# THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

**Chairman: O'Hara J**

## SUBMISSIONS ON BEHALF OF DR MOIRA STEWART

## (EVIDENCE: 18 JUNE 2013)

These submissions, on behalf of Dr Stewart, address the specific concerns raised in the Opening of this Inquiry and the observations in relation to the First RCPCH Review [See Paragraphs 624 – 668 of Opening] and the "Salmon Letter" in respect of Dr. Moira Stewart.

## 1. DELAY

*Whether you caused or contributed to an undue delay in the production of your April 2001 report for the Sperrin Lakeland Trust*

**Transcript: Page 37/19:**

**Q. Can you help us, doctor, in terms of whether you think there was anything that was within your power to achieve that could have speeded up this whole process through to the provision of a report?**

**A. I really don't think so. I mean, there's been delay at all stages from the initial contact, that telephone contact, which I can't remember, but I'm sure did take place, right through to the letter, there was two months before Dr Kelly contacted the college and then wanted to get another reviewer, which we had agreed before**

I undertook the task that, if necessary, I would ask a colleague to look at notes if I felt that was appropriate. So it just seemed to sort of go on and on. But I think at no stage did I ever feel that there was any time constraints on what I'd been asked to do.

THE CHAIRMAN: Can I ask you it in this way, doctor. To an outsider, it seems that if you're being asked to do a competency review on a consultant paediatrician, that in itself indicates a degree of urgency because although you might not have been aware of it before you started to receive the case notes, if he had turned out to be the most hopeless consultant around the trust as his employer and your college, if he was a member, would want him to be improved, controlled or removed as soon as possible. So the fact that you were asked to do this review, does that not in itself indicate a degree of -- does it not carry with it a degree of urgency? I have to say, when I say that to you, I'm not picking on you for this because, as you have just said, there seems to have been delay at just about every stage until, perhaps you would say, if you had your report done in two months on top of your other duties, nobody could reasonably ask any more of you. From a perspective as an outsider looking back on it, would you say it took longer than it perhaps should have done ?

A. That may be fair comment. I don't know, sorry, what the communication was between Dr Kelly and the college. I wasn't part of that.

THE CHAIRMAN: But from the outside, the fact that you're being asked to do a competency review and these are fairly rare events, as I understand it, does that on its own indicate some degree of urgency is required?

A. I think ... That's probably a fair comment. Whenever we looked at the other three cases, there didn't seem to be particular competency issues round Dr O'Donohoe's performance. Lucy's case was obviously very tragic and

very unique and in a totally different league from the other cases. My assumption at that time was that her case would have been referred to the coroner and that the coroner's inquest would be at least underway at that stage, so in a way this was almost a separate process to a coroner's inquest into cause of death.

THE CHAIRMAN: Okay. And just one more point on this. If it had been really urgent, would you have expected to have been pushed along the way quite a degree more by the trust?

A. If it had been really urgent, I'm not sure I would have agreed to take it on because I wouldn't have reviewed the four cases unless I felt that I could devote adequate time to them. And as you say, you know, this was very much done early in the morning or at the end of the day.

THE CHAIRMAN: Okay. Thank you very much.

## SUBMISSION

**In our respectful submission, although the process by which the review of Dr O'Donohoe's competence in relation to four cases appears to have taken from 16 July 2000 to 28 April 2011, Dr Stewart did not contribute to the delay. Dr Stewart enquired as late as 26 January 2001 when the material was to be made available to her and was told that the full set of notes would be forwarded the following week[1]. The review of the three cases that Dr Stewart looked at was completed by 28 March 2001.**

**Once involved with the Review Dr Stewart was proactive in moving the process forward. Dr Stewart wrote to Dr Jim Kelly, Clinical Director,**

[1] See Attached document 067D-002-002

**Erne Hospital on 25 January 2001 requesting the relevant case notes[2]. Dr Stewart also assisted with arranging Dr Carson's indemnity to be completed in March 2001.**

## 2. INAPPROPRIATE FLUID REGIME

*Whether you failed to state clearly in your report (April 2001) that* ***an inappropriate fluid regime had been applied*** *to Lucy Crawford in the Erne Hospital*

**Transcript: Page 58/4**

Q. Yes. Let me talk about what you were thinking. You were thinking the following: if this child has received 100 ml per hour of Solution No. 18, then that is quite the wrong approach for a dehydrated child who required normal saline?

A. Yes.

Q. And Dr MacFaul's concern about your approach is that you failed to state clearly in your report that an excessive volume of Solution No. 18 had been administered?

A. Yes, and I think I kept coming back to what I'd been asked to do, which was not to prepare a medical report, and it was obvious to me that the problems around fluid prescription and administration were not solely on the part of Dr O'Donohoe, even though as consultant he retains overall responsibility. But usually, it's a junior member of staff who writes up fluids. There were problems with recording of rates of fluid that were administered, so from the point of view of what I'd been asked to do, there were problems associated with other

[2] 036a-015-030

members of staff on duty that night.

THE CHAIRMAN: Sorry, doctor, surely the critical competence point is that Lucy was prescribed the wrong type of fluid?

A. Yes.

THE CHAIRMAN: I think the concern expressed by professor MacFaul is at what point in your report is that explicit?

A. I don't think it's as explicit as it could be.

THE CHAIRMAN: Thank you.

## SUBMISSION

**Dr Stewart accepts that the Report was not as explicit as it could have been that the wrong type of fluid had been used. However, Dr Stewart was not asked to prepare a medical report as such and clearly set out the guidelines on fluid management for children with imminent shock, and for maintenance and replacement fluids given at that infusion rate.**

## 3. THE RATE OF CHANGE IN ELECTROLYTES

*Whether you failed to provide a specific explanation in your report (April 2001) of how the hyponatraemia and* ***the rate of change in electrolytes*** *could have resulted from the high volume of Solution 18 which had been administered*

**Transcript: Page 54/6**

So what you're saying is that for a child with moderate to severe dehydration, that's the calculation, 750 ml on a 10-kilogram child, and you have explained that you round it up for ease of calculation, it would be 750 ml, and then maintenance fluids in addition to the replacement. You then say:

"The volume given, therefore, does not appear excessive."

On the basis of a 7.5 per cent dehydration, the calculation comes to somewhere between 70 to 80, and that's allowing for a slightly higher weight than she actually was. She was 9 kilograms, not 10. The fluids in terms of total volume pre-seizure were certainly excessive.

A. Mm-hm.

Q. Why did you characterise the volume given as not appearing excessive?

A. The reason I did that was because I was counting in 200 ml of bolus resuscitation fluid in -- whenever I was working out over 4 hours, the total volume would not be excessive. I think that's why I used the term "clumsy attempt", because obviously it is causing concern and debate, but that was my thinking about it, we need to factor in the bolus of resuscitation fluid in the amount that would be given over a 4 to 5-hour period.

Q. So where you say in your witness statement, and I had it up on the screen earlier, that this was a clumsy attempt to reconcile volume of fluids Lucy received from 10.30 to 3 am, with recommendations for the various types of fluid --

A. Yes.

Q. -- just to be clear then,, what you're accepting is that in terms of how you have phrased this, you were at best somewhat ambiguous and what you really should have been saying is that the total volume given doesn't appear excessive?

A. That's right.

Q. But the types of fluids, the types of volume of each fluid ought to have been identified?

A. Yes. The sentence -- I should have written the sentence: the total volume given including maintenance, resuscitation fluids and I thought I had set that out clearly earlier on, but obviously it has caused confusion.

Q. Well, you go on to say that there is debate about the most appropriate fluid to use.

A. Mm-hm.

Q. You say:

"APLS guidelines indicate the deficit should be replaced with normal saline and maintenance with Solution No. 18."

A. Mm-hm.

Q. And then you explain how it's explained in the APLS guidelines that for convenience, the two fluids can often be combined.

A. Mm-hm.

Q. In terms of the fluids necessary for replacement in a dehydrated child at that time there was no debate?

A. There was debate about how best to administer it, should there be two separate infusions, one with maintenance fluid and one with replacement fluid? And that is the ideal situation because then the replacement fluids can be tailored to ongoing losses. But due to the difficulty in getting venous access in young children and also just the practical details in trying to run two separate infusions, they're often combined as half normal saline, 0.45 per cent. So that was what I meant by the ongoing debate.

## SUBMISSION

**Dr. Stewart accepts that the explanation terms of the report should have been more explicit as to how the hyponatraemia and the rate of**

**change in electrolytes could have resulted from the high volume of Solution 18.**

## 4. THE HIGH VOLUME OF LOW SOLUTE FLUID TOGETHER WITH THE SALINE OVERLOAD

*Whether you failed to provide a specific explanation in your report (April 2001) of how a **high volume** of low solute fluid together with the saline overload could have combined to produce cerebral oedema*

**Transcript: Page 59/8**

**MR WOLFE: His further concern is that while you have set out the various aetiological possibilities that were in play, you could and should have explained to the reader how a high volume of low solute fluid could have caused the electrolyte change and led to the cerebral oedema.**

**A. Yes. I chose my words with care because, as I said, I hadn't been asked to do a medical report. As far as I was concerned at that stage, Lucy's case would have been referred to the coroner, there would have been a coroner's inquest and at that stage all relevant documentation, views of expert witnesses, and the opportunity to talk to members of staff on duty that night would have been taken into account. And at that stage conclusions would have been reached as to cause of her acute deterioration and then death.**

**SUBMISSION**

**Although accurate - Dr Stewart did not provide a specific explanation in the report (April 2001) of how a high volume of low solute fluid together with the saline overload could have combined to produce cerebral oedema - this was not a medical report as Dr Stewart explained in her evidence. Dr Stewart was entitled to assume that Lucy's death would be referred to the coroner and there would be an Inquest. At the Inquest all additional documentation, over and above that included in the Erne Hospital notes, and the role of professionals other than Dr O'Donohoe, would be taken into account in reaching conclusions as to the cause of death.**

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**Conrad Dixon**

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25th January 2001



Dr Jim Kelly
Clinical Director
Erne Hospital
Cornagrade Road
Enniskillen
BT34 6AY

Dear Dr Kelly,

I thought it might be useful to write to you following our telephone conversation yesterday. As you know I have received a copy of Dr Patricia Hamilton's letter to you and was aware that I might be approached to represent the College in trying to resolve the issues concerning Professional Competency within the Paediatric Unit in the Erne Hospital.

I think it would be helpful if I had an opportunity to go through the relevant case notes before meeting with the individuals involved. I would hope I could do this within the next few months. It may be necessary to ask a Paediatric Specialist for a opinion in one or more of the cases, should that case fall within the remit of a recognised sub-specialty. I would hope that I would be able to come to Enniskillen towards the end of March or beginning of April if this would be convenient for yourself, the Trust and the individuals involved. Once all the information has been collected I will try to make sure that a report is prepared at the earliest opportunity.

Please get back to me if the proposed timetable is unreasonable or does not fit in with your expectations

Yours sincerely

Dr Moira Stewart
Consultant Paediatrician/Senior Lecturer in Child Health

CC: Dr Patricia Hamilton, Honorary Secretary, RCPCH

Ps: Sometime I will try and talk to you about what I consider is a role of a General Paediatrician with an interest in Community. I assure you that I have never done a domicillary visit, but feel that visiting the homes of children with chronic disease is an important aspect of my work, and very enjoyable!

26 January, 2001

Dr Moira Stewart
Consultant Paediatrician
Royal Victoria Hospital
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BT12 6BA

Dear Dr Stewart

Please find enclosed a copy of all the details relating to the competency review of Dr J O'Donohoe and I also enclose, as agreed, a set of notes. I will forward a second set of notes in one week's time.

Yours sincerely

Dr JF Kelly
Medical Director
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