Witness Statement Ref. No. 275/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Michael Curtis

Title: Doctor

Present position and institution:
Deputy State Pathologist
Department of Justice
Republic of Ireland

Previous position and institution:
Assistant State Pathologist
Northern Ireland (NIO)

Membership of Advisory Panels and Committees:
Histopathology Sub-Group Committee
Royal College of Physicians of Ireland 2005-Present Date

Previous Statements, Depositions and Reports:
None

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.
MB ChB (Dundee) 1977,
MRCPath 1985
FRCPath 1995
FFPathRCPI 2005

(b) Confirm that in April 2000 you were employed in the role of Deputy State Pathologist in the State Pathologist's Office in Belfast. If this is incorrect, specify the role in which you were employed and the name of your employer.
In 2000 my role was that of Assistant State Pathologist in the State Pathologist's Office, Belfast. I was not Deputy State Pathologist, that position being occupied by my Consultant colleague Dr Alastair Bentley. My answers to questions 1(c), (d), and (e) are all on the basis that my job title was "Assistant State Pathologist". I am now a Deputy State Pathologist in Dublin.

(c) If you were employed in the role of Deputy State Pathologist, state the date of your appointment to that post, and provide a description of all of the professional posts held by you before and since that date, giving the dates of your employment in each case.

August 1977 – February 1978: House Officer in Medicine, Sunderland Royal Infirmary
February 1978 – July 1978: House Officer in Surgery, Middlesborough General Hospital
August 1978 – July 1979: Demonstrator in Pathology, University of Dundee
August 1979 – May 1986: Registrar and Senior Registrar in Pathology, University of Newcastle upon Tyne
June 1986 – May 1988: Consultant Pathologist, North Manchester General Hospital
June 1988 – March 1994: Crown Pathologist (Consultant and Senior Lecturer), University of Glasgow
April 1994 – December 1998: Consultant Forensic Pathologist in Private Practice (With several locum posts in University of Glasgow)
January 1999 – August 1999: Visiting Fellow in Forensic Pathology, New South Wales Institute of Forensic Medicine, Sydney, Australia
September 1999 – November 2004: Assistant State Pathologist, Northern Ireland
November 2004 – Present Date: Deputy State Pathologist, Republic of Ireland

(d) Describe the duties which you were required to undertake in your role as Deputy State Pathologist.

In 2000, as Assistant State Pathologist, I fulfilled the role of a Consultant Forensic Pathologist for the Northern Ireland Office. I attended scenes of crime, performed autopsy examinations, prepared reports and attended courts of law as an expert witness, both inquests and criminal trials. In addition, I would occasionally receive informal requests for advice from medical colleagues. These would usually be telephone calls and would include advice regarding the cause of death in a particular cases, and also requests for assistance from other pathologists who may have had concerns about autopsy findings.

(e) **Describe the nature of any duties which you undertook for or on behalf of the Coroner's Office, whether formally or informally, in your role as Deputy State Pathologist.**

The undertaking of forensic autopsies, some involving attendance at scenes of crime would be under the auspices of the Coroner. Attendance at inquests would be in response to court summons.

(2) **At any time prior to April 2000, had you received any form of advice, training or education in order to inform you of the medical issues associated with fluid management in paediatric cases and if so please state,**

It will be noted from my answer to question 1(c) that apart from my House Officer training in 1977 and 1978 I have worked exclusively in the field of pathology. As a result of this I have not had cause to be involved with the medical issues associated with fluid management.

(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?**

(3) **At any time prior to April 2000, 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,**

As a result of my career path, as I have noted above, I have had no opportunity or need to deal with hyponatraemia in paediatric cases.

(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?**

(4) **Prior to April 2000, describe in detail your experience of dealing with cases in which it was suspected that poor fluid management or hyponatraemia was implicated in the cause of death, including the**

To my recollection, I never had to deal with a case where these issues were directly implicated in the cause of death.

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

(b) **Nature of your involvement.**

(5) **Since April 2000, describe in detail your experience of dealing with cases in which it has been suspected that poor fluid management or hyponatraemia was implicated in the cause of death including the**

I have had no cases of this sort that I can recall where it has been suspected that poor fluid management or hyponatraemia was directly implicated in the cause of death. In the course of my work I have performed autopsies on adult cases where there has been secondary, incidental, fluid balance disturbance due to neglect and inanition in the elderly, or due to gastrointestinal malignant disease or rarely in cases of anorexia nervosa.

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

(b) **Nature of your involvement.**

II. **Questions Relating to Advice Provided by you in Relation to Lucy Crawford's Death**

(6) **In her statement to the PSNI Mrs. Maureen Dennison (of HM Coroner's Office) said:**

"On 14 April 2000 I took the report of the death of Lucy Crawford, 5.11.98 of.... The death was reported to me by Dr. Hanrahan, from ICU at Children's Royal Victoria Hospital. I have written in the circumstances of the death as he reported to me. I spoke to Dr. Curtis, Deputy State Pathologist, because I couldn't get in touch with the Coroner, that is why I have written Dr. Curtis name in the entry. I wrote DC in entry which means that Death Certificate was issued and giving gastro enteritis as the cause." **[Ref: 115-033-001]**

(a) **Please confirm that you were contacted by Mrs. Margaret Dennison in relation to the death of Lucy Crawford on 14 April 2000.**

I have no recollection of any particular call from Mrs Dennison but have no reason to suggest it did not take place. It follows that I do not remember what information, if indeed there was any information, was passed on to me by her. I do remember having occasional telephone conversations with Mrs Dennison and other members of the Coroner's Office staff, usually to arrange my attendance at inquests.

If you were so contacted by Mrs. Dennison please address the following matters:

(b) **Explain your understanding of why Mrs. Dennison contacted you.**

(c) **What information were you given by Mrs. Dennison in relation to Lucy Crawford's death?**

(d) **Were you asked by Mrs. Dennison to provide any advice or assistance to the Coroner's Office in relation to the death of Lucy Crawford, and if so, what advice or assistance were you asked to provide?**

(e) **If you were asked to provide advice or assistance to the Coroner's Office in relation to the death of Lucy Crawford, in what capacity or pursuant to what arrangements were you asked to provide that advice or assistance?**

(7) **Following, or arising out of your contact with Mrs. Dennison, did you have any discussions with Dr. Donncha Hanrahan (Consultant Paediatric Neurologist, Royal Belfast Hospital for Sick Children) in relation to the death of Lucy Crawford?**

I have no recollection of this case at all, and no memory of Dr Hanrahan. Again, it follows that I therefore have no recollection of what I may or may not have been told. I note that Dr Hanrahan has a similar difficulty and relies only on the clinical note written by his Registrar. I do not have any notes to assist me in any way. If I received a phone call, on a speculative basis, I would not keep notes. Notes would be made only on those cases where I was actually appointed and there was no daybook, or similar place to record general queries. I do not know what advice I tendered in this case, or indeed why the call was made to me. In general, it was (and remains) my practice to advise clinicians who may seek advice about a death certificate that if they have any worries or concerns they should speak to the Coroner. I will also suggest that if a death does not fall within the guidelines for referral to the Coroner, but they have any doubt about a cause of death that they should have a hospital post mortem done – that seems to me to be quite reasonable and I note that it was in fact done in this case. I do not recall if I suggested it, or if it was said to me as something which was to be done.

I should be clear and confirm that I would never suggest whether or not a Coroner's Post Mortem was required in a case which fell outwith the guidelines – that is entirely a matter for the Coroner to comment on.

It is fair to say, however, that on the assumption I did speak to Dr Hanrahan, we may have discussed the death certificate and what should be on the certificate. I cannot recall doing so.

The results of a hospital post mortem examination would not be passed onto me but may be communicated to the Coroner, if appropriate.

In general, hospital pathologists would only telephone me directly on rare occasion, usually to query a finding they had made in the course of an autopsy they had already started or completed.

If so, please address the following matters:

(a) On what date and at what time (approximately) did you discuss the death of Lucy Crawford with Dr. Hanrahan?

(b) What information were you given in relation to Lucy Crawford's death and the circumstances of her death by Dr. Hanrahan?

(c) Did you make a note of your discussion with Dr. Hanrahan? If so, please provide a copy of this note to the Inquiry. If you have disposed of the note, please indicate when you did so and why you did so.

(d) What was the purpose of the discussions which you held with Dr. Hanrahan, and what conclusions, if any, were reached?

(e) What information or advice, if any, did you give to Dr. Hanrahan as a result of those discussions?

(f) As a result of your discussions with Dr. Hanrahan what conclusions did you reach in relation to the following matters:

(i) the cause of Lucy's death;

(ii) whether a Coroner's Post Mortem was necessary;

(iii) whether an Inquest was necessary?

(g) Did you and Dr. Hanrahan discuss the completion of the death certificate in respect of Lucy? If so, what was discussed?

(h) Were you made aware of how Dr. Hanrahan intended to complete the death certificate? If so, what were you told, and did you comment on this?

(i) Did you discuss with Dr. Hanrahan whether it would be useful to arrange a hospital/consent post mortem? If so, what did you discuss and what conclusions were reached?

(j) If you or Dr. Hanrahan were of the view that a hospital/consent post mortem would be useful, please explain why this view was reached?

(k) Were you ever advised that a hospital/consent post mortem had taken place? If so, who advised you of this and what were you told?

<u>Please fully explain the conclusions which you reached on these matters, and the factors that you took into account when reaching those conclusions.</u>

(8) **Please consider the autopsy request form [Ref: 061-022-073] completed at the Royal Victoria Hospital on the 14 April 2000. Without prejudice to the other information contained in that form, please consider the following:**

I have already indicated that I do not recall the conversation with Dr Hanrahan and thus cannot comment on what he may have told me. I am able to say, however, having read the information contained within the autopsy request form, that had I had all of that information relayed to me I would have made two recommendations - the first would have been to refer the case to the Coroner and the second would have been that it may be sensible to involve a Chemical Pathologist - or medical biochemist- to look at the results in the case. These recommendations would have arisen due to knowing about dehydration and hyponatraemia in the same patient. My understanding is that dehydration would normally lead to hypernatraemia so this would be an unusual situation which warranted investigation. I am therefore sure that I did not know these details at the time I was spoken to as I suspect I would have recommended the case be reported to the Coroner and I have no reason to suggest that such a recommendation would not be followed.

"Clinical diagnosis

Dehydration and hyponatraemia

Cerebral oedema → acute coning and brain stem death." **[Ref: 061-022-073]**

And at [Ref: 061-022-075] -

"List clinical problems in order of importance

(This list will enable the pathologist to produce a more relevant report)

(1) Vomiting and diarrhoea

(2) Dehydration

(3) Hyponatraemia

(4) Seizure and unresponsiveness leading to brain stem death."

(a) **Please advise whether information of the kind set out above was brought to your attention in any discussion which you had with Dr. Hanrahan in relation to Lucy's death?**

(b) **Specify any aspect of the information set out above which was not brought to your attention?**

(c) **If any aspect of the information set out above was <u>not</u> brought to your attention, please outline whether in your view it should have been brought to your attention and explain why?**

(d) **Would your conclusions in relation to Lucy's death have been different had you been provided with that information? Please fully explain the answer that you provide.**

(e) **If you are of the view that any other information contained in the autopsy request form should have been brought to your attention but was not, identify the specific information and explain why it should have been brought to your attention.**

(f) **If you were provided with the information contained in the autopsy request form, please explain the conclusions which you reached by reference to that information.**

(9) **What information or advice, if any, did you give to the Coroner's Office following your discussions with Dr. Hanrahan in relation to the following matters:**

I have no recollection at all of this case, but if the call was to discuss the death certificate and whether it ought to be referred, and my conclusion was that a hospital post mortem would be appropriate then I would have had no reason to call the Coroner's office. I did have regular communications with the Coroner's office and could easily have called about this if I had concerns but it does not appear that I was alerted to any concerns. In those circumstances I would have had nothing to report to the Coroner's office. Had I had cause to telephone the Coroner's office, I would have sought to speak directly with the Coroner or Deputy Coroner.

(a) **the cause of Lucy's death;**

(b) **whether a Coroner's Post Mortem was necessary;**

(c) **whether an Inquest was necessary;**

And state:

(i) **Who in the Coroner's Office did you provide any of this information or advice to?**

(ii) **On what date did you provide any of this information or advice? If you can't recall the date, can you confirm whether it was the same day on which you had the discussion with Dr. Hanrahan?**

(10) **If you reached the conclusion that the death of Lucy Crawford was due to natural causes, please address the following matters:**

I have no recollection of how I reached my conclusion that Lucy Crawford died due to natural causes other than to say that I must have taken that from what I was told in the telephone conversation. I do not think I could have had all the information from the autopsy request form because, as stated above, I am of the view that I would have suggested the case be referred to the Coroner. I would have had no reason to discuss the case with anyone else. I suspect I reached the view that Lucy died of natural causes on being told she had gastroenteritis which is a natural cause of death. I can only speculate that I had no reason to consider there was anything else implicated and that would be due to what I had been told.

(a) **What factors did you take into account when reaching your conclusion?**

(b) **Did you discuss your conclusion with anyone else? If so,**

(i) **Who did you discuss your conclusion with?**

(ii) **When did you have this discussion?**

(iii) **Did you provide any advice or direction arising out of your conclusion, and if so, who did you provide that advice/direction to?**

(iv) **Were any decisions made or actions taken in response to any advice or direction issued by you?**

(11) **Did you have any discussions with the Coroner (Mr. Leckey) in relation to the cause or circumstances of Lucy's death?**

I cannot recall having any such discussions with Mr Leckey but once again if it was a case where I had not thought it ought to be referred to him then I would have had no reason to do so. I did not report to him on a daily basis, and he was not my line management, so I had no reason to report any case to him, directly.

If so, please address the following matters:

(a) **When did you have this discussion with the Coroner?**

(b) **Outline what was discussed between you and the Coroner in relation to the cause or circumstances of Lucy's death?**

(c) **Did you provide any advice to the Coroner in relation to Lucy's death, and if so, what was that advice?**

(d) **Was any action taken by the Coroner in response to any of the advice which you may have provided?**

(12) **Did you have any discussion with Mrs. Dennison or anyone else in the Coroner's Office regarding the question of whether a death certificate could be issued in respect of Lucy Crawford's death?**

I have no recollection of any such discussion but in the circumstances where I have simply advised that a death certificate can be issued, or where I knew a hospital post mortem was being carried out, I would have had no reason to do so. I would also have had no reason to discuss the

contents of such a death certificate. A death certificate is a matter for a clinician in conjunction with the Coroner's office.

If so, please address the following matters:

(a) **Who did you discuss this issue with?**

(b) **When did you discuss this issue?**

(c) **What views did you express and what views were expressed to you?**

(d) **Did you advise in relation to what would be or should be included in the death certificate? If so, what advice did you give?**

(e) **What action, if any, did you understand would be taken following this discussion?**

III. **Other Matters**

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

I have no recollection and therefore can make no meaningful comment

(a) **The cause of Lucy's death;**

(b) **The role performed by you 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 in the State Pathologist's office or elsewhere;**

(e) **Any other relevant matter.**

The Inquiry drew my attention to this matter for the first time on the 27th of September 2012, a period of twelve and a half years after the event. Genuinely, I have no recollection of the telephone consultation but accept that it most probably took place. It would appear that I had been approached for informal advice over the telephone. A Forensic Pathologist would be able to give informal general advice to a clinician about the appropriateness of offering a death certificate for a natural cause of death. The Pathologist would have no authority to accept or reject a death certificate. It appears in this case that the clinician had indicated that the death was due to natural causes i.e. gastroenteritis.

In his deposition at the inquest into the death of Lucy Crawford on the 17th of February 2004, Dr Hanrahan states that he did not have access to the patient's fluid chart at around the time of her death. Therefore, he would not have been in a position to inform me or alert me to the possibility of a fluid balance problem or electrolyte disturbance being instrumental in this child's death.

Elsewhere in his deposition, Dr Hanrahan states that he did not personally record the conversation in the case notes but had delegated this task to his Registrar.

Such a telephone inquiry for advice would not have been recorded in the State Pathologist's Office as the office held no case file for the deceased.

I would never, under any circumstances, attempt to dissuade a clinician from contacting the Coroner.

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

Signed: Michael Lauritsen **Dated:** 13th November 2012