HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

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

Telephone: [redacted]
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Your Ref: INQ T59/92

Directorate of Legal Services
Central Services Agency
25 Adelaide Street
Belfast
BT2 8FH

26th February 2004

Dear Sirs

RE: LUCY CRAWFORD - DECEASED

As promised at the conclusion of the Inquest I am enclosing copies of the following: -

1. My letter to the Chief Medical Officer.
2. My letter to the General Medical Council.
3. The letter from Dr O'Donohue admitted under Rule 17.
4. The verdict.

Yours faithfully

J L LECKEY
H M CORONER FOR GREATER BELFAST

Encs

DIRECTORATE OF LEGAL SERVICES
27 FEB 2004
Insp by
Act by
Ref. No.

LC-SLT

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?

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.

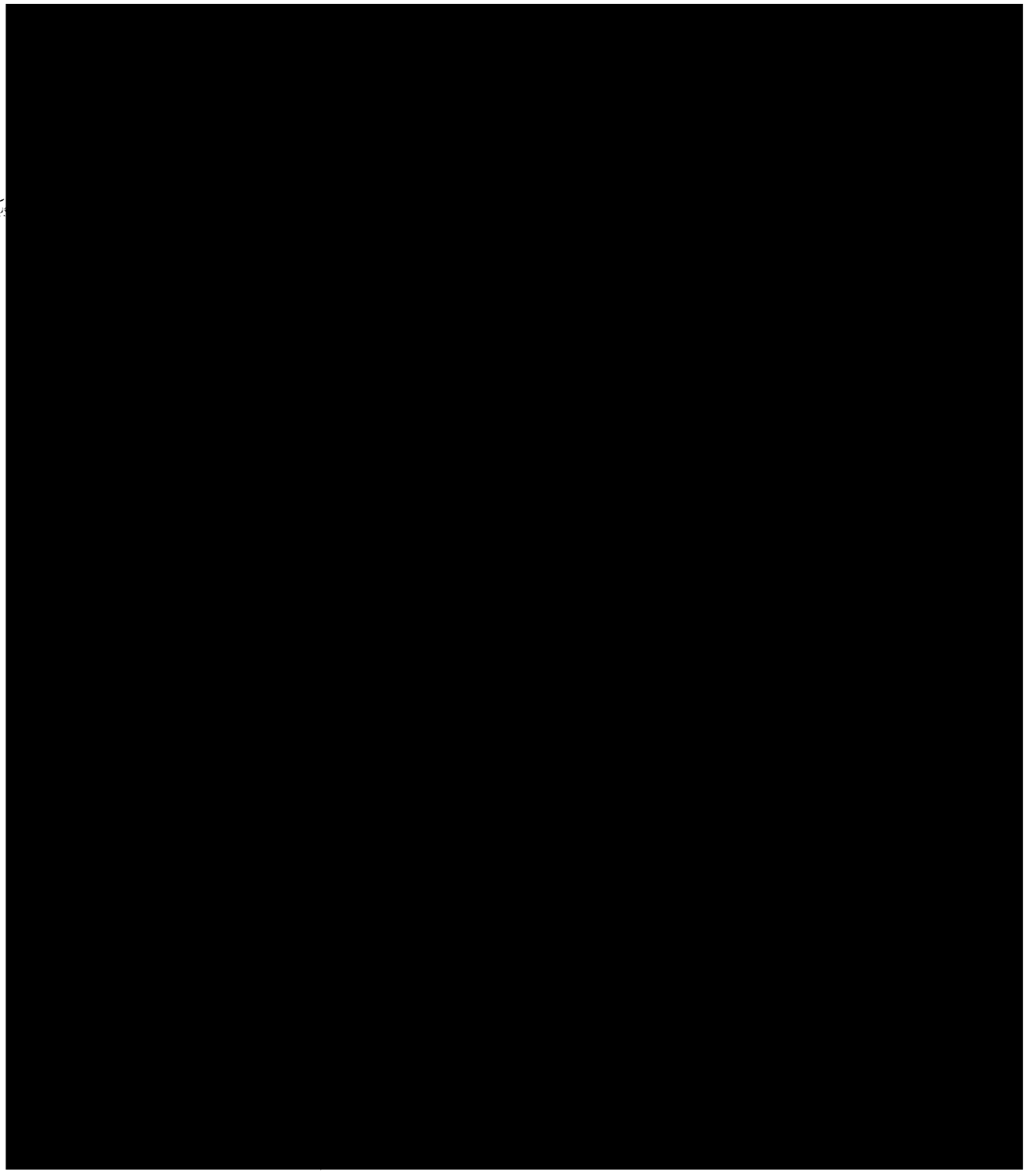
With kind regards.

Yours sincerely

J L LECKEY
H M CORONER FOR GREATER BELFAST

Enc

LC-SLT



LC-SLT

034-124-332

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ERNE HOSPITAL
ENNISKILLEN, CO. FERMANAGH, BT74 6AY. T[redacted]

Mr Kevin Doherty,
Westcott Business Services,
Fax No: 71 864 326

re: Lucy Crawford, Erne Hospital Number : 123000

I was called to see Lucy on the day of admission by the SHO on duty (Dr Malik) because he was unable to site a drip. Lucy had been admitted with a history of vomiting and drowsiness. On examination she was sleepy but rousable. Since blood had been sent for urea and electrolyte measurements I applied local anaesthetic cream to the areas where I thought I was most likely to be able to insert an IV cannula. In the meantime I gave her a bottle of fluid which she took well.

When the local anaesthetic cream had had time to take effect I inserted a cannula. While strapping the cannula in situ I saw Dr Malik writing as I was describing the fluid regime ie. 100 mls as a bolus over the first hour and then 30 mls per hour. The 100 mls was approximately 10 ml/Kg and to cover the possibility that the cannula might not last very long and the succeeding rate was relatively slow since I had seen her taking oral fluid well and presumed the rate of fluid need was relatively small. The intravenous fluid used was saline 0.18% saline/4% glucose.

I looked into the treatment room a few minutes later and Lucy was standing on the couch in front of her mother and looking better.

I was next called at approximately 03:00 because Lucy had had what sounded like a convulsion. My initial presumption was that this was a febrile convulsion. However since she showed no signs of recovering by the time I arrived and since there was a history of profuse diarrhoea I took a specimen for repeat urea and electrolytes. My recollection is that Dr Malik had started the intravenous normal saline before calling me and that the 500 mls given was virtually complete before I arrived. Her repeat urea and electrolytes measurement showed the sodium had fallen to 127. When I took over bagging from Dr Malik it was clear that there was no respiratory effort and her pupils were fixed and dilated. I continued bagging until Dr Amarson (anaesthetist) arrived and he intubated her and she was transferred to ICU.

I arranged transfer to the Paediatric Intensive Care Unit in the Royal Belfast Hospital for Sick Children and since there was no anaesthetist to travel with her I accompanied. I was unable to make a diagnosis for her deterioration prior to transfer. She was hand bagged until arrival in Belfast either by myself or the accompanying nurse from ICU. The only problem in transit was a fall in her blood pressure towards the ends of the journey at which point I started a dopamine infusion.

Sincerely,

Dr J M O'Donohoe

LC-SLT

Form 22

CORONERS ACT (NORTHERN IRELAND) 1959

VERDICT ON INQUEST

On an inquest taken for our Sovereign Lady the Queen, at THE OLD TOWNHALL BUILDING, 80 VICTORIA STREET, BELFAST in the County Court Division of GREATER BELFAST on TUESDAY the 17TH to THURSDAY the 19TH of FEBRUARY 2004, before me MR J L LECKEY HM Coroner for the district of GREATER BELFAST touching the death of LUCY REBECCA CRAWFORD to inquire how, when and where the said LUCY REBECCA CRAWFORD came to her death, the following matters were found:

1. Name and surname of deceased: LUCY REBECCA CRAWFORD
2. Sex: FEMALE
3. Date of Death: 14 April 2000
4. Place of Death: ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
5. Usual Address: [redacted]
6. Marital Status: SINGLE
7. Date and Place of Birth: 5 November 1998 at
8. Occupation: DAUGHTER OF WILLIAM NEVILLE CRAWFORD, CIVIL SERVANT
9. Maiden Surname: N/A
10. Cause of Death: 1(a) CEREBRAL OEDEMA (b) ACUTE DILUTIONAL HYPONATRAEMIA (c) EXCESS DILUTE FLUID 11 GASTROENTERITIS

Findings:

On 12th April 2000 the deceased, who was aged 17 months was admitted to the Erne Hospital, Enniskillen with a history of poor oral intake, fever and vomiting. The vomiting was sufficient to have caused a degree of dehydration and she required intravenous fluid replacement therapy. It was believed she was suffering from gastroenteritis. Her condition did not improve and she collapsed at about 3.00am on 13th April, developing thereafter decreased respiratory effort and fixed and dilated pupils. Whilst in a moribund state she was transferred by ambulance shortly after 6.00am to the Royal Belfast

Hospital for Sick Children. Her condition remained unchanged and after two sets of brain-stem tests were performed showing no signs of life she was pronounced dead at 13.15 hours on 14th April. She had become dehydrated from the effects of vomiting and the development of diarrhoea whilst in the Erne Hospital and she had been given an excess volume of intravenous fluid to replace losses of electrolytes. The collapse which led to her death was a direct consequence of an inappropriate fluid replacement therapy in that the use of 0.18% saline to make up deficits from vomiting and diarrhoea was wrong, too much of it was given and there had been a failure to regulate the rate of infusion. This led to the development of dilutional hyponatraemia which in turn caused acute brain swelling and death. The errors in relation to the fluid replacement therapy were compounded by poor quality medical record keeping and confusion by the nursing staff as to the fluid regime prescribed.

Date: 19TH FEBRUARY 2004

Signed: [signature]

Coroner for GREATER BELFAST