focus then would obviously shift back onto the Lucy Crawford case.

No it wasn't a hard decision because there was an issue unresolved in my mind that I had to try and resolve and come to terms with and that was the fact that there was an something that needed to be explained here which was unexplained and I wrote a very brief letter to the Coroner I referred the case to him and he very promptly responded and I believe he engaged with an expert in that field and who investigated the matter.

In your experience working as you have for over thirty years in the health authorities here I mean do you think the Sperrin Lakeland Trust ultimately failed Lucy Crawford both in the treatment and in the investigation of her death.

Well you know it's a very difficult to give an answer there something went wrong something went terribly wrong all I could conclude based on hindsight now was that it was a huge tragedy for the Crawford family but equally and I must be very clear about this it was a tragedy for the staff in the hospital who worked with that little girl and you know done their level best for her you know when she was there much has been said about portioning blame and responsibility and I would be very reluctant to do that because I am personally satisfied at that time the treatment that was used was what was in vogue at that time it was common and the same thing would have applied to had Lucy been applied to any other hospital in Northern Ireland what happened was a failure in the system of care that was there that was commonly used at that time the reality is that today medical knowledge is as such that its very unlikely that that would have happened today

had she been admitted more recently the main difficulty I had was in possibly starting a whole investigation and creating a lack of confidence in the children's wards in the Erin Hospital the fact that staff would be investigated and that one didn't know really what the outcome was going to be but above all for other parents of children who admit those children to hospital who are dehydrated that this could create a huge lack of confidence in the services that were provided in the hospital and that was really the major difficulty I had and I still have and I hope that through all this investigative work that that confidence now would be restored and people right across the Province will be able to with confidence admit their children to hospital knowing that there will not be a similar outcome.

But do you understand the Crawford's when they hear you saying that your major concern is for the confidence in the hospital that you aquavit their grief equally with the suffering of the nurses and the staff and the hospital that they feel that ultimately that not only did the system fail them on the night she was brought to hospital not only did the Sperrin Lakeland Trust fail them not only did you fail them and the Council fail them that ultimately here four years on that there is no one standing up them and saying "Listen where's the truth in this"

Well there's no doubt I'm totally satisfied the system of the day did fail them its very harsh to say that the hospital failed them because really and truly I believe it was the system that was in vogue at the time that failed them.

Even though it didn't answer the complaint and it didn't investigate ....

Well I you know I would see the complaint quite honestly as a separate issue as far as the experience that they had the system certainly let them down I think its sad that staff in the hospital have been singled out and will have to carry this burden and have been scapegoated almost as it were. Whereas I believe the system let them down and had there been much better communication in some of the ways that I suggested earlier on I believe the tragedy could have been averted and the important thing is in medicine whilst it's a

tragedy for the Crawford family I think that there must be learning that lessons have to be learnt and that I'm aware that practices have changed but unfortunately it was to late for Lucy.

I mean ultimately what your saying is that there has to be learning there has to be understanding from cases like this there must be. But yet when you look at what occurred a doctor put a drip into Lucy's arm infused her with 400ml of fluid over four hours and the hospital in the Crawford's mind covered that up I mean can we ultimately have faith in a hospital that did that.

Well I'm not so sure the hospital covered it up that

That's what the Crawford's would believe they didn't get any answer to their complaint.

I think that was their understanding alright again with my limited knowledge of medicine I believe the treatment that was given to Lucy was the standard treatment of that time for a little girl that went into hospital with her condition I have experience I can remember of my own going into hospital with a similar condition and went in poorly and within a matter of hours after a drip being set up she come out bouncing and as large as life but for whatever reason in Lucy's case this was not appropriate.

You say that but you're the one that sparked the inquest you're the one that identified as a lay man with huge experience but even a lay man from the medical notes being able to glean enough information that alerted you that there were similarities between the deaths yet you now understand that and you're now saying that really that there was nothing that

I think the difficulty and the difficulty for the Crawford's hearing some of your answers is that on the one hand you were the person who spotted that there was something in the case notes that alerted you to the problems with fluid management

yet you're now saying that the fluid management really wasn't inappropriate anyway. What how can you explain that in that what alerted you exactly in the case notes that there was a difficulty with Lucy's death.

I can't be specific you know I can just say it was a sixth sense there was something wrong we're now fifty months on since that and I think much has been learnt in the mean time.

I think the difficulty for the Ferguson's and the Crawford's but the difficulty here is that there was something in the case notes that you spotted what specifically was it in the case notes that spotted you that alerted you that there were distinct similarities in that hyponatraemia was responsible for those deaths.

I can't be precise you know as to what the specific issue was it just did not add up and I could not get answers to why a little girl that seemed to be healthy died in hospital as I say we're fifty months on I think much as been learnt in the meantime the practices certainly of that time have certainly changed and whilst you know this was major, major tragedy for lots of people not least the Crawford's I think you know there's been a learning issue and I don't think that this I would hope you know will not recur again,

The Crawford's have you obviously have read and you understand many of the statements that have been made by the Crawford's both at the Coroners inquest and since it one of the things that they've said to us is the concern that they became aware that while you were handling their complaint that at the Coroners inquest they found that your wife was actually handling some of the statements that were being given by the nurses at the hospital did you ever feel that there was conflict of interest there.

Absolutely not because I think we were both acting in the best interests and trying to support the Crawford family you know from two different directions my wife had a responsibility from a professional caring role and I had quite distinct separate role on the part of the consumer to try and get answers there to and at the end of the day we both had

huge disappointments you know in the outcome and how it came about and you know I can't emphasize enough how much people were shocked whilst the focus understandably is on the Crawford family a lot of other health care professionals you know people particularly the nursing profession were devastated through this experience.

So you can leviate the concerns of the Crawfords that you never discussed the case with your wife. You weren't aware of it at all and you didn't there was never any discussion at home.

No. I maintained my role. This is why I raised the issue. You know independently. You know I raised the matter because I felt there was an issue there that was unresolved and needed to be resolved. You know at least now I have the satisfaction that thanks to the coroner John Leckey the matter was fully investigated and there was an outcome and all I can trust and hope is that it never happens again.

Did you ever feel at all in that period that there was a conflict of interest?

No there was never I'm absolutely certain there was never any conflict of interest.

You would do the same again?

I would do exactly the same again. I hope that I don't come across it again but were I to do so I would do exactly the same for a little girl of 18 months that hadn't an opportunity to grow up.

There is obviously a case that has personally affected you?

Oh without a doubt you know those number of years there were always the questions. I took a very significant interest in the case. You know I even took the trouble to search out the little girls grave in South Fermanagh so that I could pay my respects there. But I am thankful that at least for me you know I had some satisfaction. I cannot speak for the

Crawford family I think there is a huge healing process that they will have to work through. But for me personally it meant that I could draw the line under the case as far as the outcomes were concerned although you know I will always carry that concern that that wee girl lost her life and indeed others including Raychel Ferguson.

Did you ever think that you wish you'd pushed it harder to get answers from the trust in order that they could actually – I'll say that again – Do you ever wish that you'd pushed the trust harder to get answers?

Well it wasn't going to make any difference Lucy had lost her life and I don't think it is going to make any difference.

Could it have saved Rachel's life could it?

It may have done so you know that is speculation. I think in the health service and you know there are two comments I would make. I think its important that the whole complaints procedure is reviewed so that it can be streamlined and it can be more responsive and you know meet the needs of people like the Crawfords that have been bereaved and secondly the final comment would be that there is a move afoot to do away with the health and social services councils and now important I think its essential that a local monitoring body is present so that these cases as I have done can be followed through rather than leaving it to the service to investigate itself.

But in this case the Western Health and Social Services Council is completely ineffective, completely unable to get answers, completely unable to be the watchdog.

Yes that is a huge disappointment that the circumstances were such that we were not able to hand Mr and Mrs Crawford a document which set out A-Z the responses to the three questions that they asked at the start.

And that was the Trusts position not to give them the answers?

Well as I say the council could not investigate it, it was up to the trust to provide those answers.

Of all the things that have happened over the last four years what is the one thing that stands out in your memory about all your experience in relation to Lucy Crawford and Raychel Ferguson and the inquest?

Well obviously it was in relation to having an understanding of some of the grief that both families went through in getting to know them and getting to know the, in a strange way, the little girls that died but above all at least through the coroner system having the satisfaction of both cases going through a coroners court and a conclusion being made by the coroners as to the cause of their deaths.

Finally the Sperrin and Lakeland Trust is now analyzing the death of Lucy Crawford again, do you have any faith in that?

Well I'm prepared to be part of that process if I'm invited. Again I'm outside the service now but I think you know its important for Mr and Mrs Crawford I think to show an investigation that's transparent and that hopefully will answer again the questions that they have raised and if it does so I think it will be a help to their healing process whilst they'll never get over the loss of the little girl at least there will be some sense of closure for them in so far as they have gone as far as they can in the whole issue of complaining about the death of Lucy.

And why do you think the trust is looking at the case again? Why do you think the trust is actually looking at the case or why does it feel the need to do so again?

Obviously the trust is not satisfied with the initial investigation and I would only hope that this time their efforts would be more successful.