

## **MEDICAL DIRECTOR**

11<sup>th</sup> March 2004

Mr John L Leckey L.L.M.  
H.M. Coroner  
Coroner's Office  
Courthouse  
Old Town Hall Building  
80 Victoria Street  
Belfast BT1 3GL

Dear Mr. Leckey

### **LUCY CRAWFORD - DECEASED**

Thank you for your letter dated 5<sup>th</sup> March 2004 enclosing post mortem report and copy depositions relating to the inquest of Lucy Crawford.

From the information provided I am surprised at the conclusion reached by the Media regarding the involvement of a Consultant Paediatrician at Altnagelvin Hospital, (Dr. Quinn).

I met with Dr Quinn to discuss the issues identified in your letter of 19<sup>th</sup> February 2004. He has advised that he agreed to review the documentation of Lucy's admission prior to her death. I enclose a copy of the report, which Dr Quinn provided to Sperrin Lakeland Trust and you will note that he clearly states the limitations of his report, which was based solely on the information contained within the records. Dr Quinn identified a number of deficiencies with the care as documented. He refers to No. 18 as being an appropriate solution at that time. Dr G Jenkins also commented at the hearing that 'in 2000 No 18 solution was commonly used for both maintenance and deficiencies in some circumstances'. Dr Quinn has also advised that he recommended at the time that Sperrin Lakeland Trust should consult an independent Paediatrician from outside the Western Board.

You are of course aware that the working party set up by the Department was precipitated by this Trust following our Critical Incident Investigation into the death of Rachel Ferguson which occurred 14 months after Lucy's death. Altnagelvin Trust endorses the guidance, which was subsequently developed and distributed throughout N Ireland.

I wish to assure you that all Paediatric Medical and Surgical Staff within Altnagelvin are aware of and follow the guidance issued by the Department of Health and CREST.

**LC-Altnagelvin**

025-006-131

In conclusion I wish to stress that Dr Quinn did not carry out a review of the case his report was provided to Sperrin Lakeland to assist them in undertaking their review.

I trust that you find this information is helpful to you please do not hesitate to contact me if you need any further information

Yours sincerely

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**Dr. Geoff Nesbitt**  
**Medical Director**

**LC-Altnagelvin**

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### **LUCY CRAWFORD - DECEASED**

Thank you for your letter dated 5<sup>th</sup> March 2004 enclosing post mortem report and copy depositions relating to the inquest of Lucy Crawford.

From the information provided I am surprised at the conclusion reached by the Media regarding the involvement of a Consultant Paediatrician at Altnagelvin Hospital, (Dr. Quinn).

I met with Dr Quinn to discuss the issues identified in your letter of 19<sup>th</sup> February 2004. He has advised that his only involvement was to review the Hospital Notes and provide comment to assist the Sperrin Lakeland Trust in their review of the case. Dr Quinn advised that his case note review should not be used in any complaints procedure as he felt that an independent Paediatric Review would be more appropriate.

You are of course aware that the working party set up by the Department was precipitated by this Trust following our Critical Incident Investigation into the death of Rachel Ferguson which occurred 14 months after Lucy's death. Altnagelvin Trust, having precipitated the CMO action, endorses the guidance, which was subsequently developed, adopted by DHSSPS, and distributed throughout N Ireland.

I wish to assure you that all Paediatric Medical and Surgical Staff within Altnagelvin are aware of and follow the guidance issued by the Department of Health and CREST.

In conclusion I wish to stress that Dr Quinn did not carry out a review of the case, his comments were provided to Sperrin Lakeland to assist them in undertaking their review. The death of this child occurred 1 year prior to the tragic episode of Raychel Ferguson in Altnagelvin. It is unfortunate that the earlier death was not brought to our attention in order to cause the alert throughout Northern Ireland, which regrettably only occurred following Raychel's death.

**LC-Altnagelvin**

025-006-133



I trust that you find this information is helpful to you. Please do not hesitate to contact me if you need any further information

Yours sincerely

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**Dr. Geoff Nesbitt**  
**Medical Director**

c.c. Dr. Henrietta Campbell, Chief Medical Officer

**LC-Altnagelvin**

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