Form 21

CORONERS CERTIFICATE

To be sent to the Registrar within FIVE DAYS after the Inquest.

To the Registrar of Births, Deaths and Marriages for the District of GREATER BELFAST

I HEREBY CERTIFY that at an Inquest held at THE OLD TOWNHALL BUILDING, 80 VICTORIA STREET, BELFAST on TUESDAY the 17TH day of FEBRUARY 2004 before me Mr J L Leckey, HM Coroner for the District of GREATER BELFAST touching the death of LUCY CRAWFORD.

I found as follows:

1. Name and Surname: 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 (if different from place of death): [redacted]
6. Marital Status: SINGLE
7. Date and Place of Birth: November 5 1998, ERNE HOSPITAL ENNISKILLEN
8. Occupation: DAUGHTER OF WILLIAM NEVILLE CRAWFORD, [redacted]
9. Maiden Surname (of woman who had married): N/A
10. Cause of Death: 1(a) CEREBRAL OEDEMA (b) ACUTE DILUTIONAL HYONATRAEMIA (c) EXCESS DILUTE FLUID 11 GASTROENTERITIS
11. 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.

Witness my hand this 19TH FEBRUARY 2004

Signature M. L. Loney Coroner for GREATER BELFAST