TRANSCRIPT OF TELEPHONE CONVERSATION BETWEEN:

TREVOR BIRNEY, UTV

And

DR. CAROLINE STEWART

Thursday, October 14th at 3.40 pm.

Stewart: Hello

Birney: Hello. Is that Doctor Caroline Stewart?

Stewart: Speaking.

Birney: Doctor Stewart, I wonder if you could help me. My name is Trevor Birney. I'm from UTV in Belfast here.

Stewart: Yes.

Birney: I'm sorry to bother you at home but I'll tell you what it is. We're working on a programme at the moment and your name has just cropped up, believe it or

not, on a document that we have and I was just seeking some clarification from you.

It's in relation to the death of a child called Lucy Crawford.

Yes.

In the post mortem that we have you gave the clinical diagnosis I think it's described as, is that right, is that how you would describe it, I'm just getting the document in front of me here, yes, you gave the clinical history on page 3 of the document which is obviously absolutely the correct clinical history which is now on the Death Certificate as the result of an Inquest "Dehydration, hyponatraemia, Cerebral Oedema, Acute Swelling and Brain Stem Death".

That's on the page for the pathologist.

Yes, the clinical history.

Yes.

When you say to the pathologist, that's what goes to the pathologist?

I was a registrar. I would write the clinical history for the pathologist which we do for any child going for a post mortem.

When would that be done Caroline? When exactly would that be done like, within hours of the death?

Oh yes.

Or like at that very time of the death?

Yes, because the body goes to the mortuary you know within hours.

Yes, so you would have provided that for the Royal pathologist who carried out the post mortem, Dr O'Hara?

Yes.

So whenever Dr O'Hara received the body he received your clinical history?

Yes, they always do.

Yes, I mean that's the ……..

That's the standard for any child that goes for a post mortem.

Yes.

Any patient in fact, any body.

Yes.

Yes.

Tell me this then. Did you, were you involved in the treatment of Lucy?

I was the registrar working there.

So you would have been aware of the case from arrival from the Erne, her condition. The thing, just the thing, just to be absolutely clear with you, you absolutely correctly identified hypnotraemia?

Ah, I'm just wondering why you're asking me all this?

Well because it fell, you see Lucy's death fell through a net somewhere, either at the Coroner's Office or at the Pathology Department in that no-one was aware of the existence of hypnotraemia whereas you were aware of it and you know you stated in your clinical history. Do you know what I mean, there wasn't .....

Nobody else was aware of it.

Pardon.

What do you mean that nobody else was aware of it?

Well the Coroner, I don't know whether you're aware of the Coroner's Inquest into Lucy's case earlier this year?

Yes.

The Coroner read a statement at the outset of it?

Yes.

You're aware of that?

No. No, I wasn't involved in the Inquest.

I know, I know, I know.

I was a junior doctor there and ……..

You would have been working for Dr Greene or Dr Hanrahan?

Yes they were both consultant supervisors you know that I was working with.

Yes. So was it on their instructions that you would have wrote that clinical history.

It was under Peter Greene's instructions in fact.

It's part of our job. It's part of what we do.

But somebody provided the clinical diagnosis to you or the clinical history to you and you put it in the document?

If you're saying that I'm the only one that said this I think that's very wrong.

Yes, exactly, yes, yes. I know like you know Dr Creane has given us or told us indirectly that he was aware at the time that it was. You see they think that there's been a fall down in the Coroner's Office here. The Coroner's Office should have twigged what you were saying but didn't>

Hm.

Do you know what I mean. I mean it should have held an Inquest into Lucy's death.

Yes.

Because of the existence of hypnotraemia which I don't have to explain to you the importance of why that should have happened but it didn't you see and at the outset of the Inquest the Coronor sort of cast the buck back to the Royal by saying that it had given a misdiagnosis.

A misdiagnosis of what?

Well it never mentioned hypnotraemia.

But what was their diagnosis?

Ah gastroenteritis, dehydration and brain swelling.

Yes. Yes, well I mean those would all have been true.

Yea, but hypnotraemia wasn't .....

Wasn't mentioned specifically.

No, no and that's where you get the problem you see. He says that "gastroenteritis, dehydration and brain swelling" and that it was appropriate for a Death Certificate

to be issued saying "gastroenteritis was the cause of death" where you and I both know that's wrong and obviously that .....

Well that was her initial problem.

Yes, but you know that .....

That is what caused the sequelae that followed.

Yea, but I don't have to start, I don't have to start now and explain what occurred. Obviously the reason that the Coroner has set out, he felt that he had to re-open the Inquest which was unique in Northern Ireland's history. He re-opened the Inquest when he heard about the presence of hypnotraemia.

Right.

And he was so concerned about it so he doesn't agree with that. You know you're saying the gastroenteritis, but that's, the gastroenteritis does appear on her new Death Certificate but hpynotraemia appears on it.

Yes, yes, well they're both correct.

Yes but the myth, I'm saying, not to put hypnotraemia on it was a mistake according to the Coroner.

Right.

A mistake that was big enough for him to go back and re-open an Inquest when he heard that she had suffered hypnotraemia.

Yea, well I mean I didn't write the Death Certificate so ……

No, I know, but I mean ……..

I was unaware of what was on it.

But when you say, if I said to you, if I'd said to you "gastroenteritis, dehydration and brain swelling" and failed to mention hypnotraemia would you castigate me afterwards or were you fit to say "well listen" …

I would assume that this person had hypnotraemia to have those consequences.

Right, yes. You would say that the hypnotraemia is in as a result of those three consequences?

Yes.

It's clear from that because as a result of shifting it even to put dehydration on a Death Certificate now if somebody dies in hospital triggers an Inquest they are so concerned about dehydration in patients.

Yes.

And you understand why they are too. The concern that we have is that because of your document we know there was a knowledge that the child died of hypnotraemia and that for some reason the Coroner was misled, that he wasn't told of the presence of hypnotraemia.

And who's fault was that?

Well he blamed, he quite clearly blamed the Royal here. He said you know "if with the benefit of hindsight it would have been helpful if I had been advised of the post mortem findings at an early stage".

And why was he not?

Well because the Royal decided to have a localized post mortem. The body didn't go for a State Pathologist post mortem because the Pathology Department was told "listen gastroenteritis, dehydration, brain swelling" you know.

Well I can't comment. I don't know what happened. I presumed it was a Coroner's post mortem.

No it wasn't. You presumed at the time it was a Coroner's post mortem?

I can't remember but I thought that it was a Coroner's post mortem but I can't remember.

Yea.

What was that, 2001?

No, it was even before that. It was the year before 2000.

2000, yea. How did you get my number here?

A little bit of research.

Through who?

Well you know we would have ways of being able to track down people, put it like that, you know in current affairs, we're doing investigative thesis. We would be, if we were needing to speak to someone, we can try and get home numbers for them and so we knew that you were off on maternity leave and that you were at home, so we thought it was best, given that you were identified in this document and likely to be identified in the programme of being the person who put name to that at that time.

But I don't think that was anything like an outlandish diagnosis when you were given

.....

No that's absolutely correct.

Low sodium. There's no occupying stress.

No well Caroline you know that's exactly true. The point is why wasn't it picked up on. You were absolutely bang on and we're stating that you were absolutely bang on in what you stated here.

Yes.

So the problem is it's not what you did it's what didn't happen after that document left you.

Why was it not communicated to the Coroner, is that what you think?

Yes.

Well I have no idea why it wasn't communicated to the Coroner.

No but if that was communicated, if your words there had been communicated to the Coroner there would have been an immediate Inquest and if that had happened maybe the death of the child up in Altnagelvin wouldn't have occurred because people would have been aware of the dangers of dehydration, hypnotraemia beforehand. That's obviously what the Ferguson family up in Derry are saying so that's the seriousness of it you know that made me want to track you down and speak to you about it directly. That the consequence of the actions of the Royal in not explaining fully to the Coroner nor the Pathologist of the State Pathology Department .....

Well I would have assumed all of her notes including her post mortem notes would have gone to the Coroner.

No it was simply a phone call between Hanrahan. Hanrahan spoke directly.

I'm very sure that he was aware of the low sodium.

And not hypnotraemia.

That's what I mean, yes.

So why did he not tell the Coroner?

I can't answer, I can't answer for him but I'm very sure that he was aware of that and probably just, you know it's so obvious that he maybe assumed that the Coroner was aware of it.

Yes, yes when you speak of low sodium. So you're explanation for his reading that it would have been simply .....

The consequence of I mean her initial problem was gastroenteritis and you know that, that, that, that was you know what first went, first happened. That was the first thing that went wrong.

Yea.

But I mean you're talking about a case that's four years ago and I don't have notes or anything.

Oh I know. Look I know and I'm sorry to .....

I don't have any defence and I think it's very unfair to be questioning me over the phone to my home.

Well I appreciate the position you're in. I don't want to let, you know I need to alert you that you know your name has been discussed in relation to this and I don't, I think it would be unfair for you simply to be sitting at home some night and your name popping up, so we thought it was only appropriate that first of all to make you aware of that.

Yes.

You know I'm sorry to do this on you and I don't really like ringing you at home and trying to, but it's important for us and we think it's only appropriate for somebody in your position that you know your name and your diagnosis .....

Yea, well I mean I don't think, I am very sure that the Royal Obs people, anybody who dealt with that case was aware you know what the blood numbers were. I don't think that's anything unusual and the fact that it wasn't mentioned was that maybe it was just, it was understood. I don't know.

Yes.

I mean, I have, my job was clinically what I did, what I recorded in the notes, what I wrote to the pathologist on the sheet and what happened in subsequent Inquests I have not been involved with at all.

Really.

And you know I can't remember details that far away whenever you say that this was mentioned and this was mentioned you know, I

Well I know you know you're obviously very aware of the general terminology surrounding this so you know I'm trying not to get into detail on it, but you can imagine the importance of this obviously is that the family thought that the child had died of a tummy bug where in fact yourself and the other doctors .....

That's what caused the whole cascade of problems.

Well I think it is quite clear, and I mean that Peter Creane has given evidence of what caused Lucy's death was the fact that 400 mls of solution 18 were pumped into her over a four hour period at the Erne Hospital and really you know she wouldn't have been in the hospital if it wasn't for the gastroenteritis but the gastroenteritis was peripheral to the death in the end in that she wouldn't have suffered cerebral

oedema if it wasn't for the low sodium levels and the low sodium levels were caused by the wrong fluid and too much had obviously been given. Is that not true?

But, but you can't say that the gastroenteritis didn't cause any part in that whole

.....

No unfortunately if she hadn't had the tummy bug she wouldn't have been in the hospital. That's true.

You know she wouldn't have become dehydrated in the first place.

Yes.

And .....

But it wasn't .....

But it's a sad fact that gastroenteritis is still one of the biggest killers of young children throughout the world and you know we treat it almost as if it is just a tummy bug, it's okay but the sad thing is that there are thousands and millions of children that die of this throughout the world.

But yes, but you, sorry when I .....

And they die of it for the same reasons.

Yes, sorry, I'm just reading from, when I read from the Coroner's findings, when he says "Lucy died from being given the wrong fluid and too much of it and the failure to regulate the rate of infusion". The Coroner didn't find anything about the gastroenteritis, or sorry you stating that she died of gastroenteritis. He's stating that she died as a result of the wrong fluid and too much of it being given.

You know you've got to go back and say why did she need the fluid.

Sorry, but I think that I understand what you're saying but if you if you give something to somebody which ultimately ends in the death you look at what you gave her and not what she had before you gave it to her, you know.

Well maybe that's a medical question.

Yes, but I mean …….

Are you medically qualified?

No but we've had expert witness who has gone through the summary experts in the UK to examine the files and they would state quite clearly that they are very

concerned about the level of knowledge, again which has been exhibited by yourself in many ways surrounding the mismanagement of fluid.

Well we've nothing to do with the fluids that she was given in Enniskillen.

No I understand that Caroline but you're simply explaining away the death of the child as a result of gastroenteritis and it's quite clear that she died through the mismanagement of fluids, you know.

But I'm saying that the whole trigger was from gastroenteritis.

Yes and you know no-one, I'm not denying that, neither are the experts but the experts who have given witness and testimony to the programme would say that she died, it was a drastic failure on behalf of the Erne Hospital to regulate her fluids which caused her death. You know if the child hadn't been brought to hospital and still had the tummy bug she probably would have survived. In fact would have been absolutely okay if she had been rehydrated but the fact .....

And how was she going to be rehydrated?

Well it should say that she had been given some of the rehydrating fluid orally.

Which I understood she had been.

Well 150 milliletres over the course of two hours but I mean that didn't have an impact whenever you start to (a) put in 400 millilitres into a child weighing only 12 kilograms over four hours and then secondly tried to arrest that situation through pouring in another 500 millilitres over the next hour free-flowing.

Have you examined all the Erne Hospital notes.

Yes. Top to bottom.

Yea, I think it's actually very unfair that you're quizzing me at this point in time. I don't have any notes in front of me and I am picking memory out of you know four years ago. If you're going to quote me on this I'll be very upset.

We're not quoting you at all Caroline. This is a phone call basically just from me to establish that you were the person who's name was on the document that we have which is a public document and it's just you know you got, let me quite categoric in this, you're analysis for the experts that are on this programme is absolutely correct. The concern is why did others not pick up what you had documented. If the Coroner's Court and the Pathologist in the Royal had identified what you stated there should have been an Inquest immediately into the death of Lucy Crawford but the fact that there wasn't obviously is a serious concern. There's a loophole there that needs closed.

Well who took the Inquest that happened then earlier this year?

Only as a result of believe it or not somebody from the Western Health and Social Services Council who was aware of the case tying the two together and writing to the Coroner and saying "I think you should look at Lucy Crawford's death" and then when he did look at the death and ask an expert to look at it he knew immediately from your documentation that she actually died of hypnotraemia and that warrants a Coroner's Inquest, an investigation and Inquest. So you know you understand where I'm coming from in this that you know your diagnosis or clinical history warranted a Coroner's investigation. That didn't happen. The question has to be why?

Yea, well I can't answer those questions.

Yes, I know but sorry, I know that and we're pursuing others about that but you understand what I'm saying that when a child dies in this fashion it warrants an investigation.

Yes.

But because the Coroner was not given the full facts surrounding her death and the telephone calls where he says then "you can't blame me because the Royal didn't tell me exactly what had occurred".

Well I can't, I can't ……..

I know, I know, I'm not ……

……

If you listen, the one person inside the Royal that we know who documented the correct analysis or diagnosis of Lucy's death was yourself and that's important to us and it's important obviously to the family as well.

Yea.

That Doctor Caroline Stewart in black and white documented the history and it's just unfortunate the others didn't pick up on what you had put there. Now I understand that you were working with Dr Creane and Dr Hanrahan …..

Yea.

And Dr Creane I think, Dr Creane I think it's fair to say has told others that he himself alerted the Coroner directly at the time of the death because he was so concerned.

Yea, well I mean I presumed that it was a Coroner's post mortem she went for.

Right.

But I can't remember.

But that's .....

I mean you're saying it was a hospital post mortem.

I was yea.

Yea.

If she'd gone for you know, and again I you know there was a good case here that it was a possibility the Coroner's office couldn't understand exactly what you were saying or what your colleagues were saying and that's why it fell down but for me trying to establish where did it fall down is the difficulty hence this is where we are today but .....

But why did the Coroner not have access to the notes?

See the Coroner simply said that, the Coroner simply said ….

They just go on a couple of phone calls.

Well it's quite incredible. "Dr Donal O'Hanrahan rang the hospital, rang my office" the Coroner said "and the clinical history given was gastroenteritis, dehydration and brain swelling. Advice was then sought from the Pathologist, passed to State Pathologist Department as to whether a clinical history warranted a Coroner's post mortem. Following the consultation between the pathologist and O'Hanrahan my office was advised it would be appropriate for a Death Certificate to be issued". Now that all now flies in the face of where we are on this if you know what I mean that really it you know did warrant an investigation and a Death Certificate should never have been issued. The Coroner has now ripped up that Death Certificate and replaced it with a new one.

And who wrote the first one.

Well.

The Pathologist.

It must have been the pathologist, yea, it must have been.

I remember at the time that the family were very keen that you know if it was possible for organ donation that that would happen.

Yea, and I think they donated the heart.

It might have been the valve.

Oh sorry you're right, the valve, you're absolutely right.

Yea, and you know there was a lot of kind of looking into that sort of things.

Why would the Royal have held it's own post mortem. You know, sorry, hypothetically why would you hold a post mortem in that sort of situation? You know if you said the Death Certificate was okay and they had written that gastroenteritis, why would you hold a post mortem of your own?

I mean I don't have notes in front of me.

I know but I'm talking hypothetically Caroline even.

You mean in any child.

Yea.

Well the way we as paediatricians the death of any child is you know an absolute tragedy for the family and any child that dies is given, if the facility and the services are there, the parents are given the option "do they want to have a post mortem" and that's you know babies and children and I know she was still very young, she was just a toddler.

She was. She was only eighteen months old.

You know. Is there something else. Is there something else there. Is there something that could affect another child. Is there, there are many unanswered questions.

So really it would have been sort of, it would have been to say to the parents "you know a post mortem may help us reach some conclusions of why this happened".

Yea, or to kind of reassure them that you know she didn't have something else wrong with her brain or something else wrong with her insides.

Yea, but you were quite clear of exactly why she died. I mean the post mortem added nothing to what you said. In the clinical notes you were absolutely bang on.

Yea, you can say in hindsight because you had a formal post mortem.

Yea. They told you absolutely.

If you didn't have a post mortem you couldn't say that.

Well of course that's true. Were you yourself concerned given the medical notes that you had seen from the Erne, where you concerned about what the level of fluid she had been given.

Well I mean we were very very concerned when she was admitted and .....

There was no notes with her either at the time, I remember. The notes didn't arrive with her I think was part of the difficulty which .....

Who told you that.

It was at the Inquest, Creane said it.

Well I don't know remember that. I certainly remember something and I remember you know a lot of discussion around that but .....

Frustration.

Aye, it's a long time ago. I remember her family and they you know I remember talking to them quite a lot and obviously this was just such a tragedy for them. It was terrible but I don't remember you know all those kind of details about the notes whether they were there or weren't there.

But you were in no doubt about what had occurred. I mean you were in no doubt that when you looked at the notes and when you heard about the level of the 18 percent solution that had been given to her what exactly had occurred.

Well I don't know. I'm not saying I was in no doubt because there was number 18 solution was used very very widely throughout paediatric practice. That was kind of normal solution to give somebody that just needed maintenance fluid but you've got to understand the difference between maintenance fluid and .....

Replacement fluid.

Replacement fluid but number 18 solution was used extremely widely throughout our paediatric practice for years.

Yes, but I think you hit the nail on the head when you talk about the difference between maintenance and replacement and it's understanding whenever you're replacing raw fluids given the difficulties that's where it's at isn't it really.

Yea.

That's where the difficulty can arise. I don't think it's any secret you know. I mean O'Hanrahan and Creane both gave evidence.

Yea, I just remember the, hearing the Inquest, was that earlier this year, maybe.

Yea.

February, March.

Yea, that's it, yea.

Yea, yea.

But I mean to sum up, and I'll not keep you any longer, really it's quite clear that everyone at the Royal was quite aware of the presence of hypnotraemia that the child had died as a result of being presented at the Erne Hospital with gastroenteritis and then as a result of the mismanagement of the fluids at the Erne.

I would just ask you to think if they had taken her home and hadn't taken her to hospital that she would have been okay.

I'm not saying that. That's a very simplistic view of it and I appreciate that.

She was obviously a very very sick little girl.

No, no, no. I don't, I think the experts who studied the case wouldn't go there at all Caroline. They would say she was ill but you know there's no point in over-stating that she was a very very very ill little girl. I mean one of our experts in the UK would state that you know, she needed rehydration but you cannot overstate that she was that sick and she was a very normal wee girl who should have gone home if the fluids had been managed properly and would have gone home if the fluids had been managed properly. That's the difference here and you know diminishing what happened in the Erne Hospital that night will not do any good.

No, I have absolutely no involvement in what ……

No, no, no, but you know what I mean, the problem is that the parents got quite a shock when you can imagine an independent expert looked at the case and stated quite clearly what had happened. This was all completely alien to them because no-one explained exactly what had occurred but when it's seen in black and white put down to one of these guys exactly what had occurred and how it occurred and how from the documentation we have in front of us.

Yea, can you let me pick up the phone downstairs because the baby's downstairs.

No problem.

Hello.

Hello yea.

Sorry. Yes, I mean I think I follow what you're saying and you're just phoning to make me aware that this is coming, is it a TV programme or…..

It is, yea.

When will that be?

In probably a couple of weeks time, probably mid October and we're going to do an hour long special on this.

Right.

And just examine how this was handled and try to tie it up and try and put a lot of pieces of the jigsaw together really.

Yea, and I mean what are you going to quote from me or is it just what you see in this documentation in front of you.

We will probably state in the programme Caroline that your clinical diagnosis was dehydration, hypnotraemia, cerebral oedema, acute cloning and brain swelling death.

Yea.

And we will use that as a document to examine what occurred immediately after you documented that and how for some reason. Can I call you back, are you okay. Yea, we'll come down now. Just give me a few minutes I'm just finishing up here, okay.

You know how that diagnosis somehow slipped through the net and wasn't picked up on because if it was being picked up on why should the .....

You're saying there would have been a straight Coroner's case.

Absolutely, no doubt about it.

Yes, yea. I assume you're aware that we contact the Coroner over many many children that die unexpectedly. The Coroner kind of gives us the impression "why are you bothering me".

Really.

Yea. You know "I don't want to ……". You know "that's that, that's that".

Oh, so really he would not understand that you're contacting him saying "look you know"…..

You know maybe a child that's got a complex disability, has very dependent needs and maybe dies in their sleep and comes into hospital you know and you can't say that they're well. They've got a lot of problems, a lot of problems but yet their death is maybe unexpected. Maybe they've just had a bit of a chest infection or something like that and we would, we would kind of look at that and say "Oh we'll phone the Coroner" you know "and just discuss this" and we say to the Coroner this patient you know they had this and this and this, they were treated for a chest infection two weeks ago, something like that, you know, lots of problems and the Coroner is you know kind of "well then that's what they died of" you know. They don't want to take it any further so we do contact them a lot directly.

Just hold on a second Caroline. I've just to give a document to somebody outside my door who's pestering me. Hold on a second, can you.

Yes.

Sorry about that Caroline. Are you saying that Coroners sometimes, or the Coroner's office sometimes aren't looking or appreciate exactly what you're saying or like …..

It's not that they don't listen but I mean we do, I'm not aware, I can't remember you know the sequence of events in Lucy's death. As I said to you I thought it went to the Coroner after she died. I thought it was the Coroner's post mortem. What I remember was that the parents were very keen that if organ donation was possible that that should take place and then obviously when you're going for a post mortem you've got to be very careful.

If I could ask you a medical question. Do you see Lucy's death as idiosyncratic or anything to do in the physiological make-up. Would you describe the death as idiosyncratic?

I'm not sure I know what you mean.

Right. Would you, if I say to you, Lucy Crawford died because it was her reaction to, her idiosyncratic reaction to the fluid that caused her death. Would you agree with that statement?

I don't know.

Or would you say Lucy Crawford died because she was given the wrong fluid and too much of it and it was nothing to do with her physiological make-up? Any twelve kilogram child in that same condition given that fluid will suffer hypnotraemia and cerebral oedema.

But any 12 kilogram child given a severe gastroenteritis .....their physiological make-up. I don't know. I can't understand Chris.

Because you don't know. Do you use drips in the wards in Antrim?

Yes of course.

Well then when Dr Ted Sumner from Great Ormond Street says that, Sumner was raising real concerns about the level of understanding among the medical profession here about the dangers of mismanaging fluids. You're a young doctor.

Well what I said to you was that you have to be clear that some fluid, in calculating fluid you've got to understand what is maintenance fluid and what is replacement fluid in the presence of dehydration and that is something that we teach medical students day in and day out. We teach our junior medical staff day in, day out and we are constantly doing it on the ward.

Yea, but you agree that 4% dextrose is a totally inappropriate fluid to make up deficits from vomiting and diarrohoea.

It's not a replacement, it's not a replacement fluid.

So it's totally inappropriate? You know the dextrose would need to .....metabolised, isn't that true and the solution is effectively .....only water.

Yea, you need, you need proper replacement fluid to, if you know for a severe dehydration.

Yes.

I mean that's standard. I don't think anybody would think anything else.

Yea. And usually Lucy would have been given an extra volume of intranvenous water to replace the loss of what she had by vomiting and diarrohea?

I don't want to answer any questions on Lucy's case.

No okay, sorry, alright okay.

But I mean I think you're really trying to push me to say something that you want to say in your programme.

No, no, no, listen Caroline, this conversation is not going to be repeated in this programme. You've got to understand that. I'm having the conversation. I was simply ringing you to, we've now got ourselves drawn in which is interesting for me because it still helps me explore this issue.

Yea.

But this is now me and you kicking around the issue of hyponatraemia.

Sorry, if you're quoting my name on the programme I want you to say that I was the specialist registrar. I was not a consultant.

Yes. No it's down here in black and white, specialist registrar.

Yea, because you know as a registrar you always word under somebody.

Yea, so you were working, on that day you were working for whom?

Well there was various consultants involved, I know.

Peter Creane or Dr Hanrahan?

And Dr Creane so I would have been .....

Was Bob Taylor there?

I can't remember whether he was there that day or not but he works there.

He does, yea. But you, it's fair for me to say that you were only representing what Creane and Hanrahan thought as well. Like that was their diagnosis. You weren't saying something off the top of your head that they wouldn't agree with. They agreed with that absolutely.

Yea.

No doubt about it? Dr Hanrahan agreed with that 100%.

Did he. Did you ask him?

Yes, no, no, don't worry, he's on my list, but I mean I've no doubt he does but he gave evidence then. You know he swore under oath.

Yea.

Why do you think he didn't?

Oh no, no.

Sorry, you just seemed concerned there now.

You know you're asking me something that happened four years ago and I don't have any notes, so ……..

I know.

I don't want to be misquoted.

You're not going to be misquoted.

Yea.

You're not going to be misquoted. I mean if you want to do an interview we'll do an interview with you and I'll bring out the camera crew there and you can get a baby photo of course and ……..

That's quite alright.

Are you sure now?

My sympathy goes to Lucy's family because I do remember them very very well. It was obviously devastating for them and devastating for staff to have to you know watch a beautiful little girl slipping away.

Well can you imagine now the difficulty is that family has now been torn apart and one of the main reasons is they believe that no-one explained to them exactly what had occurred and that's their problem and they believe that no-one had, was brave enough or honest enough or truthful enough to tell them exactly what had occurred. In fact all they got was lies and in that situation so this is not a single tragedy in the Crawfords life. This is now much much worse.

Yea.

And that if somebody had explained to them, they .....under the absolute notion and that goes back to the Erne Hospital saying that your clinical history wasn't available and the post mortem wasn't available and therefore it couldn't come to any conclusion why Lucy had died and went in and told the parents that they couldn't find her notes and that they didn't know why she had died but it's quite clear you, Hanrahan, Creane, everyone knew like how she'd died. The Erne Hospital doctors knew how she'd died but no-one was up front and honest and

actually said to them "yea, this has happened. The calculations were wrong and the fluids were mismanaged and your child died as a result of it". Now they feel that they would not be living as May Crawford says in her interview as four separate people in one house if they had been given the truth there and then and were able to deal with it. May Crawford cannot go to the graveside of her daughter because of what has occurred.

Yea, I remember they had their minister with them.

Yea.

Yes, it's very sad.

It is and as I say the documentary evidence that we get in front of us states quite clearly that there was a knowledge inside the Royal that she died of hyponatraemia so how did everyone else miss that. How did everyone ignore the evidence that was coming forward from the Royal. You know what I mean, you know, let's not beat about the bush here, you know, there's always concerns and you're not to be the first one to voice them if you do voice them about children that come up from County Hospitals, whether it's the Erne Hospital or Altnagelvin, with severe brain injuries and they have passed the buck to the Royal. You know when Lucy arrived there was nothing you could do for the Royal and in fact a comment made by

yourself or one of the other doctors was "there's nothing we can do with a dead baby".

Yea.

So why did the Royal get it. Explain that to me. Why was Lucy sent to the Royal? Do you know what I mean.

The Royal's the only place with paediatric intensive care.

But there was nothing that could be done for Lucy. Like there was nothing you could do except to do the brain stem tests, brain scans .....

But they're not going to do that down in the Erne Hospital.

Why?

Why, because they don't have paediatric anaesthetists. They don't have paediatric intensive care.

Yea. So it was up to the Royal and the Royal then left to tidy up round the Erne Hospital? Is that not true?

The Royal left it to .....

You know the Royal was left.

Oh yea. Well I mean that was the problem with it. The Royal is the regional centre so all those complex things end up in the Royal and that's you know, it's difficult working there because they see all the worst case scenarios.

Yea.

Whereas the peripheral hospitals you see all the general stuff. The children that go in and out of hospital within twenty-four hours and they're fine.

Yea.

And you're dealing with the much less serious end of children's illnesses so anything serious it goes to the regional unit which is in the Royal.

Yea.

So it would have been very inappropriate for them to keep her in Enniskillen.

No I appreciate that but do you think, do you remember anyone at the Royal sitting down and explaining to May and Neville Crawford exactly what had occurred?

Well I know that the team you know talked through what they were doing in terms of the brain stem tests and those different things. I can't remember who all talked to them and what they said.

Yes, but you know what I mean, do you think that somebody, would you in a hypothetical situation, would you have sat down and said to a family such as the Crawfords in the event of this catastrophe and said "listen this is what we believe occurred in Lucy's case". You know do you think that up front honesty is called for in these situations?

Well my personal practice is that before God and before all my patients you tell absolutely what you perceive to be the truth and if people ask you direct questions you do your best to answer them. Even at times you know when you're breaking bad news it's a terrible terrible thing to have to do but you try to be as sensitive as you can and yet let them know what you're thinking and you know break it down and try not to use clinical jargon and all that sort of stuff, but I can't comment on four years ago I was a registrar, I wasn't the one responsible to actually talk to the family. That would have been the consultant's responsibility so we also work shifts, so I wasn't there all the time that Lucy was in the Royal but I certainly remember the family and I remember the fact that you

know they had their minister with them and then she was in intensive care. I don't know, she was there twenty-four hours or something. It wasn't a long time.

No, no.

And I remember the brain stem tests being done but I wasn't the one to explain to the parents you know what you're saying to sit down with them and have a chat because I was the registrar for the consultants and that's not my job to do that.

Yea. The Royal has said to us in an email, and I'm just looking at it here, on Friday what you stated and what Hanrahan stated was because both of you were looking at the patient at different times. That's not true.

Who said this from the Royal?

Their PR people.

Right.

Both doctors were looking at the patient at different times.

Yea, yea. Well I mean I probably was as a registrar doing things when Dr Hanrahan wasn't there but I certainly remember being there with him and I remember him you know doing the brain stem tests.

Yea.

As far as I can remember it was him that did them.

Well he knew the hyponatraemia, you know the cerebral oedema had been caused by acute dilutional hyponatraemia.

Yea.

He knew that.

Yea.

So I mean both of you are singing off the same Hymn Sheet here, that's what I'm saying.

Yea.

There was no variance ....

But the Royal PR people are saying …..

Well I think that they are just getting to be honest, ……..HR I think that they're, I'm not sure what they're doing to be honest. I'm not sure. I don't know. It's difficult because I don't know whether they want to, it's difficult because the evidence now states that Hanrahan misled the Coroner. Whatever happens Dr Hanrahan for some reason misled the Coroner.

Yea, I don't understand why the Coroner wouldn't get her notes and get you know all those details.

They had just arrived. Is that what happens. When you ring the Coroner do they say "well send up the notes and the details".

Well, well that sort of page of clinical data would go up to them.

So ……

If for example a baby comes in with cuts, we phone the Coroner and the Coroner's post mortem and all those forms are sent out and they all go to the Coroner and whatever other information they want you know is given to them. It's certainly not just a phone call.

It's never just a phone call?

No, no, there's always written information goes to the Coroner.

So it's up to him then to decide?

To decide .....

Whether or not .....

Information he wants.

No, no, whether to decide it's worth an Inquest or not. It's not the paediatrics decision whether it should be an Inquest. That's up to the Coroner.

It is, yes.

So basically your duties are to give the Coroner as much information as possible in order to allow him to make that decision and that is right across any death in the hospital, not just the death of a baby.

Yea.

So you can't believe that the information wouldn't have been passed to the Coroner?

No, I find that really strange that you know the Coroner wouldn't have access to that information.

You see he states, I don't know why, he states at the opening of the Inquest that it was all done by phone calls in this case.

Yea.

Which is a bit strange you'll appreciate.

Yea. I don't understand that.

Okay.

Sorry, could I take your name again?

You can, absolutely no problem. My name is Trevor Birney, Birney.

Okay.

I'm editor of Current Affairs with UTV.

Okay.

And is there anything Caroline you want to ask me. I mean as I said to you I'm simply ringing you because I thought it was appropriate to let you know that we would be referring to your document.

Yes, I appreciate you doing that.

You know I don't want you lying at home, having the baby in bed and then upsetting the baby by screeching when you see your name coming up.

Yea.

But I don't, as I'm saying, at this point your name may not even be mentioned. It simply will refer to the documentation.

Yes.

What we're trying to do, you can imagine, we're trying to decipher exactly what occurred and where the breakdown occurred. Why there wasn't an Inquest and you're asking me well why is that so important. Well it's important because if the

Coroner had called an Inquest and had raised the concerns about hyponatraemia and mismanagement of fluids the little child that they also cared at the Royal, Rachel Ferguson, may not have died.

That I cared for?

No, no, the Royal cared for. No she came from Altnagelvin, the same sort of thing, mismanagement of fluids and she died.

Yea, I mean fluid management is a very important topic that we teach junior doctors and we teach our medical students. You know we constantly revise these things and while different hospitals might have different protocols we certainly did use number 18 widely in paediatric practice for maintenance solution and I mean that was general practice but over the last few years we have been using half normal saline as a maintenance solution.

Are you aware of the death of any other children due to this condition. Bob Taylor did have a child that died in his care back in 1995. A wee boy called Adam Strain but are you aware of the death of any other children due to this. I mean do you see this as something that happens regularly.

No, no, not at all.

But it does happen?

I'm sure it happens. I don't remember anybody else that I personally have dealt with.

Do you remember any other child at the Royal?

Not off hand. I would have to really think about it but not off hand.

No, no, but what I'm saying to you, it isn't such an irregular occurrence that if it did happen you would remember it instantly.

Oh I would remember it.

So you're saying that you don't think that there were any other children who died while you were at the Royal of hyponatraemia, cerebral oedema.

No. I do remember children dying with cerebral oedema but there are many causes of that.

Yea. But you don't remember any children at all with both hyponatraemia and cerebral oedema?

I can't off hand. I certainly don't remember any that had Lucy's scenario.

Right, but there may have been some while you were there? You know the conditions of Lucy. You know what the Coroner found. It was the wrong fluid and too much of it. Did any other children die at the Royal, whether they came from Enniskillen, Derry or anywhere else that's been given the wrong fluid and too much of it?

Not to my knowledge. I don't remember.

So your name is not going to be found anywhere?

I certainly can't think of any other children that died like that. You know I can't just speak for my own personal practice with fluids and what I teach junior medical staff and medical students is that there are at least, and I have counted this myself, there are at least in any fluid store in the ward you could count ten or more bags of clean solution that looks like water, clean colourless I.V. solutions and you've got to be just so diligent that you give the right one and know why you're giving the particular one that you're giving because they all look the same.

Exactly you know, a few of them .....

You've got to be diligent. Everything has got to be double-checked and you're talking about knowledge. Well you've got to have knowledge to prescribe the right fluids but you've also got to have people checking the fluid and make sure that what is prescribed is

actually given because if you write down a fluid and you're relying on some-one else then to erect it, you know you've got to make sure that they know what it is and then I think most places are double checked by two people whether it's nursing staff or medical staff.

Right. Let me put this to you. When you wrote hyponatraemia in the clinical history for Lucy did that mean that hyponatraemia caused the cerebral oedema or was it just an observation by you that her sodium was, or were you aware that hyponatraemia was actually dangerous?

That it was very dangerous.

You were aware that it was very dangerous?

Yes.

So it wasn't just an observation?

No, I mean it was there in black and white whatever the sodium level was, I can't remember but I know it was low.

It was. It was 127, I think it was. It was 127. Is it below 138 is, is it below 138.

135. So you were aware of hyponatraemia. You were aware of the dangers of hyponatraemia. You were aware of exactly how dangerous it was? You know there was no confusion in your mind?

But you know we were all aware that what her numbers were.

Yea, and what had caused that?

Yea.

And what had caused that was wrong fluid and too much of it? You know what I'm saying to you. I take it from your silence that that's what you're saying is yes. I'm not using this phone call for you, don't get the impression that you're saying something about a colleague. I'm simply stating the fact. The fact is and it was stated by Peter Creane under oath that that was it because too much fluid had been given and the wrong fluid.

Yea. I think you know when a patient arrives and you do, they come under your care, whether they come in from ..... or emergency or whether they come from another hospital, you do your initial blood samples. Then you've got to try and interpret them in the light of what treatment they've already been given and what the patho-

physiology of her condition so it's a multitude of things and we were I think, anybody that dealt with her at that time that she was admitted was very aware of what all these numbers were.

Right, let me say that, so there's no question that someone else looking at the clinical history wouldn't have been aware of the implications of hyponatraemia? That it wasn't just an observation, a harmless condition.

Oh no, not at all, not at all.

Everyone was aware of the implications of hyponatraemia?

Well I'm very sure that everybody that treated her knew what her blood results were.

And knew why her blood results were so?

But I can't remember, you're saying her sodium was 127, I can't remember all those kind of things.

I know, I know, listen you're doing very well for someone who can't remember those, but what I'm saying to you, whenever you looked at those sodium levels, but the important thing is that anyone looking at those notes would have known that those bloods led to the oedema?

Well there are many many causes of cerebral oedema.

But in the context of ……..

But in the context then you've got to decide you know, and that's a medical decision, decide you know what does all this add up to and what is patho-physiology of what's going on in terms of her degrees and what treatment has been given to try to rectify this biochemical abnormality or you know has what treatment she has received caused this biochemical abnormality.

And you would say it was the treatment that she was given that caused the chemicals?

Well I mean when we got her we didn't know what she'd been given.

But Dr O'Donohue that treated her was with her?

Yes, yes, but I mean you know you've got to then go through everything and …..

It took some time to get the notes and all and I don't have to go through all that again. It took some time to get the notes to see exactly what she had been given but when you seen that she'd been given …….

We probably had her blood results before you know .....

You had the medical notes.

Within a very short space of time before we got a lot of detail about what she'd been, how she'd been treated in Enniskillen.

Were you shocked when you saw the way she had been treated in Enniskillen?

Well I can't remember precise notes. I remember the staff trying to you know on the telephone ask the staff in Enniskillen what she'd been given and that sort of thing and I remember trying to work out how we correct it and what fluid we give to manage her in the Royal.

Do you remember if the Erne was able to tell you exactly what she'd been given?

I don't remember the details.

So it's quite clear it was a confusing picture that morning?

Yea.

It was confusing about what exactly she'd been given.

Yea.

Yea, which would have made life difficult for you.

Yea, yea, but that's, unfortunately that's not that uncommon that you know information, I think this is the whole point of this conversation that information didn't get to the Coroner also you're not given information and I mean you've got a very sick child in front of you. You've got what the biochemistry is and now you've got to work out what do I give her you know, what do I do now, what do I do now and you're kind of looking at you know what her clinical state is and you know is there anything that we can do for her. Is there anything we can give her and that sort of thing.

Well listen could anyone else have just shrugged off the word hyponatraemia when they read her clinical history and thought it was irrelevant as far as Lucy's death was concerned?

Could they have shrugged it off?

Yea.

I wouldn't have thought so.

You know what I mean. You know I'm being straight here. It's quite clear in the way, do you it in your own terminology and that's quite clear, but it's quite clear to me that what you're saying is that whenever you married the tests that you conducted and Dr Hanrahan conducted at the Royal to the medical notes when finally you got the information from the Erne, it was quite clear to you that she had been given the wrong fluid and too much of it and this had caused the hyponatraemia and led to the cerebral oedema.

I cannot recollect the notes from the Erne.

Yea, but I mean generally is that ……..

This is all coming through to me. You're saying this is what we heard from the Erne. From my point of view I'm the registrar, I've got a very sick child being transferred from the Erne Hospital and I do bloods and I see what the biochemistry is and I have to decide what do I treat this child with now.

Right.

You know, it's certainly very important to go back on the history and tease all those pieces of the jigsaw and try and put them together but I'm starting with a very sick child being transferred to me and I have to decide on the current biochemistry what is actually

happening in this little girl's body at the moment. How do I treat her from here and that's the kind of things are going through my head and okay here we are with a really low sodium. How do I treat that? You know it certainly is very important to say well what caused the really low sodium but as a registrar I can't be delaying my own treatment of what she needs and working out fluid balance and that sort of thing which we would have done and which we would do with any emergency coming in, so I mean that's the pressing question in dealing with her and once you've tried to manage from there then sadly for Lucy the brain stem tests showed that she was brain dead so as you say there was nothing we could treat her with that would bring her back.

Well we've got it then that you were surprised that hyponatraemia was not on the Death Certificate. You thought she was going for a Coroner's post mortem?

I thought she'd gone for a Coroner's post mortem but I mean that's just my retrospect that I thought that was a Coroner's case.

Well you see that was the problem. Is there any benign explanation Caroline, and I mean other than, how do we explain Dr Hanrahan not telling the Coroner about the hyponatraemia?

Are you saying what he told the Coroner was just dehydration, gastroenteritis and cerebral oedema.

Yea, he didn't say that. He did ……..

Hyponatraemia could be all part of that and you know it's maybe taken for granted that that went along with dehydration.

Right. But you know what I mean. It's quite clear sometimes given your comments earlier on, that you have to spell out to the Coroner exactly?

Yea.

You know what I mean.

Yea.

The clinical history was given and obviously ……

What I don't understand is you're saying that it just went through phone calls. I'm surprised that nothing was in writing. I can't believe that nothing was in writing to the Coroner.

Yea. I've got the Coroner's opening statement and he says "nothing about writing. Lucy had died the previous ……and clinical history given was gastroenteritis, dehydration, brain swelling. Advice was sought from the pathologist

in the State Pathologist's Department as to whether the clinical history warranted the Coroner's post mortem. Following a consultation between the pathologist and Dr Hanrahan my Office was advised that it would appropriate for a Death Certificate to be issued giving gastroenteritis as the cause of death". You're surprised because in all your dealings you fire up the clinical history that you've done in this case as in any other dealings with the death of a child whatever had happened you would fire away your clinical history as provided that day as for Lucy Crawford, so that they can be in no doubt exactly what you're stating. Isn't that what you were saying earlier on?

I can't remember what I'd written.

No, no, no I mean I'm not talking specifically about what you have written but what you said earlier on is that you always send documentation. It's never just a phone call.

No, never. Any time I have spoken to the Coroner, you know you inform them about a sudden death and then you say, if they say yes we'll arrange for you know a Coroner's PM, that all the information is written down and given to them.

Yea but no explanation immediately jumps to your mind why the Royal would carry out a hospital one, a hospital post mortem apart from probably just to be sure to be sure? You know that the clinical diagnosis is right.

Yea, yea.

And that there was nothing, there was no other brain damage that's led to it or anything else.

Yea.

Okay. You've been very helpful in the background in putting a lot of this, colouring in some of the background to this and you have helped to put it into context for us.

Yea, yea. I mean what I said about the gastroenteritis is that you know people thing that's just a tummy bug but it can be very very serious.

I understand that but in this case.

And the sequelae of it you know it's like any condition. Diabetes well you know we know how to manage diabetes but diabetes can have really serious sequelae and one of the things can be cerebral oedema you know and to say diabetes has no part in it you know you've got to say well there's something that causes cerebral oedema so for Lucy there was something that caused her cerebral oedema.

And that was the hyponatraemia?

Why was she hyponatraemic?

Because Dr O'Donohue had pumped 400 millilitres of fluid into her hand over a .....

Why was she dehydrated?

Well you know what I mean it's like asking why the man who was shot dead in the street was in the street.

She was dehydrated because of her gastroenteritis.

Yes, but really the fact is .....

But her biochemistry, you know that's where it all started and the biochemical abnormalities.

I know but if you were only going out for a pint of milk and then he got hit by a car, but would you ask what the driver in the car was doing as well. Do you know what I mean. He was crossing the street on a red light when he was hit by the car. That's very different from saying that he walked out in front of it.

Well she obviously had severe gastroenteritis.

No, that's not what the experts say Caroline. They say you know that she was sick yes, but she wasn't as ill as the Erne Hospital tried to say. You know what I mean unfortunately the Erne wasn't even able to provide about the capillary refill time or anything else so we don't even know what the state of her rehydration was. You know what I mean so when you say she was obviously very ill there's no evidence to back that up at all. In fact the Erne Hospital has withdrawn that.

Yea, well that's what I understood from her parents was that she was very ill.

You know she was much more ill after the drip went in.

No, I understood from her parents that when they brought her to hospital she was very very ill and you know she had not tolerated anything orally. She had severe gastroenteritis, severe diarrohoea and vomiting.

Yea.

And that's just what I remember them saying and that's just their history.

Yea.

But that's negligent not to record the capillary refill time.

It's what?

That's negligent not to record the capillary refill time.

Well it's not recorded.

Yea.

I'm just looking some documentation to see what others have said about her. I mean it was a tummy bug as Dr Sumner described it at Great Ormond Street. You know she suffered from a tummy bug, I'm just trying to check here exactly.

Well you're going to speak to Donald Hanrahan?

Well I would love to yes. I really would like to.

Yea.

I'd like to ask him exactly why. Now it's up to you how you want to deal with this Caroline. I mean I understand the position that sometimes you get yourself into. I can simply have never had this phone call with you, and if you're not going to pass

on to anyone else that you've had it with me, well that's okay but if you don't mind me telling others that I've spoken to you.

Well what are you going to say?

Well I think the important thing is then that I don't say to anyone else that I've spoken to you in order not to misrepresent you in case that you would feel that I have. So I'll simply say I'll not tell anyone else I've spoken to you. Is that fair enough?

I mean, I stand by my notes, what I wrote but that's four years ago and I don't have them, the reason I'm not answering a lot of your questions is that I don't have them in front of me and I don't want you to make up an answer that you think you know suit and I don't have any notes or anything in front of me.

No, no listen, Caroline, we have got, we've taken this case to .....

They've had an awful lot of, a very very sad experience. If they're having further grief over the whole scenario you know that's a further tragedy and if you comment on what I've written I just want to make it clear that I was a specialist registrar but not the consultant.

Yea, that's not a problem.

And .....

That's not a problem.

You know basically what I've written I've written in the notes and that was my best judgement at that time.

Well quite clearly Caroline as far as you're concerned that no-one who studied those notes and the results of the tests that you carried out, or the Notes from the Erne Hospital, could have come to any other conclusion that this death was due to gastroenteritis, hyponatraemia, cerebral oedema.

Yes, I don't think anybody would dispute all those four things being on the Death Certificate.

And one is as important as the other as far as you're concerned but all four have to be there?

Well it's a cascade of events you know. One leads to another, leads to another.

Yea. As far as you're concerned no-one could come to that conclusion without just reviewing those notes. You don't have to interview the family. You don't have to, all you have to do is look at the evidence in black and white.

Well that was .....

That's what you were doing?

That's what I was doing and I mean as I said to you when you get a sick child you look at the biochemistry of at the present moment and then you work your way – how am I going to manage this.

Okay.

To me it's very important to think of what causes you can think of for a biochemical abnormality but you've got to think first of all – what am I going to do, how am I going to treat this child, what fluids does this child need and work it out from there.

Okay.

So all those fluids would have been worked out from first principles rather than just "Oh that's what she's on. You worked out the drip. That's such and such mils now" you know "we'll go with that". We do our own calculations and you start from scratch.

Okay. Do you think Dr O'Donohue left the Royal and went back to the Erne under any illusion about what had occurred?

I have no idea.

Do you think he could have? Do you think the consultant paediatrician who had treated Lucy could have, you know as you've just stated, could have reached any other conclusion other than the one reached by yourself and others at the Royal?

I don't know. I can't answer for them.

Fair enough. Okay. I don't want to keep you any longer from your baby there.

Okay.

[redacted]**e?**

[redacted] **Listen do you want to take my number in case there's anything you want to talk to me about.**

Okay.

My number is, I'll give you the mobile which is [redacted] If there's anything at all at any point that you're worried about or you want to point out to me or whatever give me a call on that.

Yea, okay.

Alright Caroline.

Thank you.

Thank you, Bye bye.