Additional Questions to Professor Sebastian Lucas

1. In answer to question 10 of WS-275/1, Dr. Curtis (Assistant State Pathologist Northern Ireland) has stated:

   "I suspect I reached the view that Lucy died of natural causes on being told that she had gastroenteritis which is a natural cause of death. I can only speculate that I had no reason to consider there was anything else implicated and that would be due to what I had been told."

   You will appreciate the context in which Dr. Curtis has made this statement: it is some 12 years after the event; he has no notes or records; and no recollection whatsoever of the discussion with Dr. Hanrahan. He has also said that it would appear that his involvement was by way of an approach for informal advice about the appropriateness of offering a death certificate for a natural cause of death.
   Taking account of these factors, and any other matters raised in his statement which appear pertinent to you, please address the following questions:

   a. If a pathologist is told that a previously healthy child has died of gastroenteritis in the hospital setting, should he be seeking any further information before concluding that the death was due to natural causes?

   b. If so, what kind of further information should have been sought in such circumstances?

   Questions 1a & 1 b refer to Dr Curtis, in the context of his conversation with Dr Hanrahan. We would ask you to address these questions with reference to Dr Curtis.

2. In her statement Dr. Caroline Stewart (Paediatric Registrar) has commented that it was her understanding that "in the event of an autopsy, it is not normal practise to issue a death certificate before the preliminary autopsy results are known" (WS-282/1, answer to question 8(d)).

   Dr. Dara O'Donoghue (SHO in Paediatrics) has explained (WS-284/1, answer to question 17) that communication with the Paediatric Neurology team suggested to him that they were waiting for the post mortem report to clarify the cause of death and that this may have been the reason for the delay in completing the MCCD.

   Dr. Hanrahan (Consultant Paediatric Neurologist) has explained that the death certificate was completed after, rather than before the post mortem, since the post-mortem may have shed more light on the cause of death (WS-289/1, answer to question 19(h).

   If it was the practice in the RBHSC to await the preliminary autopsy results before issuing a death certificate, was this an appropriate practice? If it wasn't an appropriate practice please explain why it wasn't?

3. In her statement Dr. Caroline Stewart has commented on the issue of attendance at the autopsy review session. She has said that it was not normal practice for a paediatric registrar to attend such a session (WS-282/1, question 19). Dr. Hanrahan has said that he didn't consider attending personally. Moreover, he did not consider sending a member of his clinical team to attend as he did not believe that this would assist (WS-289/1, question 12(d))

   If it was the practice in the RBHSC that clinicians responsible for the care of a deceased child did not attend the autopsy review in the event of a consent post mortem, was it an appropriate practice?

4. We would also refer you to the statement of Dr C Gannon (Consultant Paediatric Pathologist).

   In answer to question 2(d) Dr. Gannon has stated:

   "I was asked to attend the inquest into the events surrounding the death of Lucy Crawford as Dr. O'Hara, the pathologist who had undertaken the autopsy, was too unwell to attend. The Coroner requested that a paediatric pathologist attend to give evidence regarding the autopsy findings and explain any pathological features. I was not asked to review Dr. O'Hara's work in a critical manner, or to provide a separate written pathological report, only to be available to present his report and explain any pathology."

   In advance of the Inquest Dr. Gannon obtained the histological sections created at the post mortem and she examined them microscopically (answer 2(g).

   Dr. Gannon has gone on to say in answer to question 2(h):

   "I concluded that Dr. O'Hara's report was a detailed and comprehensive examination and that based on the clinical history provided, and the histological appearance of the tissues, I would have reached the same conclusion as he did about the cause of death."
   Dr. Gannon was not called to give evidence at the Inquest.

   Taking account of this evidence, and any other matters raised in her statement which appear pertinent to you, please address the following questions:

   a. **Given the limited nature of the task that had been set for her, was it reasonable for Dr. Gannon to conclude that based on the clinical history provided and the histological appearance of the tissues, she would have reached the same conclusion as Dr. O'Hara did about the cause of death?**

   b. **If you disagree with the conclusion which she reached, please fully explain why you are in disagreement.**

5. Section 7 of the Coroners Act (Northern Ireland) 1959 expressly requires a medical practitioner "*who has reason to believe that a deceased person died either directly or indirectly…as a result of negligence or misconduct on the part of others, or from any cause other than natural illness or disease for which he*

has been seen and treated by a registered medical practitioner within 28 days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic)" to immediately notify the Coroner "*of the facts and circumstances of the case*".

Dr Hanrahan's evidence to the Inquiry [WS-289/1 page 10 answer to question 10(c)] is that he considered the Coroner would have to be informed of Lucy's death because "*the cause of death was not clear to me. Lucy had also died within a short time of admission to hospital."* Dr Hanrahan told the PSNI [Ref 116-026-006 to 116-026-007] of his conversation with Dr Curtis: "*I have no recollection of my conversation with the Coroner's Office. From the notes it does appear that I discussed the case with Dr Curtis for his advice…I'm not aware if I mentioned at this point hyponatraemia along with dehydration, but I may not have, as it was not something to the forefront of my mind at this time. I was however sufficiently concerned that the cause of death be properly examined and I assumed that I did at least say to Doctor Curtis' office, this judging from the entry in the daybook from within the Coroner's office that I did at least say that the patient died of gastroenteritis, dehydration, and brain oedema."*

If Dr Curtis, a forensic pathologist, was told by Dr Hanrahan that Lucy died of gastroenteritis, dehydration and brain oedema

a. Was it reasonable for Dr Curtis to advise Dr Hanrahan that a Coroner's post mortem was not necessary?

b. What further questions, if any, ought Dr Curtis to have asked, before advising Dr Hanrahan (if that is what he did) that a coroner's post mortem was not necessary.

6. Mr Stanley Millar, the patient advocate for Lucy's parents, records that at the meeting which he and Lucy's parents held with Dr O'Hara on 16 June 2000 [Ref: 015-006-031] the following matters were discussed:

"*The PM was not under the Coroner's Act*
The cause of death is less frequent than in years past and would not be common
Lucy probably died in the Erne…
Dehydration was an important factor
Children can 'crash' very quickly and delay in getting fluids could be crucial..."

If Dr O'Hara considered that a delay in getting fluids could have been crucial in Lucy's case,

a. What further steps if any, should he have taken?

b. Was that information which should have been brought to the attention of the Coroner?

c. If so, did Dr. O'Hara have a responsibility to report that information to the Coroner?"

7. Finally, you have commented on the non-attendance of the clinicians at the RBHSC at Lucy's autopsy. Further to that,

a. Explain the purpose and importance of clinico-pathological correlation in Lucy's case;

b. What further steps if any should have been taken following the autopsy in Lucy's case to ensure clinico-pathological correlation between pathologist and clinicians?

c. Who should have taken those steps?

d. Should their exercise have led to a report to the Coroner?