LITIGATION
23 JAN 2013
SERVICES

Witness Statement Ref. No.

274/2

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 – December 2012]		
Previous Statements, Depositions and Reports: [Identify by date and title all those made in relation to the child's death]		
OFFICIAL USE: List of previous statements, depositions and reports attached:		
Ref:	Date:	
WS-274/1	06-11-2012	Statement to the Inquiry

## 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.

- (1) In your answers to question 11(b), (c) and (g) of WS-274/1 you have stated that you obtained the lab results from a nurse at the time of your resuscitation attempts on Lucy, and that at that time you concluded that Lucy had suffered hyponatraemia which was likely to have been caused by having been given too much of the wrong type of fluid. Arising out of these answers please address the following matters:
  - (a) Who was present with you during the resuscitation attempts.

    Dr O'Donohoe, Dr Mallik, nurses Swift, Jones, McCaffrey and McManus and Sister Gladys Edmundson.
  - (b) Did you tell those who were present that Lucy had suffered hyponatraemia because she had been given too much of the wrong type of fluid?

    As far as I can remember, I did not.
  - (c) You and Dr. O'Donohoe appear to have spoken to Lucy's parents (Ref: 027-015-038). What did you tell Lucy's parents about the cause of her condition? I do not recall discussing the cause of Lucy's condition.
- (2) In your answer to question 11(d) and (i) of WS-274/1 you have mentioned having certain "informal" discussions with Drs. O'Donohoe and Anderson as well as with your anaesthetic colleagues.
  - (a) Identify the anaesthetic colleagues who you discussed Lucy's case with. Dr M Cody and Dr W Holmes.
  - (b) State precisely what you discussed with Dr. O'Donohoe about Lucy's case in the day or two after her treatment in the Erne Hospital.

The transfer to RBHSC and her condition on arrival there.

- (c) State precisely what you discussed with Dr. Anderson about Lucy's case in the day or two after her treatment in the Erne Hospital.

  The appropriate during requesitation and transfer.
  - The sequence of events during resuscitation and transfer.
- (d) State precisely what you discussed with each of your anaesthetic colleagues about Lucy's case in the day or two after her treatment in the Erne Hospital.

  Drs, Cody and Holmes and I discussed the sequence of events and possible causes of

Lucy's condition.

(e) What consideration did you give to making a formal clinical incident report in relation to the treatment of Lucy as opposed to discussing the case informally with colleagues? If you did not give consideration to reporting the case in that way please explain your omission to do so.

Apart from my statement of 20/04/2000 I thought that any other report would be the responsibility of the Paediatric team.

(3) In answer to question 12(h) of WS-274/1 you have explained why you did not mention in the statement provided by you to the Sperrin Lakeland Trust (Ref: 033-102-316) that Lucy had received too much of the wrong fluid.

You have said, inter alia, that you did not mention it because you "regarded it as an obvious conclusion."

Arising out of the answer which you have given, please address the following matters:

- (a) Why was such a conclusion "obvious" to you?

  Because of the sequence of events, the clinical observations and the laboratory results.
- (b) Identify by name the persons in the Erne Hospital to whom this conclusion was obvious or ought to have been obvious, and explain why the conclusion was or should have been obvious to each such person.

Dr O'Donohoe and Dr Mallik.

Again, because of the clinical picture the Neurological status of Lucy the fluid balance record, and the low sodium and potassium on the U&E result.

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

Signed:

IN Auterson.

Dated: 22-01-13