Mr Kevin McGinty
Attorney General's Office
2nd Floor
Royal Courts of Justice
Chichester Street
BELFAST
BT1 3JY

30th April 2003

**LUCY CRAWFORD, DECEASED**

For reasons which will become apparent I am of the opinion that an inquest ought to be held into the death of this 18 month old child. Whether there is a need for a Section 14 direction by the Attorney General is not completely clear to me but to avoid any potential legal difficulty as to my jurisdiction I felt it best to write to you formally.

Lucy died in the Royal Belfast Hospital for Sick Children on 13th April 2000. The following day my office received a telephone call from Dr Hanrahan who was the Consultant in charge of her case there and a discussion took place as to whether it would be appropriate for him to issue a death certificate. Advice was obtained from Dr Curtis of the State Pathologist's Department and following that it was agreed that Dr Hanrahan could issue a death certificate giving gastroenteritis as the cause of death. At that time there was no suggestion that the death was from other than natural causes

Earlier this year I held an inquest into the death of another child (Raychel Ferguson) who died in hospital as a result of Hyponatraemia. The publicity surrounding that inquest prompted Mr Stanley Millar, who is the Chief Officer of Western Health & Social Services Council to write to me expressing concerns as to why Lucy died. I am enclosing a copy of his letter to me of 27 February 2003.

I then became aware that following Dr Hanrahan's conversation with my office a consent post mortem was carried out in the Royal Victoria Hospital by Dr Denis O'Hara and I am enclosing a copy of his report. Whilst he does not give a formal cause of death his findings point to Hyponatraemia as being implicated. In my view Dr O'Hara should have contacted me on completion of the post mortem examination and suggested that it be converted into a coroner's case. Unfortunately he did not do so and Dr O'Hara is now absent on long term sick leave. He is seriously ill and I would not wish to trouble him at this juncture.

I decided to obtain a report in relation to Lucy's death from Dr Edward Sumner who provided me with independent expert evidence at the inquest into the death of Raychel Ferguson. In 1996 he had given similar evidence at an inquest into the death of yet another child (Adam Strain) – again from Hyponatraemia. Dr Sumner is an acknowledged expert in this particular area of medicine and he has recently retired as Consultant Paediatric Anaesthetist at the Great Ormond Street Hospital for Children in London. Essentially his view is that Lucy died from Hyponatraemia because of the nature of the fluids given to her while she was a patient at the Erne Hospital where she was treated prior to her transfer to the Royal Belfast Hospital for Sick Children. I am enclosing a copy of his report and covering letter.

As I stated above it is not completely clear to me whether it is necessary for the Attorney General to give a direction under Section 14 of the Coroners Act (Northern Ireland) 1959. However, for three reasons I have decided that I should place the position before the Attorney General. These are:-

1. The body of Lucy is no longer in the Greater Belfast district.
2. The position regarding when a coroner becomes *functus officio* is not completely clear – see paragraph 18.05 of Jervis on Coroners (12th edition)(copy enclosed
3. Lucy's death can no longer be treated as being from natural causes in view of the report of Dr Sumner. Her death was preventable.

Should you require any information please do not hesitate to let me know and if you wish to peruse the complete file I will arrange for this to be forwarded to you.

For your information I am enclosing a copy of an article on Hyponatraemia and children.

I will await hearing from you.

Your sincerely

**J L LECKEY**
**H M CORONER FOR GREATER BELFAST**

013-052-281