

**File note: Re Lucy Crawford**

17 February 2004

Telephone discussion with APW.

Dr Sumner will be involved in inquest hearing.

Talk to Bob Taylor, who was part of the team who developed paediatric guidelines for management of hyponatraemia (sp.)

There are three cases relevant to this issue:

|                 |                 |                                           |
|-----------------|-----------------|-------------------------------------------|
| Adam Strain     | dod: 28/11/1995 | Inquest held in 1996                      |
| Rachel Ferguson | dod: 09/06/2001 | Inquest held on 17 February 2004          |
| Lucy Crawford   | dod: 14/04/2000 | but inquest not held until now (Feb 2004) |

In case there is any criticism in relation to development/implementation of guidelines, PR should know to talk to Dr Taylor

Also, our solicitor might need to be prepared at HMC court in case this matter is raised, as Dr Sumner is involved in this case and was also involved in the Rachel Ferguson inquest. At the end of things they might need to say that, yes, paediatric guidelines were produced.

If Bob Taylor is happy enough then we don't need to do anything about it. PR department ought to know about the potential for this to be raised though.

Ask Bob Taylor could he assist PR to be able to address any criticism if it comes up in terms of what has been done about management of paediatric hyponatraemia, and the efforts that have been made to disseminate the guidelines and processes to other Trusts.

I spoke with Dr Peter Crean to enquire what had already happened at Day 1 of inquest re Lucy Crawford. No criticism of Royal. Criticism of Erne.

Dr Crean was on the same working party as Bob Taylor, and he agreed to speak with PR if necessary, to brief them if approached by the Press to comment on this case.

I contacted Vanya Rodgers (x [REDACTED]) in PR to make her aware of the potential for questions in this case and to let her know that she should discuss the case with Dr Crean if any issues arise in relation to the CREST guidelines and implementation/dissemination of same.

/smcc

Note for info:

From our own point of view we made sure we had an onsite analyser to monitor condition.

Adam Strain case was different to that of Rachel Ferguson / Lucy Crawford.  
After Rachel Ferguson case, a working party was set up to capture the good practices that were already in place in management of hyponatraemia (sp!) and put these into guidelines.

/smcc