Mr Justice Weir
Presiding Judge
For the Coroners Service
For Northern Ireland
Coroner's Office
Mays Chambers
73 May St
Belfast
BT1 3JL

Your Ref:

Our Ref: JOH-0303-12

Date: 12th October 2012

Dear Judge,

Thank you for your letter of 8 October.

You may know the background of my request to Mr Leckey for a witness statement but in case you don't I will set it out briefly.

The first death which I am inquiring into is that of Adam Strain in 1995. His death was referred to Mr Leckey who conducted an inquest in June 1996. The evidence which I heard in the spring indicates that there is a major issue about lessons not being learned in the RBHSC from that inquest.

In October 1996 Claire Roberts was admitted to the RBHSC. She died there two days later. The hearing into Claire's treatment and death resumes on 15 October. One of the issues concerns the fact that Claire's death was not referred by the Royal to the coroner in 1996 or even raised with him at all. There is substantial evidence, which will be tested in the coming weeks, that it should have been especially since some of the people involved in Claire's case were directly aware of the outcome of Adam's inquest just a few months earlier. When her parents saw the UTV documentary eight years later in October 2004 they contacted the Royal with the result that an inquest finally took place in 2006. It identified hyponatraemia as one of the causes of her death.

Chronologically the next death which is relevant to the Inquiry is that of Lucy Crawford who died in the RBHSC in 2000, having been treated initially and disastrously in the Erne. At the request of Mr and Mrs Crawford the Minister removed Lucy's death from my Terms of Reference but I am still investigating what happened **after** she died because that is potentially relevant to the death in Altnagelvin in 2001 of Raychel

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Ferguson. The point is that there was no inquest into Lucy's death at the time and the Ferguson family contend that if Lucy's death from hyponatraemia had been highlighted at a timely inquest the death of their daughter from hyponatraemia after an appendectomy may have been avoided.

As you know Mr Leckey eventually held an inquest into Lucy's death in 2004. This only came about because an official employed by the Western Health and Social Services Council who had assisted the Crawford family in a complaint they made to the Sperrin Lakeland trust in 2000 became aware of the inquest into Raychel's death and saw similarities between the two events. Once again therefore, as in Claire's case, it seems that the system did not work as it should have and an inquest came about by good fortune rather than by design. This will of course be a matter of concern to you in your role as the Presiding Judge for the Coroners Service

I have given you this summary because it sets in context my reasons for asking Mr Leckey to complete a witness statement. I acknowledge and appreciate the fact that he has been consistently helpful to the Inquiry, as Ms Anderson has been also. I also acknowledge that my Inquiry, established by the Minister for Health, has no authority to trespass into the realm of the Senior Coroner's judicial decision making.

If Mr Leckey cannot recall the precise facts of the nature of contacts with his office about Lucy's death then I am bound to accept that he cannot answer some specific questions. It would however be helpful if he could at least answer those questions which are designed to help us to understand what the process was at the time because in this case it is arguable (to say the least) that for whatever reason the process failed. The result of that failure is that a family was denied an inquest for four years and, possibly, that another child died.

If some questions stray into Mr Leckey's judicial remit I accept that I cannot require him to answer them. However the request was prepared with this restriction in mind so I am unclear which of the questions posed are said to stray. Perhaps Mr Leckey could clarify this point.

I would be grateful if Mr Leckey would reconsider his approach in light of what I have set out above and assist the Inquiry once again in so far as he can do so. Since this segment of the public hearings is starting in the near future it would be very helpful if any response was provided urgently.

There is likely to be a final stage of the Inquiry which will look at current procedures to see if and how they are different from those which prevailed in the last two decades. It already seems clear to me that some public reassurance will be required to show that the failings in the system which feature in Claire's and Lucy's deaths are more likely to be avoided now. Perhaps when that stage comes you and/or the Senior Coroner might be willing to contribute to the discussion?

Yours Sincerely,

John O'Hara