STATEMENT OF WITNESS

STATEMENT OF: JOHN L LECKY
Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* OVER 18

To be completed when the statement has been written

I declare that this statement consisting of 3 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 25th day of January 2005

SIGNATURE OF MEMBER by whom statement was recorded or received

R HALL

PRINT NAME IN CAPS

SIGNATURE OF WITNESS

On 14 April 2000 Dr Hanrahan of the Royal Belfast Hospital for Sick Children reported to my office the death of Lucy Crawford who had died in the Paediatric Intensive Care Unit that day. The history he gave was gastroenteritis, dehydration, brain swelling. Dr Hanrahan explained that Lucy had been transferred from the Erne Hospital two days previously. I personally did not take the telephone call from Dr Hanrahan and I believe he spoke to a member of my staff called Maureen Dennison. From the note on the file it appears that he was asked to discuss the case with Dr Mike Curtis, Assistant State Pathologist, to see whether it would be appropriate for a death certificate to be issued. The note on the file indicates that this conversation did take place and my office was subsequently advised that a death certificate would be issued giving gastroenteritis as the cause of death. As far as I was concerned this was a natural death and no concerns about the appropriateness of a death certificate being issued giving gastroenteritis as the cause of death were raised by anyone, medical staff or the parents of Lucy. On 27 February 2003 I received a letter from Mr Stanley Millar, who was then the Chief Officer of the Western Health and Social Council based at Tyrone and Fermanagh Hospital at Omagh. He referred to the similarities between the death of Lucy and another girl called Raychel Ferguson into whose death I had

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held an inquest a short time ago previously. He said he was struck by the similarities between the two tragedies and in particular the fluid management. His letter referred to a post-mortem examination having been carried out. I was unaware of this and following inquiries I ascertained that a "consent" post-mortem had been carried out by a consultant paediatric pathologist at the Royal Victoria Hospital, Dr Dennis O'Hara. Dr O'Hara is now deceased. I obtained a copy of the post-mortem report and having considered the findings I decided that I should obtain an independent expert report to ascertain if fluid management was indeed a relevant issue. I arranged for Dr Edward Sumner to prepare this report for me. He had recently retired as a consultant paediatric anaesthetist attached to Great Ormond Street Hospital for Children in London and he had prepared reports for me in relation to the death of Raychel Ferguson and Adam Strain. Adam had died on 28 November 1995 and I held an inquest into his death the following year. I have made the inquest papers, together with all correspondence and attendances, available to the police who are investigating the death of Lucy and I see little point in rehearsing the chronology for to deal with the issues that arose at the inquest. However, I would wish to draw attention to the fact that shortly after I received the letter from Mr Millar, I wrote to Lucy's parents explaining my involvement, I wrote to Professor Crane, the state pathologist about the conversation between Dr Hanrahan and Dr Curtis and the subsequent issuing of a death certificate and I wrote to the Chief Medical Officer, Dr Henrietta Campbell, informing her of the concerns raised by Mr Millar. Section 7 of the Coroners Act (Northern Ireland) 1959 imposes a duty on a medical practitioner and others to report certain deaths to a coroner. Section 7 is as follows: "7. Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he

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had been seen and treated by a registered medical practitioner within twenty – either days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death." Dr Hanrahan did report the death promptly to my office and did consult with the assistant state pathologist. I assume that neither was able to identify inappropriate fluid management as the underlying cause of Lucy's death. However, the section refers to "every medical practitioner" and I take the view that the duty to report did not stop with Dr Hanrahan but extended also to Dr O'Hara who conducted the consent post-mortem examination and to the doctors concerned with the care and treatment of Lucy in the Erne Hospital. At the time Mr Millar wrote to me I was aware that Dr O'Hara was terminally ill and because of that I saw little point in making it an issue with him. However, my view is that he should have referred Lucy's death to my office with a request that I direct that the post-mortem examination he conducted should become a coroner's post-mortem examination rather than consent post-mortem examination. Also in my view a duty to report was imposed no doctors at the Erne Hospital who would have been aware that when Lucy left the Erne Hospital for transfer to the Royal Belfast Hospital for Sick Children she was in a moribund state. Once the Erne Hospital became aware that Lucy had died I would have thought it was highly probable that her clinical management, there would have been the subject of discussion within the hospital. I find it difficult to understand why the consultant in charge did not consider it appropriate to make contact with my office. Subsequently, I learnt that Murnaghan & Fee, solicitors were acting on behalf of the Crawford family in relation to a civil claim against the hospital and that they had in their possession an expert report from Dr Dewey Evans who is a consultant paediatrician. He had reached the same conclusions in relation to fluid management, as did Dr Sumner. I find it surprising that this firm of solicitors did not see the need to report the need to me.