LUCY CRAWFORD deceased

As the events leading up to the holding of this inquest are unusual, I consider it appropriate to make a preliminary statement by way of explanation.

On 14th April 2000 Dr Donncha Hanrahan, who is a Consultant in Paediatric Neurology at the Royal Belfast Hospital for Sick Children, telephoned my office to report the death of Lucy Crawford aged 17 months. Lucy had died that day in the hospital's Paediatric Intensive Care Unit following transfer from the Erne Hospital the previous day. The clinical history given was of *gastroenteritis, dehydration* and *brain swelling*. Advice was then sought from a pathologist attached to the State Pathologist's Department as to whether the clinical history warranted a coroner's post-mortem examination being carried out. Following a consultation between the pathologist and Dr Hanrahan my office was advised that it would be appropriate for a death certificate to be issued giving *gastroenteritis* as the cause of death.

On 27th February 2003 I received a letter from Mr Stanley E Millar, Chief Officer of the Western Health and Social Services Council in which he referred to an inquest I had held a short time previously into the death of Raychel Zara Ferguson aged 9 years. She had died from *cerebral oedema due to hyponatraemia* and I understand that the publicity surrounding the inquest led Mr Miller to speculate if the two deaths had any common features. In his letter he said this:

"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 the 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."

It was only when I read Mr Miller's letter that I became aware that in fact a post-mortem examination had been carried out later by a consultant paediatric

pathologist attached to the Royal Victoria Hospital. This was not a coroner's post-mortem but a "*consent*" post-mortem for which, I assume, the consent of Lucy's parents was sought and obtained. I then obtained a copy of the post-mortem report and considered the findings of the pathologist. These indicated to me that the deaths of Raychel and Lucy might have common features and that it would be necessary to obtain a further specialist report. With the benefit of hindsight, it would have been helpful if I had been advised of the post-mortem findings at an early stage.

When I was investigating the death of Raychel I obtained an independent expert report from Dr Edward Sumner. He is a Consultant Paediatric Anaesthetist who was formerly on the staff of the Great Ormond Street Hospital for Children in London. I asked him to prepare a report for me concerning the death of Lucy. His conclusions indicated that the two deaths did indeed have common features.

I considered that it was essential for an inquest to be held into the death of Lucy. As a death certificate had been issued and, arguably, I was *functus officio,* I applied to the Attorney General for a direction under the provisions of section 14 of the Coroners Act (Northern Ireland) 1959 that an inquest should be held by me. I provided the Attorney General with all relevant documentation including the post-mortem report and the report of Dr Sumner. On 12th December 2003 I was informed that the Attorney General had exercised his powers under section 14 and that I had been directed to hold an inquest into the death of Lucy.

JOHN L LECKEY
HM CORONER FOR GREATER BELFAST