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OUR REF: RGH/I/81/GB

YOUR REF: A.49/02/25/J

24 February 2004

Mrs Susan McCombe
Senior Administrative Assistant
1st Floor, East Wing
Royal Group of Hospitals & Dental
Hospital H&SS Trust
Grosvenor Road
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N.B. Coroner's report awaited.

Dear Mrs McCombe

LUCY CRAWFORD

I refer to previous correspondence in connection with the above and in particular to the Inquest which was heard by Mr Leckey on 17th February to 19th February inclusive in the Old Court Building in Belfast.

As you will be aware, I attended the above Hearing on 17th and 19th February.

I enclose a copy of a Statement given by the Coroner, Mr Leckey on the morning of 17th February. I do not propose to comment on that document as no doubt you will find it self-explanatory.

I took the opportunity to consult with Doctor Crean, prior to his giving evidence on 17th February. I consider that nothing arose during his evidence which would cause concern for the Trust. I am pleased to confirm that Mr Brian Fee QC who represented the family did indicate to the Coroner that the family did not have any concerns or criticisms to make of the Royal Belfast Hospital for Sick Children. Indeed Mr Fee QC went on to say that the family had asked him to express their gratitude to Doctor Crean and also to the staff of the Royal Belfast Hospital for Sick Children for all the care and compassion shown to them at the relevant time.

I have read some of the articles in the local press and have noticed that this fact has not been reported.

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062-007-016



I also attended the Hearing on 19th February and consulted with Doctor Hanrahan prior to his giving evidence. Again I do not think that anything arose during Doctor Hanrahan's evidence which would cause concern for the Trust.

Indeed Mr Fee again took the opportunity to inform the Court that the family wished to express their gratitude to Doctor Hanrahan and all staff at the Royal Belfast Hospital for Sick Children.

I am not yet in receipt of the Coroner's Report. I shall forward a copy of the same to you upon its receipt.

Should you wish to discuss this matter at any time, please feel free to contact me.

Yours sincerely



Gary Daly
for Brangam Bagnall & Co

Enc

GD/ZL/24-02-04

LUCY CRAWFORD deceased

As the events leading up to the holding of this inquest are unusual, I consider it appropriate to make a preliminary statement by way of explanation.

On 14th April 2000 Dr Donncha Hanrahan, who is a Consultant in Paediatric Neurology at the Royal Belfast Hospital for Sick Children, telephoned my office to report the death of Lucy Crawford aged 17 months. Lucy had died that day in the hospital's Paediatric Intensive Care Unit following transfer from the Erne Hospital the previous day. The clinical history given was of *gastroenteritis, dehydration and brain swelling*. Advice was then sought from a pathologist attached to the State Pathologist's Department as to whether the clinical history warranted a coroner's post-mortem examination being carried out. Following a consultation between the pathologist and Dr Hanrahan my office was advised that it would be appropriate for a death certificate to be issued giving *gastroenteritis* as the cause of death.

On 27th February 2003 I received a letter from Mr Stanley E Millar, Chief Officer of the Western Health and Social Services Council in which he referred to an inquest I had held a short time previously into the death of Raychel Zara Ferguson aged 9 years. She had died from *cerebral oedema due to hyponatraemia* and I understand that the publicity surrounding the inquest led Mr Miller to speculate if the two deaths had any common features. In his letter he said this:

"I was struck by the similarities in the two tragedies and in particular the details of the solutions used in the drip set up for Lucy Crawford which are clearly recorded in the Medical Notes I hold (as supplied by the Erne Hospital).

You will appreciate my concerns over the cause for the death of an 18 month old little girl which were to my mind unexplained were rekindled by Raychel's death.

I am left with two questions which you may be able to answer

1 Are there direct parallels in the events leading up to the deaths of both girls?

2 Would an Inquest in 2000/2001 have led to the recommendations from the Raychel Ferguson inquest being shared at an earlier date and the consequent saving of her life?

I am also left with a query as to other similar uncovered deaths across the UK. At least the Altnagelvin Medical Team have "broadcast" the phenomena of Hyponatraemia and raised an awareness of the potential problem with children."

It was only when I read Mr Miller's letter that I became aware that in fact a post-mortem examination had been carried out later by a consultant paediatric

pathologist attached to the Royal Victoria Hospital. This was not a coroner's post-mortem but a "*consent*" post-mortem for which, I assume, the consent of Lucy's parents was sought and obtained. I then obtained a copy of the post-mortem report and considered the findings of the pathologist. These indicated to me that the deaths of Raychel and Lucy might have common features and that it would be necessary to obtain a further specialist report. With the benefit of hindsight, it would have been helpful if I had been advised of the post-mortem findings at an early stage.

When I was investigating the death of Raychel I obtained an independent expert report from Dr Edward Sumner. He is a Consultant Paediatric Anaesthetist who was formerly on the staff of the Great Ormond Street Hospital for Children in London. I asked him to prepare a report for me concerning the death of Lucy. His conclusions indicated that the two deaths did indeed have common features.

I considered that it was essential for an inquest to be held into the death of Lucy. As a death certificate had been issued and, arguably, I was *functus officio*, I applied to the Attorney General for a direction under the provisions of section 14 of the Coroners Act (Northern Ireland) 1959 that an inquest should be held by me. I provided the Attorney General with all relevant documentation including the post-mortem report and the report of Dr Sumner. On 12th December 2003 I was informed that the Attorney General had exercised his powers under section 14 and that I had been directed to hold an inquest into the death of Lucy.

JOHN L LECKEY
HM CORONER FOR GREATER BELFAST