Witness Statement Ref. No. 275/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Michael Curtis

Title: Doctor

Present position and institution:

Deputy State Pathologist, Republic of Ireland

Previous position and institution:
[As at the time of the child's death]

As before – per witness statement reference no 275/1

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

As before - per witness statement reference no 275/1

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

As before - per witness statement reference no 275/1

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

Ref:	**Date:**	
WS-275/1	13-11-2012	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) Arising out of your answer to question 7 of WS-275/1

You have referred to "*guidelines for referral to the Coroner*". Please address the following:

(a) In this context were you referring to a document containing *guidelines* for referral to the Coroner? If so, please identify or describe the document you are referring to, and either provide a copy or indicate from where it can be obtained?

I was not referring to any document containing guidelines. Rather I was referring to the categories of deaths which have to be reported to the Coroner by law.

(b) If you were not referring to a document, please explain your understanding of when a death did fall within the guidelines for referral to the Coroner?

As I have stated above, the term 'guidelines' means, in fact, the categories of death that should be reported to the Coroner. These include the following –

- Where a doctor did not attend a person in their last illness
- Where a doctor did not see or treat a person for the condition from which they died within 28 days of death
- Where the cause of death is not known
- Where the cause of death is sudden, violent or unnatural
- Cases of suicide
- Cases of accidental death
- Deaths in Custody
- Deaths in Foster Care
- Deaths during medical procedures
- Deaths following administration of an anesthetic
- Where there is a question of negligence or misadventure about the treatment of the person who died
- Deaths at work
- Deaths resulting from neglect
- Suspicious deaths
- Homicides

(2) Arising out of your answer to question 9 of WS-275/1

You have referred to whether the call "*was to discuss the death certificate and whether it ought to be referred*". Please address the following:

(a) Please clarify whether there was an arrangement in place between the Coroner's Office and the State Pathologist's Department, whether formal or informal, through which the Coroner's Office could refer medical practitioners to you and other pathologists, in order to discuss whether a death certificate could be issued and/or whether a death ought to be referred to the Coroner.

I am not aware of any formal arrangement between the State Pathologist's Office and the Coroner's Office. Certainly, I was never briefed regarding any such guidelines nor provided with any written guidelines from the NIO or its staff. I cannot say that there was an "informal arrangement" either. This call, which I stress I cannot recall, appears to have been an ad hoc call which I dealt with in an effort to help a clinician. I note that Mrs Maureen Dennison (at page reference 115-033-001) has indicated that she passed the call to me because she could not get in touch with the Coroner. That is not something I remember happening on any other occasion (and as I have said although I do not remember this call, I cannot dispute that it took place). I do not think that there were any steps which I *should* have taken after this call given the case was not referred on to the Coroner's office. There would only be documents produced in cases referred in, and none in a case which was just a discussion. Mrs Dennison does say in her statement (ref 115-033-001) that she noted, by hand, that a death certificate was issued and that gastroenteritis was the cause of death. I cannot say whether I called her to tell her that as I have no recollection of doing so.

(b) If so, describe how that arrangement worked, and in particular describe the steps that should have taken place after the advice of the pathologist (such as yourself) had been obtained?

(c) Clarify whether this arrangement was the subject of any guidance, procedure or protocol, whether formal or informal?

(d) If this arrangement was the subject of any guidance, procedure or protocol, whether formal or informal, was it documented? If so, please provide a copy. If it wasn't documented, describe the main elements of the arrangement and its purpose.

(3) Arising out of your answer to question 13 of WS-275/1

You have said that in his deposition at the Inquest into the death of Lucy Crawford, Dr. Hanrahan stated "*that he did not have access to the patient's fluid chart at around the time of her death.*"

Having considered Dr. Hanrahan's deposition at Ref: 013-031-111, please refer to the precise portion of the text of the deposition which you rely on to make this point.

I refer to Ref 013-031-113 of Dr Hanrahan's deposition (second paragraph) where he states that he did not have access to Lucy's fluid chart.

To expand on that, and illustrate further the reasons I believe Dr Hanrahan had not mentioned the possibility of a fluid balance problem to me, I would also like to draw attention to several sections of Dr Hanrahan's formal interview with the PSNI on the 2nd of March 2005.

At Ref 116-026-003 he states in the last two sentences of the paragraph on that page "My differential diagnosis did not include dilutional hyponatraemia, but did include infection, for example herpes, haemorrhagic shock and encephalopathy, metabolic disease, urea cycled defect. I suspected she might have cerebral odema, but was unsure of the cause."

Ref 116-026-004, halfway down the page, he states "No no the phone call which was documented from the notes directly above my entry 127. So dilutional hyponatraemia did not strike me at that stage". It is of interest that at the time of Lucy's death he was unaware of the significance of the drop in sodium level, as it was not something significant to him, it is improbable that he referred to it, or mentioned it to me. Again, this is an assumption.

At Ref 116-026-005, he states "From the clinical notes I see that Doctor Caroline Stewart noted that I discussed the matter with Doctor Curtis in the Coroner's Office, but I do not recall this conversation"

Further down that page he states "Whilst I was aware that the deceased child was hyponatraemic for a period of time, the significance of this was not apparent to me as the sodium level in the notes of 127 having dropped from 137 did not appear to me as a marked and significant drop in sodium. One often in clinical practice sees a sodium level of 127. At the time I did not believe that this drop in sodium level was sufficient to have caused brain oedema and coning"

Further in his statement, Ref 116-026-007, he states "The appropriate section of the notes was written by Doctor Caroline Stewart. I'm not aware if I mentioned at this point hyponatraemia along with dehydration, but I may not have, as it was not something to the forefront of my mind at this time"

These references simply illustrate that Dr Hanrahan, at the time he apparently called me, did not have Hyponatraemia in his mind given the sodium level of 127 which he was aware of from the notes. I have previously stated (in witness statement 275/1, question 8) that I would have referred the case to the Coroner had the Hyponatraemia been mentioned alongside dehydration. I would have been surprised by Hyponatraemia in a case where there was dehydration.

Finally, in dealing with Dr Hanrahan's evidence, I note that at Ref 116-026-007, he states "The Pathologist would have had the power to request an inquest, if felt to be necessary by referring back to the Coroner" He appears to have the mistaken impression that the State Pathologist's Office is part of the Coroner's Office. Furthermore, he is misconstrued in thinking that Forensic Pathologists order inquests.

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

Signed:

Michael Lawton

Dated: 11th January 2013