Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on TUESDAY the 17TH day of FEBRUARY 2004, at inquest touching the death of LUCY CRAWFORD, before me MR J L LECKEY Coroner for the District of GREATER BELFAST as follows to wit:-

The Deposition of DR DEWI EVANS - MB, FRCP, FRCPCH, Dobst - CONSULTANT PAEDIATRICIAN of DEPARTMENT OF CHILD HEALTH, SINGLETON HOSPITAL, SKETTY LANE, SWANSEA, SA2 8QA who being sworn upon his oath, saith

At the request of Murnaghan & Fee Solicitors, 37 Townhall Street, Enniskillen I prepared a report into the events leading to the death of Lucy Crawford.

I now produce a copy of my report as exhibit C 2

I agree with how Dr Turner formulated the cause of death. I accept that the weighing of babies/toddlers may be inaccurate. On admission children should always be weighed. At 1(c) Excess dilute fluid. The notes showed that she had been given too much fluid anyway. The fluid was too dilute & the rate of infusion was too rapid. If she had more fluid than in the notes it would not have been a lot more, the very bad note-keeping is inexcusable. There was a breakdown in communication between the nursing & medical staff.

TAKEN before me this 17TH day of FEBRUARY 2004

Coroner for the District of Greater Belfast

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of 20 , at inquest touching the death of , before me

Coroner for the District of

as follows to wit:—

The Deposition of DR. DEWI EVANS

of

(Address)

who being sworn upon his oath, saith

Mr. Good: On admission to Erne Lucy's weight 9.1, at RBHC 9.8. I accept the fluid intake explains the difference. Probably the fluid intake in the Erne was accurate. The treatment of young children is difficult. I do not think the medical staff in the Erne addressed the dehydration adequately. I agree with Dr. Dunnar as to about 5% dehydration. I have never used .18 solution in my practice in Lucy's circumstances. That solution is not used at all in my department. At no time would it have been reasonable to have used that solution. The lack of proper equipment did not affect the fatal outcome. When Lucy collapsed I do not believe the reaction of the medical staff was sufficiently prompt. My criticism is in part based on the statement of Mr Crawford.

Mr. Fee: Someone with Lucy's symptoms should not have been prescribed .18 solution. It should not have been used for deficits. It was a fundamental error to have used it. The rate of infusion was also a fundamental error as was the decision to change to .9 solution on a free-running rate. There is no record of the

P.T.O.

matter referred to in para 44 having been attended to. It should be mandatory to have a written prescription of to fluid management. The publication referred to at para 37 is a book — first edition published 1993. It states 19 solutions for dipsicks. It deals with fluid replacement therapy generally. I would be astonished if there had been a report out criticizing the care and management of Lucy.

TAKEN before me this 18th day of February 20 04

Coroner for the District of Greater

013-024-089a

The witness concerned: Dr Dewi Evans

I agree with how Dr Sumner formulated the course of death. I accept that the weighing of babies/toddlers may be inaccurate. On admission children should always be weighed. At 1(c) Excess Dilute Fluid. The notes showed that she had been given too much fluid anyway. The fluid was too dilute and the rate of infusion was too rapid. If she had more fluid than in the notes it would not have been a lot more. The very bad note-keeping is inexcusable. There was a breakdown in communication between the nursing and medical staff.

Mr Good: On admission to Erne Hospital Lucy's weight 9.1 at Royal Belfast Hospital for Sick Children 9.8. I accept the fluid intake explains the difference. Probably the fluid intake in the Erne was accurate. The treatment of young children is difficult. I do not think the medical staff in the Erne addressed the dehydration issue adequately. I agree with Dr Sumner as to about 5% dehydration. I have never used No 18 solution in my practice in Lucy's circumstances. That solution is not used at all in my department. At no time would it have been reasonable to have used that solution. The lack of proper equipment did not affect the fatal outcome. When Lucy collapsed I so not believe the reaction of the medical staff was sufficiently prompt. My criticism is in part based on the statement of Mrs Crawford.

Mr Fee: Someone with Lucy's symptoms should not have been prescribed No 18 solution. It should not have been used for deficits. It was a fundamental error to have used it. The rate of infusion was also a fundamental error as was the decision to change to No 9 solution at the free running rate. There is no record of the matters referred to in paragraph 44 having been attended to. It should be mandatory to have written prescription as to fluid management. The publication referred too at paragraph 37 is a book-first edition published 1993. It states No 9 solution for deficit. It deals with fluid replacement therapy generally. I would be astonished if there had been a report not criticising the care and management of Lucy.