Witness Statement Ref. No. 038/3

NAME OF CHILD: Raychel Ferguson

Name: Peter Crean

Title: Dr.

Present position and institution:

Previous position and institution:
[As at the time of the child's death]
Consultant Paediatric Anaesthetist- Royal Belfast Hospital for Sick Children ("RBHSC").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between November 1995-present]

In N Ireland:
Chairman of the Paediatric Anaesthetic Group in N Ireland 1999-2004
Member of N Ireland Working Group on Hyponatraemia in Children 2001-2002
Member of the Human Organs Enquire Implementation Sub-group on the guidance to the HPSS and consent 2002-2004.
Member of the Human Organs Enquiry Implementation Sub-group on Public Information and Communication 2003.
Northern Ireland Regional Paediatric Fluid Therapy Working Group 2006.
Member of 'Pediatric Surgery Working Group Phase 1', Department of Health, N Ireland. 2008
Member of the Paediatric ENT Surgery Group, Department of Health, N Ireland, 2008-9
Guideline and Audit Implementation Network (GAIN). Member of Guideline Development Group on Hyponatraemia in Adults. 2008-9

National:
Member of Working Group on Paediatric Anaesthesia and Emergency Care in District General Hospitals 2004-6.
"Care of the acutely ill or injured child: a team response" published 2006
Member of External Reference Group, Children's Hospital Service Pilot Improvement Review, Healthcare Commission. 2004-2005
Member of the Children's Surgical Forum, Royal College of Surgeons, England 2005-07
President of the Association of Paediatric Anaesthetists of Great Britain and Ireland 2005-7
'Joint statement on the provision of general paediatric surgery provision in the District

General Hospital', 2006. Member of the working group and co-signatory as President of the APA.
Member of working group revising 'Children's Surgery: a first class service'. 2006-07. 'Surgery for children – delivering a first class service' published July 2007
NICE Guideline Development Group on Sedation in Children 2008 - 2010
NCEPOD Advisor 2009 – 2011 on deaths following surgery in children. 'Are We There Yet?' Published October 2011.
Chairman of NICE Guideline on 'Intravenous fluid therapy in children'. Appointed April 2013

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

WS-038/1
WS-038/2

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:
Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) **In respect of Question 6 of your Witness Statement WS-038/2 p.6, the circumstances in which the RBHSC may have ceased the practice of prescribing Solution 18 to post-operative children and your failure of recollection in this regard, kindly advise:**

(a) Whether and what hospital documentation would record any change in the practice of prescription and use of Solution 18 in the RBHSC in the year preceding 10th June 2001;

I have no knowledge of what this might be.

I can only suggest that a review of patient notes prior to this date would show fluid administration practices at that time.

(b) Whether or not such a change in practice would have been referred to within the context and deliberations of the Working Group for the Prevention of Hyponatraemia?

I anticipate that the practices, at that time, would have been deliberated by the Working Group, however, I unable to recollect the changes in practice mentioned above having been referred to.

(2) **In respect of the RBHSC role as a *"Regional Centre of Excellence"* do you consider it to have held any particular responsibility for the dissemination of learning and good practice to Area Hospitals in Northern Ireland?**

I am not aware of any formal role that RBHSC had in the dissemination of learning and good practice.

Anaesthetists in RBHSC fostered informal links with consultant anaesthetists in the Area Hospitals. For example, we have always made it clear that any consultant anaesthetist from an Area Hospital was welcome to spend time in RBHSC for a 'refresher' in paediatric anaesthesia. Only occasionally has this offer been taken up. Also the consultant anaesthetists in RBHSC would always be available, when contact by colleagues in other hospitals, for advice and help.

I set up the Paediatric Anaesthetic Group in N Ireland in 1999 to provide a forum for discussion amongst those involved in anaesthetising children in the Provence.

Initially, I had fears that some anaesthetists may have concerns that these meetings would involve the Regional Centre 'telling the Area Hospitals what to do', as opposed to being a forum for discussion. I recollect that, to counter any such potential fears, I invited Dr Morrell Lyons, a senior and highly regarded anaesthetist and former President of the Association of Anaesthetists of Great Britain and Ireland, to facilitate the first meeting of this Group.

After this initial meeting subsequent meetings took place every six months and the agenda was determined by the group.

(3) **In relation to Dr. McKaigue's recollection, in respect of Adam Strain's case, that on a number of occasions Dr. Taylor *"discussed issues which had been raised about the anaesthetic, with both Dr. Crean and myself. I also believe I discussed the same issues separately with Dr. Crean.***

Arising out of these discussions, as a group of consultant paediatric anaesthetists we came to the conclusion that it would not be advisable to give iv no 18 solution at a rate faster than normal maintenance rates i.e. it should not be administered as a bolus to replace a fluid deficit because of the risk of the patient developing hyponatraemia" **(Ref: WS-156/1 p.30) please state:**

(a) Whether this is accurate;

I have no recollection of these discussions.

(b) Whether you disseminated this view with other anaesthetists or clinicians from other hospitals;

I believe it was my practice to have administered No 18 Solution only to provide maintenance fluid requirements in normal children, at a time when this fluid was being used as a maintenance fluid. Other fluid requirements would have been met with the administration of Normal saline or Hartmann's Solution. This would have been my teaching to trainees in RBHSC at that time. I am unable to recollect, however, if and how I disseminated this information outside the RBHSC.

(c) Whether you shared it with the Paediatric Anaesthetic Group Northern Ireland;

A case of hyponatraemic encephalopathy was discussed at the meeting 26 November 2001 in an effort to highlight issues concerning fluid administration in children. From memory this was the first time fluid management in children was discussed by the Group, however, I am now unable to remember the specific issues discussed.

(d) Whether you published it;

I personally have not published this.

(e) Whether you incorporated it into teaching?

For as long as I can remember my teaching would have been as in 3 (b), at the time when No 18 solution was being used as a maintenance fluid.

(4) In relation to Dr. Ian Carson's email to the Chief Medical Officer, dated 30th July 2001, and his introductory comment *"Please find attached document on the above subject drawn up by Dr. Bob Taylor and his colleagues. It reflects current 'opinion' among experts in the management of these children, however it does not yet command full support amongst Paediatricians"* **(Ref: 026-016-031) please:**

(a) Identify this document;

I am unable to identify this document.

(b) Explain why it had not yet commanded the full support of Paediatricians?

I am unable to answer this question as I do not know what was written in the document.

(5) In relation to the same email and Dr. Ian Carson's assertion that *"the problem today of 'dilutional hyponatraemia' is well recognised (see reference to BMJ Editorial). The anaesthetists in RBHSC would have approx. 1 referral from within the Hospital per month. There was also a previous death approx. 6 yrs ago in a child from the Mid-Ulster. Bob Taylor thinks that there have been 5-6 deaths over a 10 year period of children with seizures"* **please state:**

(a) Whether these figures appear plausible to you;

They do not appear plausible to me.

(b) Whether you know anything about the child from the Mid-Ulster and if so what?

I do not know about a child from the Mid-Ulster Hospital.

(6) **In respect of the minute of the Paediatric Anaesthetic Group in Northern Ireland meeting 26th November 2001 (Ref: WS-038/1 p.14) and the note *"a case of hyponatraemic encephalopathy in a child following surgery was discussed"* please advise:**

(a) Did you introduce discussion of this case to the meeting;

Yes.

(b) Was this child Raychel Ferguson and if not kindly identify the child?

Yes.

(7) **In relation to H.M. Coroner's Memorandum dated 11th October 2001 (Ref: 012-052c-275) and his note that you *"said that there was mismanagement of this case in the Altnagelvin Hospital"* and *"the parents wish to speak to* [you]. *It was agreed that* [you] *could say nothing more than the treatment Raychel received in the Intensive Care Unit"* please state:**

(a) Whether this is an accurate note of your discussion with the Coroner;

I have no detailed recollection of the conversation; however, I have no reason to doubt the accuracy of the Coroner's note.

(b) If not please indicate what was said;

(c) Why do you think Mr. and Mrs. Ferguson wished to speak with you;

I often offered to parents, whose children died in PICU, an open invitation to speak to me at any time in the future, if they wished to do so. However I have no recollection of the specific wishes of Mr and Mrs Ferguson at that time.

(d) Did you place your opinion as to the mismanagement of this case in writing at that time (if not why not);

I believe that my opinion was expressed during a conversation with the Coroner. The central issue of my discussion appears to have been in relation to what areas of her overall care I could discuss. I did not treat Raychel in Altnagelvin; my comment relating to mismanagement was only an opinion based on the facts available to me at the time. If I had formally been asked for an opinion I am sure I would have provided this in writing.

(e) Whether you communicated this opinion with Altnagelvin Hospital (if not why not);

I have now little memory of the events surrounding Raychel's death and am unable to remember what discussions may have taken place. It would appear that staff in Altnagelvin has serious concerns relating to her care, as can be seen by their subsequent actions after her death.

(f) **Whether you communicated this opinion to Mr. and Mrs. Ferguson (if not why not);**

I have no recollection of the conversations between myself and Mr and Mrs Ferguson.

(g) **Why was it agreed that Mr. and Mrs. Ferguson should be told nothing more than the detail of the treatment Raychel received in Intensive Care:**

The Coroner's note states that I 'could say nothing more than the treatment Raychel received in the Intensive Care Unit', not that Mr and Mrs Ferguson should be told nothing more than this.

(h) **Do you believe that you explained to them your understanding of the facts and circumstances of Raychel's death?**

As I now have no recollection of the discussion I am unable to comment.

(8) **Did you make any note or record of your communications with Mr. and Mrs. Ferguson and the information you provided to them? If so please provide details, if you did not please explain why not?**

Recordings of conversations with Mr and Mrs Ferguson are present in the Relative Counselling Records (063-022 and 063-023). However it was not my practice to record all conversations with parents.

(9) **Was Raychel Ferguson's case reported as an Adverse Incident within the RBHSC in accordance with the Policy TP9/00 as exhibited by you at Ref: WS-292/2 p.45?**

I do not believe it was reported at that time. I think that if an adverse event occurred in RBHSC, and it was considered to have led to an unexpected death, then it would have been reported. However, I do not believe an event occurring in another hospital would have been reported.

In recent years events occurring in the referring hospital would also be reported. This information would be shared across Trusts. Unexpected and unexplained deaths would also be escalated to Serious Adverse Incident status for review.

(10) **Was Raychel's death reported to NCEPOD by the RBHSC?**

It is my understanding that deaths are not reported to NCEPOD.

To date there have been three reviews on perioperative deaths in children. During a review I believe that information on deaths is sought by NCEPOD through their local NCEPOD co-ordinators.

My knowledge of NCEPOD procedures is limited and the Inquiry may wish to contact NCEPOD directly for further information.

(11) **In respect of Mr. Brangam's letter to Mr. Walby dated 16th January 2003 (Ref: 064-022-063) and the statement that *"Dr. Crean has indicated to me that the facts surrounding an earlier matter (Adam Strain deceased) were not on all fours with the present case but, I believe, it would be prudent for you to speak directly with Dr. Ian Carson in relation to this matter, particularly, given it would appear that the Department has some knowledge of the circumstances surrounding this particular incident"* please describe:**

(a) **The relevance, as at January 2003, of the *"facts surrounding an earlier matter (Adam Strain***

deceased)" **to the preparation for the Inquest into the death of Raychel Ferguson;**

I have no recollection of this conversation and am unable to comment.

(b) The knowledge the Department had of the circumstances surrounding Adam Strain's case?

I have no recollection of this.

(12) In relation to the letter from Mr. Walby to Mr. Brangam dated 26th January 2003 (Ref: 064-010-054) and the note *"I have spoken to Dr. Crean and he will stick to his brief at the Inquest and he is aware you will want to consult with him finally just before the hearing"* please state:

I think the reference for the letter in question is actually 064-019-054

(a) What do you think was meant by the reassurance that you *"will stick to* [your] *brief at the Inquest"*;

I do not know.

(b) Did your discussion with Mr. Walby touch upon the Adam Strain case?

I have no recollection of the conversation.

(13) In respect of your evidence at Inquest please state:

(a) Whether you mentioned the case of Adam Strain;

I have no recollection of this.

(b) Whether you mentioned mismanagement of the case of Raychel Ferguson in Altnagelvin Hospital (and if not why not);

I provided, for the Coroner, a deposition summarising my involvement in the care of Raychel. The Coroner, at the time of the Inquest, led the discussions with me when I was giving evidence. I did not appear at the inquest as an expert witness. I do not believe I was asked to comment on the appropriateness of her care in Altnagelvin.

(c) Whether you think you offered all relevant information in your possession to the Inquest;

I believe that I did.

(d) With regards to the transcript note of the evidence at Inquest made by the Trust's solicitors *"? RBHSC- since 1st inquest more aware- always aware but heightened awareness and affected management"* (Ref: 160-010-024) - what this note and evidence meant?

I have never seen this note before. I now have little recollection of my appearance at the Inquest and have no memory of the proceedings.

(14) In respect of Mr. Ferguson's evidence to this Inquiry given 26th March 2013 (Ref: Transcript p.161-163) and his assertion that you made the following comment *"the words coming from his mouth were, before he went out 'what's Altnagelvin trying to do here, pass the buck?' That sticks with me from that meeting... Sorry the actual words he did say was, 'don't comment me on this, are they trying to pass the buck here?"* please state:

(a) **Did a conversation along these lines take place;**

I have no recollection of this conversation and I do not recognise this as a phrase that I would use.

(b) **If so, what did you mean by asking if Altnagelvin was trying to pass the buck;**

(c) **If you did say this, was it to express an element of irritation with the actions of the Altnagelvin Hospital? And if so please describe;**

(d) **If you felt that there was mismanagement of Raychel's case did you also think that Altnagelvin were trying to distance themselves from the consequences;**

(e) **Why were Mr. and Mrs. Ferguson not supposed to quote you in respect of this?**

(15) *"Having been involved in the care of Raychel Ferguson in 2001, and with the knowledge gained as a member of the N Ireland Working Group on Hyponatraemia in children 2001-2002, I believe I was reminded of distinct similarities in the management and subsequent collapse of both Lucy and Raychel"* **(Ref: WS-292-2 p.5). In relation to this please state:**

(a) **Whether the case of Raychel Ferguson came to the attention of the Working Group;**

I am afraid I am unable to recollect the discussions at that time. I believe the case of Raychel Ferguson prompted the formation of this Working Group so I can only assume that her case was known to the Group.

(b) **Whether the case of Lucy Crawford came to the attention of the Working Group;**

I have no recollection of this.

(c) **Whether the case of Adam Strain came to the attention of the Working Group;**

I have no recollection of this.

(d) **Whether the case of Claire Roberts came to the attention of the Working Group?**

I have no recollection of this.

(16) **In relation to the Special Advisory Committee to the CMO upon which you served please state:**

I have no recollection if any of the children named below were mentioned at the Specialist Advisory Committee.

(a) **Whether the case of Raychel Ferguson came to the attention of the Special Advisory Committee;**

(b) **Whether the case of Lucy Crawford came to the attention of the Special Advisory Committee;**

(c) **Whether the case of Adam Strain came to the attention of the Special Advisory Committee;**

(d) **Whether the case of Claire Roberts came to the attention of the Special Advisory Committee?**

(17) **In respect of H.M. Coroner's letter dated 3rd March 2003 to Dr. Sumner (Ref: WS-292/2 p.43)** *"Dr. Peter Crean, who gave evidence at the Raychel Ferguson Inquest has looked at the medical notes for me and is of the opinion that the issues regarding Lucy are not as clear cut as those concerning Raychel. However, he has concerns about the management of Lucy whilst a patient at the Erne Hospital"* **please state:**

(a) The circumstances in which you came to assist the Coroner with these matters;

I believe the Coroner contacted me by telephone in regard to this.

(b) Whether you told the Coroner about the case of Claire Roberts;

I believe I only became aware of Claire Roberts when she was added to the Inquiry.

(c) Whether the case of Adam Strain was mentioned?

I have no recollection of this.

(18) **Please provide such additional comment as you think appropriate. It would be of very considerable assistance if you could also attach any such further document that may be helpful.**

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: P. Crean. **Dated:** 29.05.13.