077/1

Witness Statement Ref. No. 077/1

# INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

**Name:** ~~**Dr**~~ **Ian Carson**

**Title:** **Dr** ~~Deputy Chief Medical Officer, DHSSPS.~~

**Present position and department/employer:**

Deputy Chief Medical Officer, DHSSPS

**Length of time in post:** Appointed on full-time secondment from the Royal Hospitals HSS Trust, with effect from 1st August 2002

**Previous position and department/employer in 1995:**

Consultant Anaesthetist, Cardiac Surgical Unit, Royal Hospitals HSS Trust. 1975 –2002.
Trust Medical Director & Deputy Chief Executive, Royal Hospitals HSS Trust. 1993 –2002.

**Previous position and department/employer in 2000:**

In addition to the above positions, I was appointed as a special adviser in Clinical Governance to the Chief Medical Officer with effect from November 1999. This was on a part-time secondment basis for one day per week and continued up to and including 31st July 2002.

**Previous position and department/employer in 2001:**

Unchanged from the position in 2000; namely, Trust Medical Director & Deputy Chief Executive, Royal Hospitals HSS Trust, and part-time secondment as special adviser in Clinical Governance to the Chief Medical Officer.

**Membership of Professionals Bodies:**

Fellow of the Faculty of Anaesthetists, Royal College of Surgeons in Ireland.
Association of Anaesthetists of Gt.Britain & Ireland.
British Association of Medical Managers.
British Medical Association.

**Particular areas of interest**
*[Please attach additional sheets if more space is required]*

**(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?**

- **Adam Strain:** I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Adam Strain's death in the Royal Belfast Hospital for Sick Children in November 1995.
However, on reviewing documents submitted including (059-001-002), my understanding is that Dr George Murnaghan (Director of Medical Administration, Royal Hospitals) and I had discussed the findings of HM Coroner's Inquest, on or around 17th to 21st June 1996.

- **Raychel Ferguson:** I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Raychel Ferguson's death in the Royal Belfast Hospital for Sick Children in June 2001.
However, I do recall on 18th June 2001, at a meeting of Trust Medical Directors held in the Department of Health, which I chaired in the absence of the Chief Medical Officer, Dr Raymond Fulton (Medical Director, Altnagelvin Hospital) referred to the death of a young child following an appendicectomy at Altnagelvin. It was not an agenda item, and I do not recall the context in which the matter would have been raised. However, on reviewing documents submitted including ~~(Check Ref for this)~~ (006-002-241) correspondence from Dr Nesbitt to Dr Fulton dated 14th June 2001, it could be inferred that Dr Fulton considered it necessary to mention the lack of agreement regarding peri-operative fluid management in children. At that time these meetings of Trust Medical Directors were a relatively informal exchange of issues relevant to the Department and to the work of Medical Directors. The meeting was not minuted, and there is no reference to this discussion documented in 'matters arising' at the subsequent meeting held on 13th December 2001.

- **Lucy Crawford:** I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Lucy Crawford's death in the Royal Belfast Hospital for Sick Children in April 2000.
On 5th March 2003, I received from the Chief Medical Officer a copy of Mr John Leckey's letter (006-010) to her dated 3rd March 2003, along with enclosures from Mr Stanley Millar (006-012-297)) and a copy of the post-mortem report.

**(ii) Describe in detail the steps you took:**
**(1) to discover why the children died;**
**(2) why the DHSSPS was not made aware of the deaths at an earlier stage; and**
**(3) to ensure that lessons would be learned for the future.**

**(1)** I had no personal role in determining the cause of death of the three children.
However, on reviewing documents submitted including (059-001-002), my understanding is that as part of a risk management review an investigation was conducted in the Royal Belfast Hospital for Sick Children on 2nd – 4th December 1995 to rule out any possibility that faulty anaesthetic equipment may have contributed to the cerebral injury sustained by Adam Strain.

**(2)** Prior to the current guidance in regard to 'Reporting Serious Adverse Events', there was no mandatory reason for a Trust Medical Director to report a death (even an unexpected death) to the DHSSPS. All unexplained deaths, in which it was not possible for the medical practitioner to issue a death certificate, or where a death was associated with a medical intervention (usually anaesthesia or surgery), would be reported to HM Coroner's office. During the period in question, Medical Directors would not normally have reported to DHSSPS cases referred to HM Coroners, unless there was some evidence to suggest that a medical practitioner's practice or performance was sufficiently serious to warrant disciplinary procedures, including referral to the General Medical Council. It would be customary practice for the Medical Director to communicate such concerns to the CMO, and also to the HSS Board through the Director of Public Health.

**(3)** **Adam Strain** – The Anaesthetics, Theatre and Intensive Care Directorate in the Royal Hospitals Trust developed recommendations for the prevention and management of hyponatraemia during anaesthesia for major paediatric surgical procedures. The Paediatric Renal Transplant guidelines were also updated in September 1996. Aspects relating to anaesthetic record keeping in the case were reviewed at a subsequent Audit meeting on 10th December 1996

**Particular areas of interest (Cont'd)**

**(iii) Give details of your colleagues within the DHSSPS with whom you discussed the steps to be taken in response to the deaths of Adam, Lucy and Raychel to include the reasons why and when they were contacted by you and the outcome of your discussions.**

I was not involved with DHSSPS colleagues in subsequent responses to the deaths of Adam Strain.

Following the Medical Directors meeting held on 18th June 2001, I gave a verbal feedback on the meeting to Dr Campbell and made reference to Dr Fulton's comment regarding the postoperative death of a child (Raychel Ferguson) in Altnagelvin.

Following the inquest to the death of Lucy Crawford, I informed the Departmental Board at its meeting on the 27th February 2004 of the circumstances of the case and the Coroners findings. (~~… Ref No…~~004-019-237)
Later that same afternoon, I accompanied Dr Campbell at a meeting with representatives from Sperrin Lakeland Trust (Mr Hugh Mills, Mr Eugene Fee, Ms Bridget O'Rawe and Dr Jim Kelly) to discuss the recent inquest and to hear what steps were being taken by the Trust in light of the Coroner's findings.
My hand-written note of that meeting (006-024~~(… Check Ref No…~~) included reference to work undertaken by the Trust concerning the performance and practice of Dr O'Donohoe, the involvement of the Royal College of Paediatrics and Child Health in specific case reviews, and details of the subsequent medical negligence claim in respect of the Lucy Crawford case.
There was a general discussion on the sequence of events following the transfer of Lucy Crawford to the RBHSC Intensive Care Unit. The Trust described the steps that they were taking to identify the key learning points from the case. I pointed out that the recently appointed Clinical & Social Care Governance Support team had experience in the area of training for 'root cause analysis', and I suggested to Mr Mills that he should make contact with Ms Anne O'Brien (Director, Northern Ireland C&SCG Support Team) to request their assistance. I indicated that I would speak to her in advance of a formal approach from the Trust.

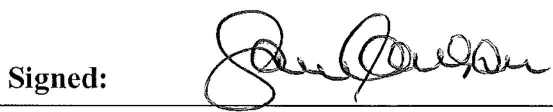
**(iv) Describe in detail your role, if any, in the preparation of guidance in respect of hyponatraemia in children, to include details of colleagues in Northern Ireland and in the rest of the UK with whom you discussed the content of such guidance.**

I was not involved in the preparation of guidance in respect of hyponatraemia in children. This work pre-dated my appointment as Deputy Chief Medical Officer.

The Chief Medical Officer requested that Prof Sir Cyril Chantler review and quality assure the Department's hyponatraemia guidance. I was present at the final meeting of the Review of the Medical School (QUB) held on 8th July 2004, and chaired by Prof Sir Cyril Chantler. Following the close of the meeting, there was a brief discussion on the subject of hyponatraemia, and Dr Campbell's request to have the Northern Ireland guidelines quality assured.
I spoke by telephone on one occasion, in Dr Campbell's absence, with Prof Chantler, to clarify Dr Campbell's request, and we discussed some of the current scientific literature. I have no record of that telephone conversation.

**Other points you wish to make including additions to any previous Statements, Depositions and or Reports**
*[Please attach additional sheets if more space is required]*

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

**Signed:** 

**Dated:** 8 July 2005