

WITH THE COMPLIMENTS OF

(39)

Enclosed as per letter
from Murnaghan +
Fee.

Reversythe. 27/1/4



NORTHERN IRELAND

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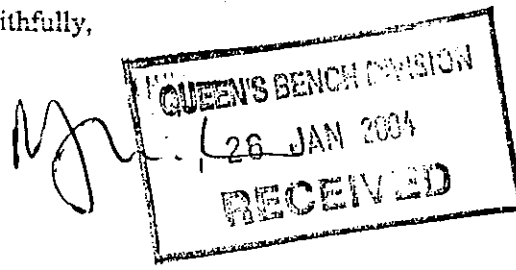
23rd January, 2004

**Re: Neville Crawford and May Crawford
As Personal Reps. Of the Estate of Lucy Crawford deceased
QBD – 2001 No 3036**

Dear Sir,

We refer to the enclosed Report from Dr. Jenkins. These extracts should have been returned to the Solicitors acting on behalf of the Defendant in the matter.

Yours faithfully,



Appeals & Lists Office,
DX 455 NR,
BELFAST 1

Enc

DONAL FEE, LL.B.; KEVIN MURNAGHAN, BCL, Notary Public; *

NESSA MURNAGHAN, BCL.; SINÉAD KELLY, LL.B.

ALSO AT: MAIN STREET, FIVEMILETOWN. TEL: 0 [REDACTED] FRIDAYS ONLY

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RF (LC Aftermath) - DLS

165-040-002

**MEDICAL REPORT NEVILLE & MAY CRAWFORD on behalf of
LUCY CRAWFORD (Deceased) -v- Sperrin Lakeland Health & Social Care Trust**

Strictly Private and Confidential

Comment

This child's admission to Erne Hospital was very typical of gastroenteritis in this age group. This is often associated with high temperature and vomiting with or without diarrhoea and young children can become very unwell. The standard treatment is to administer fluids either orally or (if there is significant dehydration or vomiting) by the intravenous route. The solution used is one which is commonly used in Paediatric practice to provide **maintenance** fluids in these circumstances as it replaces small amounts of electrolytes but also gives Dextrose which is required by young children who are unable to take calories orally during the acute phase of the illness. Initial physical findings were suggestive of poor peripheral circulation with delayed capillary refill time >2 seconds. The GP noted that the mucosae were moist but there is little specific detail in the admission note regarding evidence of dehydration. However, the urea was 9.9 which is slightly elevated suggesting a mild degree of dehydration but with normal electrolytes at that time. This would again be very typical of the condition and would not normally indicate anything other than appropriate fluid replacement with careful monitoring and nursing observation. However, in this situation the intravenous fluids for **replacement** should contain a higher content of sodium (eg "normal saline" - 0.9% NaCl - sodium chloride).

In these circumstances it is always very difficult to understand an episode of sudden collapse. Sudden onset of convulsions is most commonly due to high temperature in young children and this was considered. However, the features were not typical and the temperature had in fact improved since admission. It is unclear as to what alternative diagnoses were considered at this time but the blood test for electrolytes was appropriately repeated immediately. This showed a significant fall in sodium from 137 to 127 and in potassium from 4.1 to 2.5, together with an increase in glucose from 4.5 to 10.9. These changes do raise the question as to the fluid management in the period from insertion of the IV line at 2300 to the collapse at around 3.00 am. Unfortunately there appears to have been confusion between the staff involved as to the fluid regime ordered by the Consultant. In addition it is difficult to interpret the records made by nurses on the fluid balance chart and no totals have been calculated for this period. It will be most important to determine from the staff involved **exactly how much of each type of fluid** was given at each stage throughout this time period, and following the change of fluids to normal saline through until the child arrived in the Paediatric Intensive Care Unit in Belfast.

Other aspects of this tragic case demonstrate a rapid and effective response by the medical staff concerned. In particular both the Consultant Paediatrician and Consultant Anaesthetist appear to have been available within a very short time period of being called and to have done their best in the difficult circumstances involved in caring for a child of this age in an adult intensive care setting for stabilisation and transfer in the absence of a Paediatric transfer service in Northern Ireland.

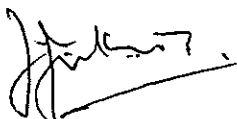
Over recent years concerns have begun to be expressed regarding the use of 0.18% saline in Dextrose as a standard solution for intravenous use in young children and a number of cases of

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symptomatic hyponatraemia have been identified, some resulting in death or cerebral damage. It has been suggested that a more appropriate solution would contain a higher level of sodium and this has recently been the subject of discussions involving the Department of Health, Social Services and Public Safety and production of guidelines. However, it must be emphasised that this is a very recent development and that many Paediatric Units are continuing to use the solution which was initially given in this case. Although the sodium level of 127 is not in itself usually associated with severe problems, it is likely to be the rate at which the sodium falls rather than the absolute level which can cause problems in this setting.

While no definite conclusions can be drawn regarding the cause of this child's deterioration and subsequent death, there is certainly a suggestion that this was associated with a rapid fall in sodium associated with intravenous fluid administration and causing hyponatraemia and cerebral oedema. In these circumstances successful defence of the case would depend on clear documentation regarding the fluid type and rate prescribed, together with clear records as to the exact volumes of each fluid which were in fact received by the child throughout the time period concerned. This is where I would anticipate great difficulty in achieving a successful defence as there appears to have been confusion between the staff involved with inadequate documentation and record keeping. In this respect, unless this can be clarified in a satisfactory manner, it is my opinion that management fell below the standard which would be accepted by a responsible body of medical opinion as reasonable practice at the relevant time.



Dr J G Jenkins MD FRCP FRCPCH
Senior Lecturer in Child Health and Consultant Paediatrician

7/3/2002