HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

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22nd March 2004

Dear Rita,

LUCY CRAWFORD, DECEASED

As you know there has been considerable media interest into the deaths of Raychel Ferguson and Lucy Crawford. I saw your interview on BBC Northern Ireland on March 18th and UTV is broadcasting a special programme on Thursday – "The Issue". The inquest into the death of Conor Mitchell is still to be held and again, it will raise questions concerning fluid management of children. I thought I would make some observations on the issues that have been raised and which you may wish to consider.

I have no objection to alerting you to any hospital death referred to me which raises concerns. Usually, where such a death is reported the initial means of investigation is a post-mortem examination. If the findings of the post-mortem examination indicate that there is indeed a cause for concern an inquest will almost certainly be held. As you know the previous practice within my district of allowing the Clinical Directors of the various hospitals to obtain statements from the staff involved has now been discontinued following an approach from PSNI that this practice is no longer appropriate. All hospital deaths are now referred to ACC Sam Kincaid who will appoint an investigating officer and that officer will arrange for the medical staff to be interviewed and statements taken. Your colleague, Dr Ian Carson, is aware of these developments and chaired a meeting several weeks ago at which I was present along with a number of Medical Directors and representatives of the PSNI.

On request I will provide you with a list of all hospital deaths in my district which are currently under investigation. Whilst all raise concerns of varying degree, I would mention the deaths of [redacted], Conor Mitchell, [redacted] in particular. Dr Miriam McCarthy has been aware for some time of the circumstances of the death of Connor Mitchell which has similarities to Raychel Ferguson and Lucy Crawford as it too raises the issue of fluid management. (I have obtained a report from Dr Edward Sumner.) However, the circumstances of the death are not similar in all respects. I would be happy to co-operate by allowing one of your colleagues to call at my office to look at any of the files.

As you know the Government is at present considering which of the recommendations of the Fundamental Review and the Shipman Inquiry should be implemented. As a major problem will be finding time for legislative change Government is anxious, where possible, to progress by way of protocols. Recently, I drafted a protocol concerning the reporting of hospital deaths to my office. Therefore, there may be merit in developing a protocol addressing what the interface should be between your Department and coroners. Although I have always valued my dialogue with you and your colleagues, I suspect there is little or no dialogue between other coroners in Northern Ireland and your Department. Having spoken to coroner colleagues in England and Wales, I get the strong impression that too is the position there between coroners and your counterpart, Sir Liam Donaldson.

In the interview you gave on BBC television you mentioned that the death of Raychel Ferguson could have been prevented if the full circumstances of the death of Lucy Crawford had been known sooner and you mentioned the desirability of there having been an earlier inquest into Lucy's death. I believe the papers I have provided you with explain what happened when Lucy's death was reported to my office and why a coroner's post-mortem examination was not then ordered. In any event an inquest should not be seen as the means of disseminating medical knowledge. A range of factors either alone or in combination may delay an inquest being held e.g. availability of the post-mortem report, witness statements, the report of an independent expert or judicial review. When he gave evidence in the inquests in to the deaths of Adam Strain, Raychel Ferguson and Lucy Crawford, Dr Sumner was at pains to state that his views on fluid management of children did not constitute "new" medical knowledge.

For your information, I am enclosing a copy of a letter dated 11th March 2003 which I sent to Professor Crane and I would draw your attention to the paragraph at the top of the second page. A doctor reporting a death to a coroner may not give the complete picture and, indeed, for a variety of reasons may not know it. Knowing the key questions to ask is vital. However, the reality is that I, my colleagues and my staff (none of us are medically qualified) may not know what the key questions are. Neither may a pathologist. In this case advice was sought from Dr Michael Curtis of the State Pathologist's Department. It is noteworthy that following the hospital post-mortem no concerns were at any time expressed to me by Dr Denis O'Hara, who carried out the hospital consent post-mortem, Lucy's family, Murnaghan & Fee Solicitors who act on behalf of the family, any member of the medical staff at the Erne Hospital or the Royal Belfast Hospital for Sick Children, which included the respective Medical Directors, or Dr Quinn from Altnagelvin Hospital who undertook

the independent review. (Incidentally, several weeks before the inquest commenced I was in telephone contact with Dr O'Hara. He had seen the report of Dr Sumner and he did not agree with all the conclusions.) Any of these persons could have expressed concerns to me at any time and I then would have considered afresh the need to carry out further investigations and to hold an inquest.

Two of the recommendations in the recently published Position Paper of the Home Office are the appointment of a Medical Examiner and a Medical Adviser to the Chief Coroner. It is not clear whether these recommendations are restricted to England and Wales or will extend to Northern Ireland. Some may conclude that these proposed new tiers of medical scrutiny and advice will solve the sort of problems that arose in relation to the death of Lucy. I am not so confident. If the Medical Examiner or the Medical Adviser does not have a background in the relevant medical sub-speciality, will he or she know the key questions to ask in relation to such a death? In my letter to Professor Crane I mentioned that the Consultant Surgeon in charge of Raychel Ferguson at Altnagelvin Hospital said in evidence at the inquest that he had never heard of hyponatraemia. My conversations with many members of the medical profession from diverse backgrounds indicates that he is not alone. One of the principal reasons for the establishment in the mid-1950s of the State Pathologist's Department was that it should be a resource for coroners. However, I am sure you will agree that pathologists cannot be expected to be experts in all areas of medicine. It is likely that Dr Curtis, when making inquiries from Dr Hanrahan in relation to the death of Lucy Crawford, did not know the key questions to ask. Will the Medical Examiner or Medical Adviser be in any better position than Dr Curtis or the Consultant Surgeon I have referred to?

As ever, I would welcome your views and, in particular, how you see the way forward. Also, would you be willing to comment on the recent letter which you will have received from Dr Nesbitt, the Medical Director of Altnagelvin Hospital? I have asked Dr Nesbitt if he would object to my sending a copy to Murnaghan & Fee, Solicitors, and the General Medical Council which is now in correspondence with me.

With kind regards.

Yours sincerely

J L LECKEY
HM CORONER FOR GREATER BELFAST

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