HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref: BMcL-0124-13

Our Ref: HYP B04/05

Date: 28th August 2013

Mr B McLoughlin
Assistant Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – RAYCHEL FERGUSON PRELIMINARY

I refer to the above matter and to your letter of 18th July 2013.

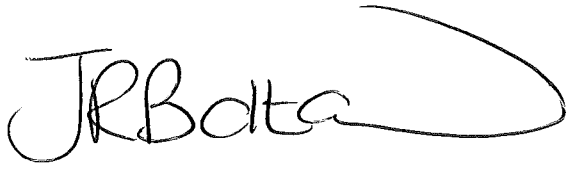
For clarification where the letters "LA" appear in relation to a document it is intended to confer that the Trust is claiming privilege over those documents based on the legal advice contained within them. Likewise the letters "LP" confer that litigation privilege is being asserted over that document. Any reference to "LLP" should read "LP".

We have reviewed our position and agree that privilege does not attach to the Statement of Claim, Notice of Further and Better Particulars, Defence or Replies to Particulars and therefore now enclose a copy of same herewith. I also enclose an amended copy of the Index for your ease of reference.

Document 39 is a statement dated 24th March 2004 made by the Sperrin Lakeland Trust and an undated statement made by the Western Board. Both of these documents were provided to the Inquiry in 2004. Please refer to Inquiry reference 067B-039-074 – 067B-039-077. Please note that these statements appear to be the attachments referred to in Ms Hall's email to Mr Mills, Mr Fee and Ms O'Rawe dated 25th March 2004 (document 38). We shall revert to you on the remainder of the matters raised in your letter as soon as possible.

Please find enclosed a copy of document 206 which appears to have been omitted from the copy documents sent to you.

Yours faithfully



Joanna Bolton
Solicitor Consultant

NUMBER	DATE	DOCUMENT	LP CLAIMED	INQ REF
		NB: Documents 1-21 attached to Treasury Tag at front of file		
1		File Cover		
2		Medical Records index		
3	24/08/2005	Letter J O'Donoghoe to Mr J Kelly		
4		List of Pleadings		
5		Pleadings:- • Writ of Summons • Memorandum of Appearance • Statement of Claim x2 • Notice of Further & Better Particulars • Defence • Replies to Notice for Further & Better Particulars • Notice of Legal Aid • Plaintiff's Notice to Produce • Notice of Setting Down • Notice of Intent to Proceed • Notice of Intent to Proceed	LLP LLP LLP	
6	25/06/2001	Clinical Negligence Case Review Summary	LA	
7	15/10/2001	Email Cover Sheet P Good to DLS enclosing documents at No 8 below	LA	
8	12/10/2001	Letter from P Good to A Maginness enclosing draft Defence and draft Notice for Particulars	LA	
9	12/04/2001	Clinical Negligence Case Review Summary	LA	
10	12/10/2001	Letter from P Good to A Maginness enclosing draft Defence and draft Notice for Particulars (same as No 8 above)	LA	
11	12/04/2002	Clinical Negligence Case Review Summary (same as No 9 above)	LA	
12	08/06/2002	Letter from P Good to A Maginness	LA	
13	19/07/2002	Clinical Negligence Case Review Summary	LA	
14	14/02/2003	Clinical Negligence Case Review Summary	LA	
15	24/03/2003	Letter from P Good to A Maginness	LA	
16	21/05/2003	Clinical Negligence Case Review Summary	LA	
17	Undated	CRU Document		
18	02/12/2003	Fax from P Good to D Scott	LA	
19	10/12/2003	Fax from P Good to D Scott	LA	
20	13/01/2004	Email Cover Sheet P Good to A Maginness enclosing document at No 21 below	LA	
21	31/12/2003	Letter from P Good to A Maginness	LA	
22	24/04/13	File Note – Internal DLS	LP	
23	08/02/2008	File Note – Internal DLS	LP	
24	16/07/2007	File Note – Internal DLS	LP	
25	20/12/2004	Letter from Dr J Jenkins to DLS- acknowledgement of fee payment	CFI	

26	11/11/2004	Letter from H Mills to D Scott	LA	
27	06/09/2004	Email from M McGurk for B O'Rawe to D Scott		
28	26/07/2004	Letter from Arthur Cox Solicitors to DLS		
29	Undated	Telephone Attendance – DLS to K Doherty	LP	
30	05/07/2004	Letter from D Scott to Arthur Cox Solicitors		
31	05/07/2004	Letter from A Maguire, DLS to K Doherty	LP	
32	16/06/2004	Letter from L McLaughlin, Westcare to DLS	LP	
33	04/06/2004	Letter from Arthur Cox Solicitors to B O'Rawe		
34	13/05/2004	Letter from L McLaughlin, Westcare to DLS	LP	
35	07/05/2004	Letter from DLS to K Doherty	LP	
36	23/04/2004	Email from M McGurk for B O'Rawe to D Scott enclosing document at No 38 below		
37	20/04/2004	Notes of Review Meeting		
38	25/03/2004	Email from B O'Rawe to D Scott enclosing documents at No 40 below		
39		Undated WHSSB statement and SPLT statement dated 25/03/2004		
40	13/01/2004	Email from DLS to K Doherty	LA	
41	16/12/2003	Telephone Attendance – Murnaghan & Fee to D Scott	LP	
42	15/12/2003 15/12/2003 16/12/2003	Telephone Attendance – DLS to Dr Jenkins' secretary File Note – Internal DLS File Note – Internal DLS	LP LP LP	
43	12/12/2003	Telephone Attendance – D Scott to B O'Rawe Telephone Attendance – P Good to D Scott Telephone Attendance – D Scott to B O'Rawe Telephone Attendance – D Scott to Westcare Telephone Attendance – D Scott to K Doherty	LA LA LA LA	
44	11/12/2003	Telephone Attendance – K Doherty to D Scott Telephone Attendance – D Scott to K Doherty Telephone Attendance – K Doherty to D Scott Telephone Attendance – K Doherty to D Scott	LA LA LA LA	
45	11/12/2003	Telephone Attendance – D Scott to P Good Telephone Attendance - D Scott to Dr Jenkins	LA/LP	
46	12/12/2003	Letter from DLS to P Good	LA/LP	
47	12/12/2003	Telephone Attendance – DLS to P Good	LA/LP	
48	11/12/2003	Letter from Murnaghan & Fee to DLS		
49	12/12/2003	Letter from DLS to L McLaughlin, Westcare	LP	

50	10/12/2003	Letter from A Maginness to Murnaghan & Fee	LP	
51	11/12/2003	Letter from Murnaghan & Fee to DLS	LP	
52	10/12/2003	Letter from DLS to Murnaghan & Fee	LP	
53	10/12/2003	Letter from D Scott to Murnaghan & Fee	LP	
54	10/12/2003	Fax confirmation sheet re Letter from D Scott to Murnaghan & Fee (referred to at No 54 above)	LP	
55	10/12/2003	Email from B O'Rawe to D Scott	LA	
56	19/11/2003	Email from K Doherty to D Scott	LA	
57	10/11/2003	Telephone Attendance – D Scott to P Good	LA	
58	10/12/2003	Email from B O'Rawe to D Scott (same as No 56 above)	LA	
59	10/12/2003	Telephone Attendance – D Scott to B O'Rawe Telephone Attendance – D Scott to P Good Telephone Attendance – K Doherty to D Scott	LA LA LA	
60	09/12/2003	Consultation Note – P Good BL, D Scott - Dr O'Donoghoe, Dr Auterson - 4 pages	LA	
61	02/12/2003	Telephone Attendance – D Scott to Dr Jenkins' secretary Telephone Attendance – D Scott to Westcare Telephone Attendance – Dr Jenkins to D Scott	LP LP LP	
62	02/12/2003	Fax cover sheet DLS to K Doherty	LA	
63	02/12/2003	Fax Confirmation Sheet (re fax referred to at 63 above)	LA	
64	02/12/2003	Fax cover sheet DLS to P Good BL	LA	
65	02/12/2003	Fax Confirmation Sheet (re fax referred to at 65 above)	LA	
66	02/12/2003	Telephone Attendance – D Scott to K Doherty Telephone Attendance – D Scott to P Good Telephone Attendance – D Scott to K Doherty File Note – Internal DLS	LA LA LA LP	
67	21/11/2003	Telephone Attendance – D Scott to P Good	LP	
68	21/11/2003	Telephone Attendance – D Scott to P Good	LP	
69	19/11/2003	Email from K Doherty to D Scott	LA	
70	15/10/2003	Telephone Attendance – Dr Jenkins' secretary to DLS Telephone Attendance – DLS to Dr Jenkins' secretary Telephone Attendance – D Scott to K Doherty	LP LP LP	
71	20/10/2003	Letter from D Scott to K Doherty	LA	
72	15/10/2003	File Note – Internal DLS	LP	
73	22/09/2003	Letter from Murnaghan & Fee to DLS		

74	30/06/2003	Email from L McLaughlin, Westcare to DLS	LP	
75	27/06/2003	Letter from DLS to L McLaughlin, Westcare	LP	
76	27/06/2003	Telephone Attendance – DLS to L McLaughlin, Westcare	LP	
77	27/06/2003	Email from L McLaughlin, Westcare to DLS	LP	
78	18/06/2003	Attendance Note – D Scott & K Doherty	LA	
79	11/06/2003	Email from B O'Rawe to D Scott with email from J Kelly to B O'Rawe	LA	
80	11/06/2003	Letter from D Scott to Dr Jenkins	LP	
81	11/06/2003	Letter from D Scott to P Good	LA/LP	
82	11/06/2003	Letter from D Scott to K Doherty	LP	
83	06/06/2003	File Note – Internal DLS	LP	
84	06/06/2003	Email from B O'Rawe to D Scott	LA	
85	05/06/2003	Telephone Attendance – D Scott to K Doherty	LP	
86	03/06/2003	Fax from P Good to D Scott	LA	
87	03/06/2003	Faxed Letter from Murnagahn & Fee to D Scott		
88	03/06/2003	Letter from Murnaghan & Fee to D Scott (same as No 88 above)		
89	Undated	File Note - Internal DLS	LP	
90	03/06/2003	Telephone Attendance – DLS to Dr Jenkins' secretary Telephone Attendance – D Scott to Murnaghan & Fee	LP LP	
91	Undated	Telephone Attendance - D Scott to K Doherty	LA	
92	29/05/2003	Telephone Attendance – D Scott to Murnaghan & Fee Telephone Attendance – D Scott to Murnaghan & Fee	LP LP	
93	29/05/2003	Telephone Attendance – Murnaghan & Fee to DLS	LP	
94	27/05/2003	Telephone Attendance – DLS to Murnaghan & Fee	LP	
95	31/05/2003	Clinical Negligence Case Review Summary	LA	
96	07/05/2003	Letter from D Scott to K Doherty	LA	
97	07/05/2003	Letter from D Scott to P Good	LA	
98	29/04/2003	File Note – Internal DLS	LP	
99	29/04/2003	Coroner's Office Compliments slip		
100	25/04/2003	Letter from Mr J Leckey to Dr J Kelly		
101	28/04/2003	Telephone Attendance – D Scott to Dr J Kelly's secretary Telephone Attendance – D Scott to B O'Rawe	LA LA	
102	28/04/2003	Telephone Attendance – D Scott to Mr J Leckey		
103	28/04/2003	Telephone Attendance – Mr J Leckey to DLS		
104	08/04/2003	Consultation Note – 2 pages	LA	

105	08/04/2003	Telephone Attendance – B O'Rawe's office to DLS	LP	
106	01/04/2003	Letter from DLS to Dr J Kelly	LP	
107	01/04/2003	File Note - Internal DLS	LP	
108	28/03/2003	Letter from DLS to L McLaughlin, Westcare	LP	
109	26/03/2003	Letter from L McLaughlin, Westcare to D Scott	LP	
110	28/03/2003	Letter from DLS to Dr J Kelly with handwritten note	LP	
111	28/03/2003	Letter from DLS to P Good	LP	
112	28/03/2003	Letter from DLS to Dr J Kelly	LP	
113	26/03/2003	Telephone Attendance – D Scott to L McLaughlin, Westcare Telephone Attendance – D Scott to P Good	LP LP	
114	25/03/2003	Telephone Attendance – Dr J Kelly to D Scott	LA	
115	25/03/2003	Fax cover sheet D Scott to Dr J Kelly	LP	
116	25/03/2003	Fax Confirmation Sheet Telephone Attendance – DLS to Dr J Kelly's secretary	LP	
117	18/03/2003	Compliments Slip – Dr J Kelly to D Scott	LP	
118	18/03/2003	Telephone Attendance – D Scott to P Good	LP	
119	18/03/2003	Fax cover sheet D Scott to P Good	LA	
120	18/03/2003	Fax Confirmation Sheet re fax D Scott to P Good (referred to at No 120 above)	LA	
121	18/03/2003	File Note – Internal DLS	LP	
122	18/03/2003	Attendance Note - D Scott & B O'Rawe	LA	
123	18/03/2003	Fax from B O'Rawe to D Scott enclosing letter from Dr W Holmes to Dr J Kelly dated 07/03/2003		
124	12/03/2003	Telephone Attendance – B O'Rawe to D Scott's secretary Telephone Attendance – D Scott to B O'Rawe's secretary	LP LP	
125	12/03/2003	Telephone Attendance – D Scott to K Doherty Telephone Attendance – P Good to D Scott	LA LA	
126	06/03/2003	Telephone Attendance – D Scott to K Doherty Telephone Attendance - P Good to D Scott	LA LP	
127	04/03/2003	Telephone Attendance – K Doherty to D Scott	LP	
128	03/03/2003	Telephone Attendance - P Good to D Scott Telephone Attendance – D Scott to K Doherty	LA LA	
129	14/02/2003	Clinical Negligence Case Review Summary	LA	
130	17/02/2003	Email from B O'Rawe to D Scott	LA	
131	17/02/2003	Further copy of Email from B O'Rawe to D Scott (same as No 129 above)	LA	
132	17/02/2003	File Note recording conversation between D Scott & B O'Rawe	LA	

133	13/02/2003	Telephone Attendance – P Good to D Scott's secretary	LP	
134	04/02/2003	Telephone Attendance – P Good to D Scott Telephone Attendance – D Scott to Westcare	LA LP	
135	16/01/2003	Letter from D Scott to P Good	LA	
136	30/12/2003	Letter from Murnaghan & Fee to DLS		
137	19/12/2002	File Note – Internal DLS File Note – Internal DLS	LP	
138	21/11/2002	Letter from L McLaughlin to DLS	LP	
139	28/11/2002	Letter from D Scott to P Good	LA	
140	28/11/2002	Letter from D Scott to K Doherty	LP	
141	26/11/2002	Letter from D Scott to K Doherty	LA	
142	26/11/2002	File Note – Internal DLS	LP	
143	25/11/2002	Letter from Murnaghan & Fee to DLS		
144	22/11/2002	Letter from Murnaghan & Fee to DLS		
145	19/11/2002	Letter from DLS to K Doherty	LP	
146	18/11/2002	File Note – Internal DLS	LP	
147	08/11/2002	Telephone Attendance – K Doherty to DLS Telephone Attendance – DLS to P Good	LP LP	
148	06/11/2002	File Note – Internal DLS Telephone Attendance – DLS to K Doherty	LP	
149	04/10/2002	Letter from DLS to P Good	LA	
150	04/10/2002	Letter from DLS to K Doherty	LP	
151	30/09/2002	Letter from L McLaughlin, Westcare to DLS	LP	
152	21/10/2002 04/10/2002 10/10/2002	File Note – Internal DLS File Note – Internal DLS File Note – Internal DLS	LP LP LP	
153	26/09/2002	Letter from DLS to K Doherty	LP	
154	26/09/2002	Letter from DLS to P Good	LP	
155	19/09/2002 19/09/2002 19/09/2002 19/09/2002 19/09/2002 24/09/2002 25/09/2002 25/09/2002	Telephone Attendance – P Good to DLS Telephone Attendance – DLS to K Doherty Telephone Attendance – K Doherty to DLS Telephone Attendance – DLS to P Good Telephone Attendance – P Good to DLS Telephone Attendance – DLS to K Doherty Telephone Attendance – K Doherty to DLS Telephone Attendance – DLS to P Good	LP LP LP LP LP LP LP LP	
156	17/09/2002	Telephone Attendance – K Doherty to DLS Telephone Attendance – K Doherty to DLS Telephone Attendance – DLS to P Good	LP LP LP	
157	29/08/2002 05/09/2002 09/09/2002 09/09/2002 09/09/2002 17/09/2002 17/09/2002	Telephone Attendance – DLS to K Doherty Telephone Attendance – K Doherty to DLS Telephone Attendance – DLS to P Good Telephone Attendance – P Good to DLS Telephone Attendance – DLS to K Doherty Telephone Attendance – DLS to K Doherty Telephone Attendance – DLS to K Doherty	LP LP LP LP LP LP LP	
158	Undated	File Note – Internal DLS	LP	
159	Undated	Email – Internal DLS A Cassidy to D Scott	LP	
160	Undated	File Note – Internal DLS	LP	

161	29/08/2002	Telephone Attendance – DLS to K Doherty	LP	
162	02/08/2002	Fax - Handwritten note from P Good to A Cassidy on letter from A Cassidy to P Good of 02/08/2002	LP	
163	08/08/2002	Letter from Dr J Jenkins to DLS acknowledging receipt of fee	CFI/LP	
164	02/08/2002	Letter from A Cassidy to P Good with post-it note dated 6.08.02	LP	
165	05/08/2002	Brief Index	LP	
166	Undated	File Note – Internal DLS	LP	
167	25/07/2002	File Note – Internal DLS	LP	
168	19/07/2002	Clinical Negligence Case Review Summary	LA	
169	Undated	File Note – Internal DLS	LP	
170	18/06/2002	Letter from D Scott to K Doherty	LA	
171	13/06/2002	File Note – Internal DLS	LA	
172	14/05/2002 27/06/2002	File Note – Internal DLS Telephone Attendance – DLS to CRU	LP LP	
173	16/05/2002	Letter from D Scott to P Good enclosing Brief	LA	
174	12/04/2002	Clinical Negligence Case Review Summary	LA	
175	08/04/2002	Letter from Westcare to DLS	LP	
176	21/03/2002	Letter from Sperrin Lakeland Radiology Department to Westcare	LP	
177	10/04/2002	Fax cover sheet - DLS to Westcare	LP	
178	11/03/2002	Letter from Westcare to DLS	LP	
179	06/03/2002	Letter from DLS to Westcare	LP	
180	26/02/2002	Letter from Westcare to DLS	LP	
181	06/03/2002	File Note – Internal DLS	LP	
182	14/02/2002	Letter from D Scott to Dr J Jenkins enclosing Statement of Facts and Documentation	LP	
183	14/02/2002 13/02/2002	File Note – Internal DLS File Note – Internal DLS	LP	
184	01/02/2002	Letter from DLS to Westcare	LP	
185	29/01/2002	Letter from Westcare to DLS	LP	
186	Undated	File Note – Internal DLS	LP	
187	19/12/2001 11/01/2002 28/01/2002	File Note – Internal DLS File Note – Internal DLS File Note – Internal DLS	LP	
188	15/11/2001	Clinical Negligence Case Review Summary	LA	
189	Undated	File Note – Internal DLS	LP	
190	24/10/2001	File Note – Internal DLS	LP	
191	17/10/2001	Letter from D Scott to DLS	LA	
192	12/10/2001	Letter from D Scott to K Doherty	LA	
193	15/09/2001	Letter from Murnaghan & Fee to DLS with handwritten note	LP	
194	15/10/2001	Letter from DLS to Murnaghan & Fee		
195	Undated	File Note – Internal DLS	LA	
196		Copy Defence & Notice for Further and Better Particulars	LP	
197	12/10/2001	File Note – Internal DLS	LP	
198	Undated	File Note – Internal DLS	LP	

199	13/09/2001	Letter from D Scott to Murnaghan & Fee		
200	13/09/2001	Letter from S Ramsey, DLS to P Good	LP	
201		Brief Index	LP	
202	12/09/2002	File Note – Internal DLS	LP	
203	07/09/2001	Letter from Murnaghan & Fee to DLS		
204	23/08/2001	Letter from Westcare to DLS	LP	
205	21/08/2001	Letter from D Scott to K Doherty	LP	
206	24/08/2001	Telephone Attendance – DLS to Coroner's Office		
207	20/08/2001	File Note – Internal DLS	LP	
208	25/06/2001	Clinical Negligence Case Review Summary	LA	
209	25/06/2001	Handwritten Clinical Negligence Case Review Summary	LA	
210	09/07/2001	File Note – Internal DLS	LP	
211	26/06/2001	Letter from DLS to Murnaghan & Fee		
212	26/06/2001	Letter from DLS to K Doherty	LP	
213	22/06/2001	Letter from Murnaghan & Fee to DLS		
214	21/06/2001	Letter to Murnaghan & Fee from DLS		
215	19/06/2001	File Note – Internal DLS	LP	
216	14/06/2001	Letter from Murnaghan & Fee to DLS		
217	18/05/2001	Letter from K Doherty to DLS	LA	
218	04/06/2001	Letter from DLS to Westcare	LP	
219	04/06/2001	Letter from DLS to Murnaghan & Fee		
220	27/04/2001	Letter from Murnaghan & Fee to DLS		
221	08/05/2001	Letter from Westcare to DLS	LP	
222	18/11/2002	Consultation Note – P Good BL & D Scott – Dr Kelly - 2 pages	LA	
223		Index		
224	06/02/2004	Jenkins Report		
225	17/10/2003	Statement T Jones		
226	10/10/2003	Statement T McCaffery		
227	10/10/2003	Statement S McManus		
228	08/10/2003	Statement B Swift		
229	20/04/2000	Statement Dr Auterson		
230	07/05/2003	Compliments slip Dr Kelly to D Scott		
231	25/04/2003	Letter Coroner to J Kelly		
232	08/06/2002	Letter Counsel to A Maginness	LA	
233	07/03/2002	Dr Jenkins Report		
234	14/04/2000	Post Mortem Report x 2		
235	22/04/2003	Letter enclosing Report – Dr E Sumner x 2		
236		Complaints file (incomplete)		
237	14/04/2000	Post Mortem Report		
238	07/03/2002	Dr Jenkins Report x 2		
239	11/09/2003	Statement T McCaffery		
240	27/04/2000	Handwritten Statement T McCaffery		
241	21/04/2000	Letter E Fee to T McCaffery		
242	02/02/2003	Pediatrics Vol 111 No 2		
243	2003	The Ulster Medical Journal		
244	2003	Prevention of Hyponatraemia in Children		

245	10/12/2003	Fax Dr O'Donohoe to D Scott with enclosures		
246	18/02/2001	Dr Evans Report		
247	22/04/2003	Letter enclosing Report – Dr E Sumner		
248	20/09/2003	Statement S McManus		
249	16/09/2003	Statement B Swift		
250	20/04/2000	Statement Dr Auterson		
251		Old File Cover		
252		Old File Cover		
253		Old File Cover		

2001 No. 3036

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND
QUEENS BENCH DIVISION

BETWEEN

NEVILLE CRAWFORD and MAE CRAWFORD
as Personal Representatives of the estate of Lucy Crawford deceased

Plaintiffs

-and-

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST

Defendant

Writ of Summons issued on the 15th day of June, 2001

STATEMENT OF CLAIM

Served this 7th day of September 2001
by Murnaghan & Fee, Project House,
37 Townhall Street,
Enniskillen, Co. Fermanagh BT74 7BD
Solicitors for the Plaintiffs

1. The Plaintiffs are the parents and the administrators of the estate of Lucy Crawford deceased (hereinafter called "the deceased") and sue under and by virtue of the Fatal Accidents (NI) Order 1977 on their own behalf and on behalf of the other dependants of the deceased for loss and damages sustained by them and other dependants of the deceased by reason of her death caused as hereinafter appears, and under and by virtue of the Law Reform (Miscellaneous Provisions) Act (NI) 1937 on behalf of the said estate by reason of the death of the deceased.

2. On the 12th day of April 2000 the deceased was admitted to the Erne Hospital, Enniskillen which is under the care, custody and control of the defendant, its servants and agents.

3. The deceased had a history of vomiting on admission. She was given fluids intravenously by the servants or agents of the defendant. As a result of the treatment the deceased received on the 12th and 13th April 2000 her condition deteriorated. At 3am on the 13th April 2000 she suffered a

cerebral oedema. She was transferred from the Erne Hospital to the Royal Belfast Hospital for Sick Children and arrived there at 08.00 on the 13th April 2000. Brain stem tests were then carried out and the results were negative. Treatment was discontinued and the deceased died on the 14th April 2000 at 13.15hr.

4. The said injuries and death were caused by the negligence of the defendant, its servants or agents as follows;

PARTICULARS OF NEGLIGENCE

(a) failure to properly assess the deceased on admission to the hospital which includes failure to record blood pressure, assess or record the degree of dehydration, failure to take a note of capillary refill time of over 2 seconds

(b) failure to insert an intravenous line in time or at all

(c) failure to properly calculate and record the fluid replacement required by the deceased

(d) failure to provide a doctor with reasonable care and skill to insert the intra-venous line within a reasonable time

(e) failure to assess or make any clinical observations in regard to the deceased when inserting the intravenous line which would have included monitoring her heart rate, blood pressure, CRT, level of dehydration, level of consciousness and awareness

(f) failure to give accurate instruction regarding fluid replacement both with regard to volume and type of fluid;

(g) failure to provide adequate resuscitation equipment or procedure

(h) failure to train the nursing staff in resuscitation techniques or procedure

(i) failure to resuscitate the deceased when she collapsed and suffered a cerebral oedema

(j) failure to accurately record the intra-venous fluids given to the deceased

(k) giving the deceased an inappropriate amount of fluids considering her condition

(l) treating the deceased in such a way that she suffered a cerebral oedema

(m) giving an inappropriate concentration of fluid in light of the deceased's condition

(n) causing a fall in the conscious level of the deceased

(o) causing respiratory arrest in the deceased

(p) causing the death of the deceased

(q) failure to monitor blood pressure adequately or at all

(r) failure to monitor heart rate adequately or at all

(s) failure to monitor urinary output adequately or at all

(t) Failing to treat the deceased with reasonable care and skill which would have involved taking precautions which expressly or impliedly are alleged in the foregoing particulars to have been omitted

The Plaintiff will further rely in proof of the negligence alleged upon such other facts as may be known to the Defendant, but not to the Plaintiff and which may be given in evidence by the Defendant and its witnesses at the trial of this action.

5. By reason of the aforesaid acts, and omissions the deceased suffered personal injuries, pain and suffering, loss of amenity, loss and damage and her death was caused and her estate has suffered loss and damage

PARTICULARS OF INJURIES

Dehydration, cerebral oedema, tonic clonic convulsion, loss of consciousness, loss of respiratory function

PARTICULARS OF SPECIAL DAMAGE TO ESTATE

Funeral expenses	£1,000.00 approximately
Headstone	£1,800.00 approximately

6. By reason of the said acts and omissions the plaintiffs, as parents of the deceased have suffered bereavement and they and the other persons named below have suffered and will suffer loss and damage.

PARTICULARS PURSUANT TO FATAL ACCIDENTS ORDER

Persons on whose behalf the action is brought

[redacted]

PARTICULARS OF NATURE OF THE CLAIM

The deceased was a robust healthy child who was born on the 5th November 1998. The persons named above have suffered grief loss and damage as a result of the tragic death of their sister.

And the Plaintiff claims damages and interest thereon pursuant to Section 33A of the Judicature Act (Northern Ireland) 1978.

(a) under the Law Reform (Miscellaneous Provisions) Act (NI) 1937

(b) under the Fatal Accidents (NI) Order 1977

SINEAD McKEAGNEY BL

2001 No. 3036

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND
QUEENS BENCH DIVISION

BETWEEN

NEVILLE CRAWFORD and **MAE CRAWFORD**
as Personal Representatives of the estate of Lucy Crawford deceased

Plaintiffs

-and-

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST

Defendant

Writ of Summons issued on the 15th day of June, 2001

STATEMENT OF CLAIM

Served this 7th day of September 2001
by Murnaghan & Fee, Project House,
37 Townhall Street,
Enniskillen, Co. Fermanagh BT74 7BD
Solicitors for the Plaintiffs

1. The Plaintiffs are the parents and the administrators of the estate of Lucy Crawford deceased (hereinafter called "the deceased") and sue under and by virtue of the Fatal Accidents (NI) Order 1977 on their own behalf and on behalf of the other dependants of the deceased for loss and damages sustained by them and other dependants of the deceased by reason of her death caused as hereinafter appears, and under and by virtue of the Law Reform (Miscellaneous Provisions) Act (NI) 1937 on behalf of the said estate by reason of the death of the deceased.

2. On the 12th day of April 2000 the deceased was admitted to the Erne Hospital, Enniskillen which is under the care, custody and control of the defendant, its servants and agents.

3. The deceased had a history of vomiting on admission. She was given fluids intravenously by the servants or agents of the defendant. As a result of the treatment the deceased received on the 12th and 13th April 2000 her condition deteriorated. At 3am on the 13th April 2000 she suffered a

cerebral oedema. She was transferred from the Erne Hospital to the Royal Belfast Hospital for Sick Children and arrived there at 08.00 on the 13th April 2000. Brain stem tests were then carried out and the results were negative. Treatment was discontinued and the deceased died on the 14th April 2000 at 13.15hr.

4. The said injuries and death were caused by the negligence of the defendant, its servants or agents as follows;

PARTICULARS OF NEGLIGENCE

(a) failure to properly assess the deceased on admission to the hospital which includes failure to record blood pressure, assess or record the degree of dehydration, failure to take a note of capillary refill time of over 2 seconds

(b) failure to insert an intravenous line in time or at all

(c) failure to properly calculate and record the fluid replacement required by the deceased

(d) failure to provide a doctor with reasonable care and skill to insert the intra-venous line within a reasonable time

(e) failure to assess or make any clinical observations in regard to the deceased when inserting the intravenous line which would have included monitoring her heart rate, blood pressure, CRT, level of dehydration, level of consciousness and awareness

(f) failure to give accurate instruction regarding fluid replacement both with regard to volume and type of fluid;

(g) failure to provide adequate resuscitation equipment or procedure

(h) failure to train the nursing staff in resuscitation techniques or procedure

(i) failure to resuscitate the deceased when she collapsed and suffered a cerebral oedema

(j) failure to accurately record the intra-venous fluids given to the deceased

(k) giving the deceased an inappropriate amount of fluids considering her condition

(l) treating the deceased in such a way that she suffered a cerebral oedema

(m) giving an inappropriate concentration of fluid in light of the deceased's condition

(n) causing a fall in the conscious level of the deceased

(o) causing respiratory arrest in the deceased

(p) causing the death of the deceased

(q) failure to monitor blood pressure adequately or at all

(r) failure to monitor heart rate adequately or at all

(s) failure to monitor urinary output adequately or at all

(t) Failing to treat the deceased with reasonable care and skill which would have involved taking precautions which expressly or impliedly are alleged in the foregoing particulars to have been omitted

The Plaintiff will further rely in proof of the negligence alleged upon such other facts as may be known to the Defendant, but not to the Plaintiff and which may be given in evidence by the Defendant and its witnesses at the trial of this action.

5. By reason of the aforesaid acts, and omissions the deceased suffered personal injuries, pain and suffering, loss of amenity, loss and damage and her death was caused and her estate has suffered loss and damage

PARTICULARS OF INJURIES

Dehydration, cerebral oedema, tonic clonic convulsion, loss of consciousness, loss of respiratory function

PARTICULARS OF SPECIAL DAMAGE TO ESTATE

Funeral expenses	**£1,000.00 approximately**
Headstone	**£1,800.00 approximately**

6. By reason of the said acts and omissions the plaintiffs, as parents of the deceased have suffered bereavement and they and the other persons named below have suffered and will suffer loss and damage.

PARTICULARS PURSUANT TO FATAL ACCIDENTS ORDER

Persons on whose behalf the action is brought

[redacted]

PARTICULARS OF NATURE OF THE CLAIM

The deceased was a robust healthy child who was born on the 5th November 1998. The persons named above have suffered grief loss and damage as a result of the tragic death of their sister.

And the Plaintiff claims damages and interest thereon pursuant to Section 33A of the Judicature Act (Northern Ireland) 1978.

(a) under the Law Reform (Miscellaneous Provisions) Act (NI) 1937

(b) under the Fatal Accidents (NI) Order 1977

SINEAD McKEAGNEY BL

2001 NO: 3036

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN

NEVILLE CRAWFORD AND MAE CRAWFORD
AS PERSONAL REPRESENTATIVES OF THE ESTATE OF
LUCY CRAWFORD (DECEASED)

Plaintiffs

AND

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST

Defendant

NOTICE FOR FURTHER AND BETTER PARTICULARS

TAKE NOTICE that you are hereby required to furnish to the Solicitors for the Defendant within 8 days of service of this Notice upon you, the following Further and Better Particulars:

1. In that it is alleged in paragraph 4(a) that there was a failure to properly assess the Deceased on admission, specify those steps that should have been taken by the Defendant, its servants or agents following an assessment of the Deceased which it is alleged were omitted.

2. Specify when it is suggested or alleged that an intravenous line should have been inserted.

3. Specify each and every respect in which it is alleged that the Defendant, its servants or agents:

/(a)

(a) failed to calculate; and

(b) failed to record

the fluid replacement required by the Deceased. State the fluid replacement that it is alleged was required by the Deceased.

4. Identify the doctor who it is alleged did not exhibit reasonable care and skill in the insertion of an intravenous line.

5. Specify the "reasonable time" in terms of duration or period when the intravenous line should have been inserted.

6. State the adverse affects of the alleged failure to assess or make clinical observations regarding the Deceased when inserting the intravenous line.

7. Specify each and every respect in which it is alleged that there was a failure to give accurate instructions regarding fluid replacement, both as to volume and type.

8. Specify the type of fluid that should have been given.

9. Specify the volume of fluid that should have been given during the period when the Deceased was under the care of the Defendant.

10. Specify each and every respect in which it is alleged that the Defendant, its servants or agents failed to provide "adequate resuscitation equipment or procedure". Identify those items of equipment that were allegedly not available or used by the Defendant and the elements of the procedure that were lacking.

11. Specify those features of the nursing staff's training that represented a failure in terms of resuscitation techniques and procedure.

12. Specify each and every element or aspect of the resuscitation of the Deceased which is alleged to have been negligent.

13. In respect of the allegation that the Deceased was given "an inappropriate amount of fluids considering her condition", state the amount of the inappropriate fluids and specify what it is alleged would have been an appropriate amount of fluids.

14. In respect of the allegation that the Defendant the Deceased "an inappropriate concentration of fluid in light of the Deceased's condition", specify the nature of the inappropriate concentration and the concentration it is alleged should have been given to the Deceased. Identify those elements of the Deceased's condition which dictated the appropriate or inappropriate concentration of fluid.

15. **Specify each and every respect in which it is alleged for the period when the Deceased was in the care of the Defendant that there was a failure:**

(a) to monitor blood pressure;

(b) monitory heart rate; and

(c) monitory urinary output.

16. Provide a detailed elemental breakdown of the sums in respect of:

(a) funeral expenses; and

(b) headstone,

vouching all necessary documentation.

17. Specify and quantify the nature and amount of:

(a) loss; and

/(b)

(b) damage that has been occasioned by Andrea Crawford and Wayne Crawford, being the persons on whose behalf the Action is brought under the Fatal Accidents (Northern Ireland) Order 1977.

AND FURTHER TAKE NOTICE that if you fail to furnish the said Replies within the time specified application will be made to this Honourable Court for an Order compelling Replies and use will be made of this Notice to fix you with the costs thereof.

Dated this 15 day of October 2001,

SIGNED: A Maginness

A MAGINNESS ESQ
Solicitor for the Defendant
25 Adelaide Street
BELFAST

TO: The Plaintiffs and their Solicitors
Murnaghan & Fee
Project House
37 Townhall Street
Enniskillen
Co Fermanagh
BT74 7BD

1nfbpb4

2001 NO: 3036

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

Between:

NEVILLE CRAWFORD AND MAE CRAWFORD
AS PERSONAL REPRESENTATIVES OF THE ESTATE OF
LUCY CRAWFORD (DECEASED)

Plaintiffs:

AND

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST

Defendant:

DEFENCE

Served this 15 day of October 2001,

By A. Maginness, 25 Adelaide Street,

Belfast, Solicitor for the Defendant.

1. Paragraph 1 of the Statement of Claim is admitted.

2. Paragraph 2 of the Statement of Claim is admitted.

3. Paragraph 3 of the Statement of Claim is admitted save that the Defendant denies that the deterioration in the Deceased's condition was attributable or caused by her treatment while a patient of the Defendant.

4. The Defendant denies that it, or its servants or agents, were guilty of the alleged or any negligence and deny each and every particular of negligence as alleged in paragraph 4 of the Statement of Claim as if the same were herein set forth and traversed seriatim.

/5.

5. The Defendant denies that any personal injury, pain and suffering of the Deceased were caused or contributed to by any act or alleged admission on the part of the Defendant, its servants or agents. The Defendant denies that the death of the Deceased was caused or occasioned by any acts or omissions on the part of its servants or agents, and accordingly denies that the Deceased's Estate has suffered any loss or damage.

6. The Defendant denies that the bereavement of the parents of the Deceased was caused or occasioned by any act or alleged omission on the part of the Defendant, its servants or agents, and denies that any of the persons named in paragraph 6 have suffered any loss or damage attributable to any act or alleged omission on the part of the Defendant its servants or agents.

PATRICK GOOD

1defb4
151001

No 2001 No 3036

IN THE HIGH COURT OF JUSTICE IN Northern Ireland
QUEEN'S BENCH DIVISION

BETWEEN:

NEVILLE CRAWFORD and MAE CRAWFORD
as Personal Representatives of the estate of Lucy Crawford deceased

Plaintiffs:

-and-

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST

Defendant:

TAKE NOTICE that in reply to the Defendant's Notice for Further and Better Particulars dated the 15th October 2001 the Plaintiff states as follows:

1. Paragraph 4(a) of the Statement of Claim details the steps which the Defendant, its servants or agents failed to take to properly assess the deceased on admission. Following assessment the Defendant, its servants or agents should have carried out the steps detailed in 4(b) to 4(t) of the Statement of Claim.

2. The intravenous line should have been inserted as soon as possible after admission or by 9.00pm at the latest. The Plaintiff was admitted at 7.30pm and IV access was not successful until 11.00pm. This delay was unreasonable in the circumstances. Assistance from a more experienced doctor should have been sought sooner.

3. The Plaintiff's notes show no calculation or record of the fluid replacement required by the Plaintiff. The normal fluid requirement of a child of the Plaintiff's age is 100ml per kilo per 24 hours. On admission the Plaintiff weighed 9.14kg. Her normal fluid requirement would therefore be 914ml. Assuming a dehydration level of 7.5% the Plaintiff would have lost 7.5% of her body weight. This is 750ml. The Plaintiff's total fluid replacement is therefore 914+750=1,664ml per 24 hours or 70ml approximately per hour. These recommendations are contained in the Advanced Paediatric Life Support Guidelines 3rd edition. The decision to infuse 100ml per hour was wrong. The decision to use 0.18% NaCl was wrong. The decision to pour in 500ml of 0.9% NaCl at the end was wrong.

4. Dr Malik who first saw the Plaintiff was unable to insert an intra-venous line with reasonable care and skill within reasonable time. This gave rise to a situation where IV line was not inserted in the Plaintiff until 11.00pm.

5. See 2 above.

6. The Plaintiff suffered a Cerebral Oedema and collapsed at 3am on the 13th April 2000. Brain swelling caused by her treatment at the Erne Hospital caused the tonic clonic convulsion and significant fall in conscious level.

7. Dr O'Donoghue failed to give accurate instruction regarding fluid replacement both with regard to volume and type of fluid to the nurses or more junior doctors treating the Plaintiff. He did not record the giving of any instructions or the instructions themselves in the Plaintiff's medical notes and records which would be standard practice. Failure to write up instructions regarding fluid balance is negligent

8. The type of fluid that should have been given is 0.45% NaCl and 4% dextrose at a rate of 70ml per hour according to the Advanced Paediatric Life Support Guidelines 3rd edition. If there was evidence of hypovolaemic shock medical staff should have considered giving an initial bolus infusion of either 0.9% sodium chloride or human albumin solution (HAS) in a dose of 20ml per kg.

9. The volume of fluid that should have been given when the deceased was in care of the Defendant, its servants or agents was either
180ml + 245ml (70ml X 3.5 hours) = 425ml assuming no IV was inserted until 23.00hr
or
180ml + 455ml (70ml X 6.5 hours) = 635ml assuming IV line was inserted at 20.00hr.
Both equations allow 0.5 hours for the infusion of 180ml HAS

10. It is not alleged that failure to resuscitate contributed to the Plaintiff's death. After the cerebral oedema occurred the Plaintiff's pupils were fixed and dilated and she was beyond help.

11. The nursing management was inadequate up to the time of collapse as outlined in paragraph 4 of the Statement of Claim.

12. The Plaintiff does not allege that the Defendant was negligent by failing to resuscitate.

13. The deceased had increased in weight from 9.14kg to 12kg. If the weights are accurate the difference can only be explained by the presence of additional fluid of 2860ml. The appropriate amount of fluid is given at 9 above.

14. The deceased was given 0.18% NaCl and 0.9% NaCl both of which were inappropriate considering the condition of the deceased. The appropriate concentrations are given at 8 above. The factors which are used to calculate the appropriate concentration of fluid are weight on admission, normal weight and percentage dehydration.

15. (a), (b) and (c) should have been monitored and recorded during the deceased's treatment by the Defendant, its servants or agents and particularly on admission, when each new doctor assessed the deceased and at regular intervals by the nursing staff.
Blood Pressure should have been monitored 2 hourly or ½ hourly if outside the normal range or changing significantly.
Heart rate should have been monitored continuously or hourly.
Urine out put should have been monitored continuously or hourly by catheter, urine bag or weighing nappies. A record of volume or weight should have been kept.

16.

(a) Funeral expenses herewith £800.00 as per account from Wesley Elliott, Funeral director

(b) Headstone herewith £1,830.00 as per account from Wesley Elliott, Funeral director

17.

(a) general damages for pain suffering and loss of amenity by the deceased from the time of admission to the Erne Hospital to the time of death.

(b) bereavement.

Dated this 22nd day of November, 2002

Murnaghan & Fee,
Solicitors for the Plaintiffs,
37 Townhall Street,
Enniskillen,
Co. Fermanagh.

To: A Maginness Esq,
Solicitor for the Defendant,
25, Adelaide Street,
BELFAST.

Spoke to Graham at the Coroners office
- a death certificate was issued on
14 April 2000 in regard to Lucy Crawford.
24/8

Sharon
White to Kevin

HSC Business Services Organisation

Directorate of Legal Services
Practitioners in Law to the Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
BMcL-0128-13

Our Ref:
HYPS071/01

Date:
28th August 2013

Mr B McLoughlin
Assistant Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir

RE: INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS - DEPARTMENTAL AND ADDITIONAL GOVERNANCE SEGMENT SOUTHERN TRUST

I refer to the above and your letter of 8th August 2013 (BMcL-0128-13).

I now enclose the following for your attention: -

1) Organisational Chart for Craigavon Area Hospital Group Trust 2003/2004;
2) Current organisational Chart for the Southern Health and Social Care Trust.

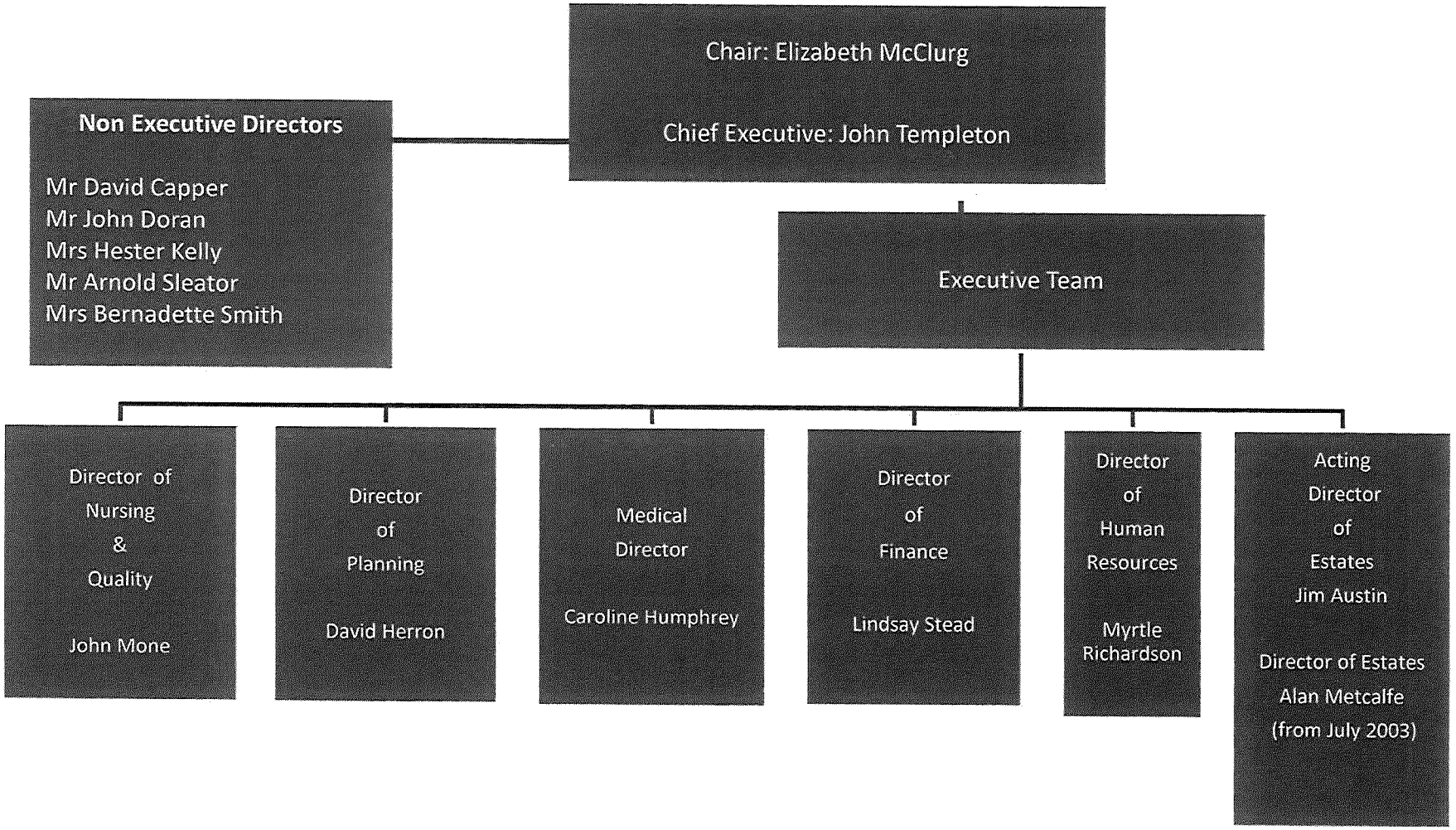
This completes the Southern Trust's response to your aforementioned correspondence.

Yours faithfully

JRBolton

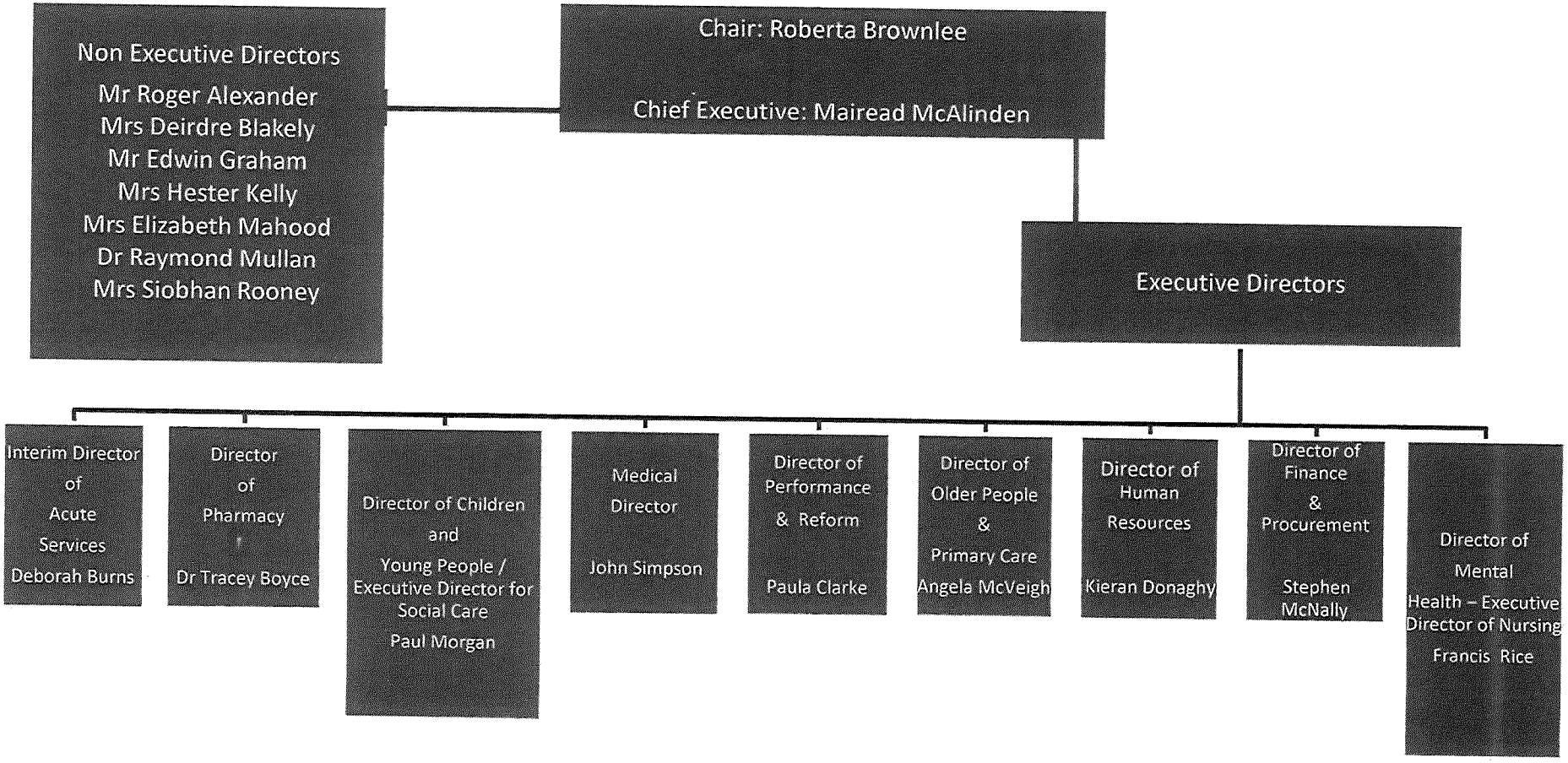
Joanna Bolton
Solicitor Consultant

Craigavon Area Hospital Group Trust – Organisational Structure, 2003/04



CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Southern Health & Social Care Trust – Organisational Structure – Present Day



HSC Southern Health and Social Care Trust

Quality Care - for you, with you