Witness Statement Ref. No. 277/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: John Leckey

Title: Mr.

Present position and institution:

Previous position and institution: Her Majesty's Coroner for Greater Belfast
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – August 2012]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
115-034-001	25-01-2005	Statement to PSNI
WS-277/1	26-10-2012	Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

(1) Arising out of your answer to question 3 of WS-277/1

(a) Please clarify whether the arrangement for seeking advice from a pathologist in the State Pathologist's Department (in cases where the medical background to a death was complex) was the subject of any guidance, procedure or protocol, whether formal or informal?

(b) If this arrangement was the subject of guidance, procedure or protocol, whether formal or informal, was it documented? If so, please provide a copy of the relevant document.

(c) If the arrangement wasn't documented, please explain how it was supposed to work, describe its purpose, its key elements, and the steps that should have taken place after the advice of the pathologist had been sought.

(2) Arising out of your answer to question 4(h) of WS-277/1, please indicate the relevant part of Mrs. Dennison's statement which addresses the question of whether the advice that a death certificate would be issued giving gastroenteritis as the cause of death, was scrutinised by either you or your office? If the advice was scrutinised please describe the scrutiny which it was given.

(3) Arising out of your answer to question 8(a) of WS-277/1, the Inquiry is conscious that you have provided a file containing correspondence. The file does not contain any response from Professor Crane to your correspondence. Therefore, should the Inquiry conclude that there was no response to your correspondence from Professor Crane and that the issues raised in that correspondence were not taken forward?

(4) If the issues were taken forward (in particular the issues around your concern that when the deaths of children are reported to your office the proper questions may not be asked etc.) please outline how that was done.

(5) Arising out of your answer to question 8(f) of WS-277/1, please consider your file of correspondence and firstly, identify for the Inquiry the piece of correspondence issued by you to Dr. H. Campbell which informed her of the concerns raised by Mr. Millar. Secondly, please provide or refer to any response which you received from Dr. Campbell to that correspondence. The Inquiry appreciates that you have forwarded Dr. H. Campbell's letter to you of 28 June 2004, but this does not appear to be a particular response to correspondence issued by you.

(6) In 2000 was there any written guidance in place in order to assist or advise medical practitioners in relation to issues relevant to the reporting of deaths to the Coroner, including when a death should be reported, and the nature of the information which should be reported to the Coroner's Office?

If so, please provide a copy of this document to the Inquiry or advise the Inquiry where it might be obtained.

(7) In 2000 was there any written guidance in place in order to assist or advise staff in the Coroner's Office in relation to the issues relevant to the reporting of deaths, including the information that should be obtained from reporting medical practitioners, and the steps to be taken when the cause of death was uncertain.

If so, please provide a copy of this document to the Inquiry or advise the Inquiry where it might be obtained.

(8) Was it any part of the role of staff in the Coroner's Office to advise the reporting medical practitioner that a death certificate could be issued? Please, fully explain the role of the staff member in this context.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Dated:

Coroners Service for Northern Ireland

JOHN L LECKEY LL.M.
SENIOR CORONER
FOR NORTHERN IRELAND

The Inquiry into Hyponatraemia-related Deaths

Additional statement of Mr John L Leckey, Senior Coroner for Northern Ireland

I have received a letter dated 8th January 2013 from Anne Dillon, Solicitor to the Inquiry, asking me to comment on additional matters:-

(1) Arising from question 3 of WS-277/1

(a) Prior to the formation of the Coroners Service for Northern Ireland in 2006 there were 7 Coroners' Districts. The Greater Belfast District had the largest workload. From my own knowledge I can state that in Greater Belfast the practice had evolved of seeking from time to time advice and guidance from the State Pathologist's Department. Such advice would be sought only if it was unclear to either the Coroner or the staff if it was appropriate for a Death Certificate to be issued by the reporting doctor or if there should be a post-mortem examination. This arrangement was informal. I cannot speak for the practice of the Coroners for the other 6 Districts.

(b) Not applicable.

(c) See (a) above. Where it was unclear whether a Death Certificate should be issued or if the circumstances of the death necessitated a post-mortem examination clarification could be provided by the reporting Medical Practitioner speaking direct to one of the pathologists or the pathologist making contact with the reporting Medical Practitioner. The Coroner's Office would normally be advised of the outcome of that. That would usually indicate to the Coroner whether the death should be the subject of a Death Certificate or post-mortem examination. As I have indicated previously the Medical Practitioner was not bound to accept the opinion of the pathologist.

(2) Arising from question 4(h) of WS-277/1

There was direct contact between the reporting doctor, Dr Hanrahan, and Dr Michael Curtis of the State Pathologist's Department. That direct contact led to a Death Certificate being issued on the presumed basis that the death was a

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natural one and the cause was known. I indicated in my previous statement that Dr Hanrahan was not bound to accept the advice of Dr Curtis but in this instance he chose to do so.

(3) Arising from question 8(a) of WS-277/1

I am unaware of any response from Professor Crane.

(4) It remains my concern that when the death of a child is reported to my office the proper questions may still not be asked. Needless to say it is vital that there is complete candour on the part of the Medical Practitioner reporting the death and that as much information as possible is given. That points to the need for the Medical Practitioner not to be a Junior Doctor but someone who has been involved in the treatment of the patient at a senior level. I should add that this concern is lessened following the appointment of Dr Gillian Clarke as Medical Advisor to the Coroners Service. However, Dr Clarke was formerly a GP and not a Paediatric Anaesthetist. Dr Edward Sumner, who was my expert witness at these inquests, expressed a firm view that the diagnosis of Hyponatraemia was outwith the experience of a General Practitioner and might not be diagnosed by anyone who is not a Paediatric Anaesthetist. Consideration has been given to whether a Medical Examiner's system would solve the problem as that system would ensure that all deaths would be scrutinised by someone medically qualified. However, again I would make the point that much would depend on whether the Medical Practitioner acting as Medical Examiner had the specialist knowledge to identify Hyponatraemia. I would add that Coroners are concerned only with those deaths that are reported to them. Death Certificates are issued without any reference to the Coroner where the Medical Practitioner is of the opinion that he or she has the statutory power to do so: death was from a natural illness, the deceased was treated for that illness within 28 days of death and the Medical Practitioner is satisfied to the best of his knowledge and belief as to the cause of death.

(5) Arising from question 8(f) of WS-277/1

To the best of my knowledge Dr Campbell's letter of 28th June 2004 was not sent in response to any correspondence from me.

(6) My understanding is that written guidance was (and still is) included in the pad of Death Certificates that would be issued to doctors. I understand a copy of this has been furnished to you. In addition, my understanding is that the role of the Coroner and the reporting of deaths was part of the undergraduate medical course at Queen's University and, presumably, other medical schools in the United Kingdom. Further, I understand that it constituted (and still does) part of induction training by hospitals in Northern Ireland for each new intake of doctors.

(7) The current office manager has been unable to locate any written staff guidance on recording death reports that would have been available for Coroner's office staff to refer to in 2000.

(8) Yes. A large number of queries are received by the Coroners Office. In many instances this is because the reporting doctor wishes reassurance that a Death Certificate is appropriate or for advice as to how to draft the causal chain. Now many of these queries are dealt with by the Medical Advisor to the Coroners Service, Dr Gillian Clarke. I would repeat the point I made earlier that Coroners are concerned only with those deaths that are reported to them. The vast majority of deaths lead to the issue of a Death Certificate which is not scrutinised by anyone medically qualified. As I mentioned earlier a Medical Examiner's system would be required for that level of scrutiny. Some measure of scrutiny is provided by the staff at the various Registrar of Deaths Offices. However those staff are not medically qualified and where they have concerns either as to the circumstances of the death or how the cause of death is formulated on the Death Certificate they refer to my Office. Approximately 14,000 die annually in Northern Ireland and of that number about 4,000 deaths are reported to my office. Therefore the vast majority of deaths in Northern Ireland are not subject to any independent medical scrutiny. It should be remembered that the role of the Coroner is reactive and not proactive in that the Coroner deals only with deaths that are reported.

John L. Lowry

21/1/13