[redacted]

Mr John Leckey
H.M. Coroner
Old Townhall Building
80 Victoria Street
BELFAST BT1 3GL

Lucy Crawford Deceased

Dear Mr Leckey

Thank you for your letter of 16 January 2004.

I am pleased you have made arrangements for an inquest into the death of Lucy Crawford.

It is my intention to attend at least the opening of the proceedings on Tuesday 17 February 2004.

I am very happy for you to explain my involvement with the tragic death of Lucy as recorded in my letter to you of 27 February 2003. (see attached).

In relation to the Pathologist's role may I make two points :-

- When I with Mr and Mrs Crawford on the 16 June 2000 met Dr D O'Hara in the Pathology Department on RVH site the explanation for death related to Broncho Pneumonia, Dehydration, Gastroenteritis and Cerebral Oedema.
- I note Dr O'Hara's report which you forwarded on 21 November 2003 was completed and signed on 6 November 2003 i.e. 43 months after the Post Mortem examination was undertaken.

Yours sincerely

Stanley E. Millar

E-Mail: [redacted]

IN CONFIDENCE

Our Ref: H0003-20.203

Date: 27 February 2003

Mr J L Leckey
Coroner for Greater Belfast
Old Townhall Building
80 Victoria Street
BELFAST BT1 3GL

Dear Mr Leckey

Lucy Crawford Deceased

The enclosed leaflet explains the role of the Western Health and Social Services Council in providing support to people who wish to complain about Health and Social Services.

In the spring of 2000 I was contacted by the parents of a **Lucy Crawford** (DOB 5-11-98). Lucy was taken ill on 12 April 2000 and was admitted by her GP into Erne Hospital Enniskillen with a relatively minor condition of vomiting. A drip was set up and the family was assured Lucy would be home next morning. During the early hours of 13 April 2000 Lucy fitted and collapsed. She was transferred to the Royal Belfast Hospital for Sick Children on a life support system. On **14 April 2000** the life support was switched off. A post mortem examination was undertaken and a "swollen brain with generalised oedema" was discovered.

In my supporting role I arranged for the parents to meet the Consultant Pathologist who conducted the PM. I also contacted the Coroner's Service to ask about the arrangement of an Inquest but I was told it was not necessary.

Following the Raychel Ferguson Inquest I with other Members of the Western Health and Social Services Council received a briefing on the Events which led up to Raychel's death.

I was struck by the similarities in the two tragedies and in particular the details of the solutions used in the drip set up for Lucy Crawford which are clearly recorded in the Medical Notes I hold (as supplied by Erne Hospital).

You will appreciate my concerns over the cause for the death of an 18 month old little girl which were to my mind unexplained were rekindled by Raychel's death.

I am left with two questions which you may be able to answer.

(1) Are there direct parallels in the events leading up to the deaths of both girls.

(2) Would an Inquest in 2000/2001 have led to the recommendations from the Raychel Ferguson Inquest being shared at an earlier date and the consequent saving of her life?

I am also left with a query as to other similar uncovered deaths across the UK. At least the Altnagelvin Medical Team have "broadcast" the phenomena of Hyponatraemia and raised an awareness of the potential problem with children.

Your advice on the foregoing would be appreciated.

Yours sincerely

Stanley E Millar
Chief Officer

Enc: Complaints Leaflet