BRANGAM BAGNALL & CO.

Solicitors

Commercial Mews, 69-71 Comber Road, Dundonald, Belfast BT16 0AE

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OUR REF: RGH/I/81/GB

YOUR REF: A.49/2002/25/J

15 March 2004

Mr A P Walby FRCS Ed
Associate Medical Director
Litigation Management Office
Royal Group of Hospitals & Dental Hospital
Health & Social Services Trust
Royal Victoria Hospital
1st Floor East Wing
Grosvenor Road
Belfast
BT12 6BA
DX 3860 NR BELFAST 14

Dear Mr Walby

LUCY CRAWFORD (DECEASED)

Thank you for your letter of 3rd March.

I note your comments.

I cannot say whether Dr O'Hara was present in Court during the Hearing. As you will be aware, I spoke with Dr Crean and also Dr Hanrahan on 17th and 19th February. I enclose copies of the following documents which I have received from the Coroner for your attention;

- Letter from the Coroner to the Chief Medical Officer.
- Letter from the Coroner to the General Medical Counsel.
- Letter from Dr O'Donohue admitted under Rule 17.
- Copy of Coroner's verdict.

I do not propose to comment on the enclosed documents as no doubt you will find them self-explanatory. Suffice it is to say that I do not believe that there is anything within the above documents which is of concern to the Trust.

19/3/04

Noted

Also at Hildon House, 30-34 Hill Street, Belfast BT1 2LB

Telephon [redacted] *Fax* [redacted] *DX No.* [redacted] *e-mail:* [redacted]

George D. H. Brangam S. A. Crothers

Gary Daly Eimer Coll Karen Houston

Should you wish to discuss this matter or require further assistance, please do not hesitate to contact me.

Yours sincerely

Gary Daly
for Brangam Bagnall & Co
[redacted]

Enc

GD/ZL/12-03-04

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

The Fitness to Practice Directorate
The General Medical Counsel
178 Great Portland Street
LONDON
W1 N6JE

23rd February 2004

Dear Sirs

INQUEST INTO THE DEATH OF LUCY CRAWFORD – DECEASED

On 19th February I concluded an Inquest into the death of a 17 month old girl called Lucy Crawford who died in the Royal Belfast Hospital for Sick Children on 14th April 2000. I am enclosing a copy of my verdict which gives particulars of the deceased, the cause of death I arrived at and my findings.

At the conclusion of the Inquest and having heard submissions from legal representatives acting on behalf of the family and the Hospital Trust I announced that I would be reporting the circumstances of the death to the Chief Medical Officer for Northern Ireland, Dr Henrietta Campbell, and the General Medical Council. The reason I decided to do so was that I had very serious concerns about the quality of the medical care Lucy received whilst a patient in the Erne Hospital, Enniskillen and in particular, the role of two of the medical staff – Dr Amer Ullas Malik and Dr J M O'Donohue who is a Consultant Paediatrician. Dr O'Donohue declined to give any evidence at the Inquest and as a consequence of that decision I read out a statement he had made previously. (Incidentally I understand Dr Malik has now returned to Pakistan. (His GMC registration number is 5187318).

In order to enable you to consider this referral I am enclosing a full set of the Inquest papers comprising: -

1. A list of witnesses.
2. A preliminary statement I made at the commencement of the Inquest.
3. The post mortem report.
4. A copy of the Death Certificate originally issued.

5. A copy of the report of Dr Edward Sumner.
6. A copy of the report of Dr Dewi Evans.
7. A copy of the report of Dr John G Jenkins.
8. Copy correspondence from Sperrin Lakeland Trust to the father of Lucy, Mr Neville Crawford. I would draw your attention to the third paragraph of the letter where it states "the outcome of our review has not suggested that the care provided to Lucy was inadequate or of poor quality." This is at variance with the views of the three experts (Dr Sumner, Dr Evans and Dr Jenkins) and evidence given by Dr Auterson who is a Consultant Anaesthetist at the Erne Hospital and was involved with the treatment of Lucy whilst she was a patient there.
9. Copy depositions. Where I have made a long hand note summarising additional evidence given, I am enclosing a typed transcript of this.
10. Relevant correspondence.

I should be grateful if you would acknowledge receipt of this letter. If you feel I can assist further in any way please do not hesitate to contact me.

Yours faithfully

J L LECKEY
H M CORONER FOR GREATER BELFAST

Encs

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ERNE HOSPITAL
ENNISKILLEN, CO. FERMANAGH, BT74 6AY. TELEPHONE [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;

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 Aumerson (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 mak a diagnosis for her deterioration prior to transfer. She was hand bagged until arrival in Belfast eith by myself or the accompanying nurse from ICU. The only problem in transit was a fall in her blo pressure towards the ends of the journey at which point I started a dopamine infusion.

Sincerely,

Dr J M O'Donohoe

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