Witness Statement Ref. No.	274/1

NAME OF CHILD: **RAYCHEL FERGUSON (LUCY CRAWFORD)**

Name: Thomas Auterson

Title: Doctor

Present position and institution:

Consultant Anaesthetist, South West Acute Hospital Enniskillen since 21.6.2012.

Previous position and institution:

[As at the time of the child's death]

Consultant Anaesthetist, Erne Hospital Enniskillen 1992-2012

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – August 2012]

None

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

20.4.2000 Statement to SLHSCT
17.2.2004. Deposition of Witness at Inquest

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 an Inquiry reference number, then please provide a copy of the document attached.

I. Questions in Relation to your Career Background and Training

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of April 2000:

(a) State your medical and professional qualifications, and the date on which they were obtained.
M.B., B.C.H.,B.A.O., Queen's University Belfast December 1977
F.F.A.R.C.S.I. Dublin May 1987

(b) State the date of your appointment in the Erne Hospital and specify the post to which you were appointed.
Consultant Anaesthetist, Erne Hospital. Appointed 18.2.1992. Commenced work on 1.7.1992.

(c) List all of the professional posts held by you before and since the date of your appointment at Erne Hospital, and provide the dates of each such appointment and its duration.
From 1979 until 1992 I was a Trainee in Anaesthetics working in the Teaching Hospitals in Northern Ireland. I was appointed Consultant Anaesthetist at the Erne Hospital, Enniskillen, taking up this Post in July 1992, where I remained until 21st June 2012; when I transferred to the South West Acute Hospital, Enniskillen.

(2) At any time prior to your involvement in Lucy's case, had you received any form of advice, training or education in order to inform you of the appropriate approach to fluid management in paediatric cases and if so please state,

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

General training and ad-hoc education from several Senior Anaesthetists throughout my time as a Junior Trainee in Anaesthetics from 1979-1992. This included types of IV fluids, and rates of administration for maintenance and resuscitation.

(3) At any time prior to your involvement in Lucy's case, had you received any form of advice, training or education in order to inform you of the issues relating to hyponatraemia in paediatric cases and if so please state,

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

I cannot recall any formal training concerning hyponatraemia, but the subject was mentioned in some informal teaching on wards and in theatre.

(4) Prior to April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children.

Prior to April 2000, I cannot recall dealing with any cases of children with hyponatraemia.

(5) Since April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children.

Since April 2000, I have not been involved in any hyponatraemia cases in children.

II. Issues Relating to the Efforts that Were Made to Establish the Cause of Lucy's Death

(6) In April 2000, what was your understanding of the procedures which were applicable in the Erne Hospital or Sperrin Lakeland Trust in circumstances where an adverse incident had occurred leading to an unexpected death?

In the event of an adverse incident, all those involved would have been required to submit a statement of fact, regarding the incident, to the Trust Management.

(7) **Please outline the steps that you would have expected to have been taken pursuant to those procedures in such circumstances?**

There then would be a Trust Enquiry regarding the adverse incident, and also possible, an inquest by the Coroner.

(8) **Please describe in detail all steps which were taken by you after Lucy's death to inform yourself of the causes or the potential causes of her deterioration and death.**

Review of the fluid balance chart and lab results lead me to believe that hyponatraemia played a significant part in Lucy's deterioration and death.

(9) **Please describe in detail all steps taken by you in order to assist others in understanding the cause of Lucy's deterioration and death, and outline what was said or done by you to assist this understanding.**

My original statement to the Trust shortly after this incident and my testimony at the inquest.

(10) **Did anyone at the Sperrin Lakeland Trust ask you to assist the Trust in understanding the cause of Lucy's death, and/or whether medical treatment received at the Erne Hospital may have contributed to her death? If so, please outline the following:**

(a) **Who asked you to assist?** No one

(b) **When were you asked to assist?** Never

(c) **What assistance were you asked to provide?** None

(d) **What assistance were you able to provide?** I was not asked

(11) *"Initially hyponatraemia did not occur to me though it did later when I got lab results. On the ward fluid management is the responsibility of the surgeon or physician in charge – sometimes in consultation with the anaesthetist. I agree that in Lucy's case too much of the wrong fluid was given. I agree that the wrong fluid was given and that the rate of infusion was wrong."* (Ref: 013-025-093)

Arising out of the foregoing please address the following matters:

(a) **Please confirm what lab results you were referring to in your deposition to the Coroner, and specify what those results were.** Serum electrolytes. Sodium 127 mmol/L (normal 135-145) Potassium 2.5 mmol/L (normal 3.5-5.0). I cannot remember the other values on the lab report.

(b) **When (approximately) did you obtain those lab results?** The results were given to me during my resuscitation attempts on Lucy, by a nurse who took the results by telephone from the lab.

(c) **Having obtained the lab results, what conclusions did you reach in relation to whether hyponatraemia was a factor which was relevant in Lucy Crawford's case?**

I suspected hyponatraemia from the electrolyte report and the fluid balance record and the child's neurological status.

(d) **Did you discuss these conclusions with any of the following persons:**

(i) Dr. Jarlath O'Donohoe;
(ii) Dr. Amer Ullah Malik;
(iii) Dr. James Kelly;
(iv) Dr. Trevor Anderson;
(v) Mr. Eugene Fee;
(vi) Mr. Hugh Mills;
(vii) Anyone else?

I cannot remember clearly, but I think I discussed the case informally with Drs O Donohoe and Anderson, and my Anaesthetic colleagues in the following 24-48 hours.

(e) **If you did discuss your conclusions with anyone please address the following matters:**

(i) **Who did you discuss your conclusions with?** Drs O Donohoe and Drs Anderson & Anaesthetic colleagues
(ii) **When did you have any such discussion?** In the following day or two
(iii) **What did you discuss?** I discussed the resuscitation and transfer of Lucy to Belfast
(iv) **Was any action taken on foot of any discussion which took place?** No

(f) **If you <u>did not</u> discuss your conclusions in relation to the relevance of hyponatraemia in Lucy's case with anyone else, please explain why you did not do so?** N/A

(g) **When did you reach the view that Lucy was given too much of the wrong fluid?**
At the time of resuscitation – it could be the most likely cause of hyponatraemia

(h) **What factors did you take into account when reaching the view that too much of the wrong fluid had been given to Lucy?**
Her general condition, neurological status and the lab results and details on the fluid balance chart.

(i) **Did you discuss your view that Lucy had been given too much of the wrong fluid with any of the following persons:**

(i) Dr. Jarlath O'Donohoe;
(ii) Dr. Amer Ullah Malik;
(iii) Dr. James Kelly;
(iv) Dr. Trevor Anderson;
(v) Mr. Eugene Fee;
(vi) Mr. Hugh Mills;

I cannot remember clearly, but I think I discussed the case informally with Drs O Donohue and Anderson, and my Anaesthetic colleagues in the following 24-48 hours.

(j) If you did discuss your view with anyone please address the following matters:

(i) Who did you discuss your view with? Drs Donohue, Anderson and Anaesthetic colleagues
(ii) When did you have any such discussion? In the following day or two
(iii) What did you discuss? I can't remember
(iv) Was any action taken on foot of any discussion which took place? No

(k) If you did not discuss your view that Lucy had been given too much of the wrong fluid with anyone else, please explain why you did not do so? N/A

(12) You provided a statement to Sperrin Lakeland Trust dated 20 April 2000 (Ref: 033-102-316). The statement was included as part of the report of the review of Lucy Crawford's case (Ref: 033-102-264).

Please address the following matters arising out of the provision of that statement:

(a) Who asked you to provide the statement? I think it was either Mr. Eugene Fee or Dr J Kelly (Medical Director)

(b) Were you told why a statement was required? This is standard practice following such an incident

(c) Were you told the purpose for which the statement would be used? It would be used as part of a Trust Enquiry.

(d) What were you asked to address in the statement? The facts surrounding my part in the incident.

(e) Did you receive any assistance in drafting the statement, and if so, from whom? No

(f) Did you have any discussion in relation to the statement whether before or after it was provided? If so, please address the following matters: No

(i) Who did you have the discussion with?
(ii) When did the discussion take place?
(iii) What was the purpose of the discussion?
(iv) What was discussed?
(v) Was any action taken on foot of the discussion?

(g) Why does your statement not discuss hyponatraemia? Whilst I did not mention the word "hyponatraemia" in my statement, a serum sodium of 125 is by definition hyponatraemia i.e. an abnormally low level of sodium in the blood

(h) Why does your statement not discuss your view that Lucy had received too much of the wrong drug? Because if hyponatraemia was the cause of Lucy's condition, then too much of the wrong I.V fluid could have been the most likely cause. I did not mention this as I regarded it as an obvious conclusion.

(i) At any point in time were you asked by anyone in the Erne Hospital or the Sperrin Lakeland Trust to discuss, whether formally or informally, what had happened to Lucy to cause her condition to deteriorate on the morning of the 12 April 2000? If so, please address the following matters: No

(i) Who asked you to discuss these matters?
(ii) When were you asked to discuss these matters?
(iii) What were you asked?
(iv) What views did you express?

(13) Did you at any time give any consideration to reporting he death of Lucy Crawford to the Coroner? Please explain your reasons for not reporting Lucy's death to the Coroner.

I would have expected the Doctor certifying the cause of death to consider reporting it to the Coroner.

(14) At any time (before or after Lucy's death) did you discuss her case with any clinician at the Royal Belfast Hospital for Sick Children? If so, please address the following matters:- No

(a) Who did you discuss Lucy's case with?
(b) When was it discussed?
(c) What was discussed?
(d) Were any conclusions reached?
(e) Was any action taken on foot of the matters that were discussed?

III. Other Matters

(15) How would you categorize the quality of care which was provided to Lucy Crawford at the Erne Hospital? In addressing this question please refer to each of the factors which have caused you to reach this view.

The quality of care was less than satisfactory in regard to the prescription of IV fluids and record of subsequent administration.

(16) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The cause of Lucy's death;

Lucy's death was tragic and unfortunately probably avoidable

(b) The role performed by you, the Sperrin Lakeland Trust or others in terms of the steps that were taken to reach conclusions in relation to the cause of Lucy's death;

(c) The procedures which were followed in order to review or investigate issues relating to the cause of Lucy's death;

(d) Lessons learned from Lucy's death and how that affected your practice at the Erne Hospital or elsewhere;

Since then the prescription and administration of IV fluids has been reviewed and strict protocols now exist.

(e) Any other relevant matter.

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

Signed T.N. Anderson Dated: 6th November 2012