Dr Henrietta Campbell
Chief Medical Officer
Castle Buildings
Upper Newtownards Road
Stormount Estate
Belfast
BT4 3SJ

23rd February 2004

LUCY CRAWFORD - DECEASED

At the conclusion of the Inquest I invited submissions as to whether I should take any further action, either under Rule 23 (2) of the Coroner's Rules (a copy of which I enclose) or by referring the papers to the Director of Public Prosecutions under Article 6 (2) of the Prosecution of Offences (NI) Order 1972. Having considered submissions from the legal representatives I decided that the appropriate course was for me to refer the Inquest papers to you and to the General Medical Council but not the Director of Public Prosecutions.

Accordingly I am enclosing a full set of the Inquest papers with the exception of the reports of the expert witnesses and the correspondence of Sperrin Lakeland Trust which I forwarded to you with my letter of 19th February 2004.

Whilst the protocol devised by your working party has not been criticised in any way (in fact it has been praised) by any of those who gave evidence either at this Inquest or the Inquest into the death of Raychel Ferguson, nonetheless, there may be merit in the working party examining the Inquest papers in relation to the death of Lucy to see if any changes to the protocol might be required. In addition, the evidence at the Inquest highlighted serious shortcomings in medical record keeping and the understanding of the nurses as to the fluid regime that had been prescribed. Is it the responsibility of the Medical Director of a hospital to ensure that proper standards of medical record keeping are maintained?

LC-SLT(HM)

031-064-108

Is there any monitoring of the standard of medical record keeping? Are nurses now briefed on a regular basis as to the implications of the protocol? I pose these questions as they relate to issues which really do concern me.

I look forward to receiving your views.

With kind regards.

Yours sincerely

J L LECKEY
H M CORONER FOR GREATER BELFAST

Enc