Witness Statement Ref. No. 282/1

NAME OF CHILD: RAYCHEL FERGUSON(LUCY CRAWFORD)

Name: Caroline Stewart

Title: Doctor

Present position and institution:

Consultant Paediatrician, Antrim Hospital, NHSCT

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

Paediatric Registrar, RBHSC, Belfast working in Paediatric Neurology for 6 months and covering all medical areas including PICU on call.

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

Committee Member of Managed Clinical Network in Paediatric Diabetes in NI 2009- present

Not a member of any advisory panel.

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

Statement for PSNI, relating to Lucy Crawford's death, March 2005

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

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 to your statement.

I. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) State your medical qualifications as of the 14th April 2000.

My qualifications were MB, BCh, BAO, DCH, MRCPCH on 14.4.00

(b) State the date you qualified as a medical doctor. June 1990 QUB Medical School

(c) Describe your career history before you were appointed to the Royal Belfast Hospital for Sick Children (RBHSC).

I worked as a junior doctor in paediatrics from 1991; rotating through Altnagelvin Hospital, Ulster Hospital, RBHSC, Antrim Hospital, Craigavon Hospital, Royal Maternity neonatal unit and Cupar Street clinic. This included both hospital and community based paediatrics. I was in my 4th year of registrar training in Paediatrics in 2000.

(d) State the date of your appointment to the RBHSC and the capacity in which you were employed

I started working in Paediatric neurology in February 2000 as a paediatric registrar for a 6_month post.

(e) State the date of your appointment to the role of Specialist Registrar in Paediatrics at the RBHSC.

My appointment as a Specialist Registrar in RBHSC in Paul Ward (Neurology) was from beginning of February 2000 – beginning of August 2000.

(f) Describe your work commitmernts to the RBHSC from the date of your appointment, stating the locations in which you worked and the periods of time in each department/location.

From February 2000 I worked in Paul Ward RBHSC, with the paediatric neurologists on the ward and in out patient clinics. When I was on call at nights and weekends, I covered all medical problems throughout the children's hospital as the paediatric registrar.

(g) Describe your duties as Specialist Registrar in Paediatrics in the RBHSC on the 13th and 14th April 2000.

During my regular working hours (9am – 5pm) I was based with the paediatric neurology team, working with the consultants and nurse specialist and allied professionals. My on call commitment covered all the medical areas of the hospital including A&E, PICU, medical wards and any medial problems arising throughout the children's hospital. I was on call from 5pm on

12th April 2000 to 9am on 13th April 2000. As the medical registrar, my job involved liaison with the various consultant paediatric specialists on call regarding any problems in any of their patients and I also reviewed all the patients admitted to PICU overnight. I frequently was requested to assess patients in A&E. I resumed my daytime role in paediatric neurology at 9am and usually worked until lunch time after the night on call. The European Working Time Directive of a 48-hr working week was not introduced to our rota at that stage. I do not remember other patients I was involved with that night apart from Lucy Crawford who was admitted to PICU. On the 14th April 2000 I worked with the paediatric neurology team from 9am to 5pm. Part of this time included dealing with Lucy Crawford, who was in PICU.

(2) Provide full details of any advice, training or instruction which you had received prior to April 2000 in relation to either of the following matters:

- **The treatment of a child suffering from dehydration due to gastroenteritis**
- **The completion of Medical Certificates of Cause of Death (MCCDs)**

I do not remember any formal training on the management of children with gastroenteritis. As a medical student I had general teaching on infectious diseases (including gastroenteritis). As a junior doctor I had informal one-to-one guidance in prescribing IV fluids and also teaching in ward rounds from my senior colleagues. A lot of medical knowledge was gained from personal reading and study around the subject.

I do not remember formal training in completing death certificates; it was learned on the job as a junior doctor, observing others and being guided by senior doctors.

And address the following-

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

(b) When was it provided?

(c) What form did it take?

(d) What information were you given?

The training was informal, usually one-to-one as clinical cases were treated on wards and it was a continuous process of constantly learning as a junior doctor from senior consultants and registrars. A lot of personal study and reading was also a very relevant form of self instruction. I do not remember specific dates or set periods of training.

(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 :

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

(b) When was it provided?

(c) What form did it take?

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

I do not remember specific training in relation to hyponatraemia, it was part of the general management of many aspects of fluid balance in paediatrics, and came under the treatment of

almost every medical condition. Children who required IV fluids were generally the most critically patients on the ward and their management would have been regularly reviewed by a registrar or consultant. The management of fluid therapy in neonatal units was very structured and we were trained informally as SHO's by registrars how to use computer TPN (Total Parenteral Nutrition) programmes to work out fluid balance, additives for electrolyte deficiencies and volumes of IV and enteral (oral route) fluids on a daily basis.

(4) Decribe in detail your experience, prior to April 2000, of dealing with children with hyponatraemia including :

(a) Estimated numbers of such cases;

(b) Nature of your involvement;

(c) Outcome of the cases.

I am unable to quantify the numbers of cases that I dealt with as a paediatric registrar prior to 2000. My understanding of the definition of hyponatraemia was as follows: mild hyponatraemia if the sodium level was below 135 and severe hyponatraemia if below 130. There were many children admitted with mildy low sodiums that did not get IV fluids and spontaneously recovered. As junior doctors in paediatrics we frequently saw children with mild dehydration who were managed with oral rehydration therapy and moderate-severe dehydration who had IV fluids. As I was involved in managing hundreds of children with dehydration, I do not remember how many had a sodium level below 135 or specific details of any cases. However, a sodium level of less than 135 was a common finding in general paediatrics.

(5) Describe in detail your experience, since April 2000, of dealing with children with hyponatraemia, including:

(a) Estimated numbers of such cases;

(b) Nature of your involvement;

(c) Outcome of the cases.

Since 2000, the training and management of IV fluid therapy in paediatrics has been formally addressed. I do not know exactly how many children I have dealt with who had moderately low sodiums and cannot recall any specific examples, but the number is likely to be hundreds. It is a relatively common finding to have mild hyponatraemia with dehydration in children, and also with respiratory illness (eg bronchiolitis). My involvement now as a consultant paediatrician is to oversee the general management, monitor electrolyte results and regularly review IV fluid prescriptions.

II. QUERIES REGARDING ENTRIES IN THE HOSPITAL NOTES

(6) *"Coroner (Dr Curtis on behalf of coroners) contacted by Dr Hanrahan- case discussed, coroners pm is not required, but hospital pm would be useful to establish cause of death +rule out other (symbol). Parents consent for pm."* **[Ref: 061-018-067]**

(a) Please confirm that you made this note in the records.

Yes.

(b) Were you present when Dr. Hanrahan's conversation with Dr Curtis (and/or the Coroner's office) took place?

I cannot remember if I was present and heard this conversation or not.

If so, please address the following matters:

(i) State the time and date of the conversation(s);

(ii) Provide full details of the conversation(s) that you heard and in particular, state precisely what you heard discussed in relation to the cause or circumstances of Lucy's death and whether a Coroners post mortem was required;

(iii) Was the Coroner's Office and/or Dr. Curtis told about Lucy's fluid management and the presence of hyponatraemia?

I cannot remember any details mentioned above.

(c) Whether or not you heard any aspect of the conversation(s) please clarify whether Dr Hanrahan gave you an account of his conversation(s) with Dr Curtis (and/or the Coroner's office). If so, provide full details of the account given to you by Dr Hanrahan.

I have written in the notes the fact that the conversation took place, but I cannot remember if Dr Hanrahan gave me an account of his conversation with Dr Curtis.

(d) Insofar as you are aware, why did Dr Hanrahan contact Dr Curtis (and/or the Coroner's office)?

My understanding was that he wanted to inform the coroner because she had an acute event which led to her death and the cause of this was not clear.

(e) Did Dr Hanrahan tell you, following his conversation with Dr Curtis and/or the Coroner's Office, that a death certificate could be issued?

I do not remember any conversation about writing a death certificate.

(f) Insofar as you are aware, why was it concluded that a coroner's post-mortem was not required?

I recorded the fact that the coroner did not want a PM but I do not remember what reason was given.

(g) What word(s) are denoted by the triangle symbol in the notes?

This symbol denotes "diagnosis".

(h) Who decided that a hospital post-mortem would be useful?

From the notes, I think it was a joint decision of Dr Curtis and Dr Hanrahan.

(i) Did you agree that a hospital post-mortem would be useful? If so, why?

I do not remember making any personal opinion on this.

(j) Explain fully the reasons, as you understood them, why a hospital post -mortem was considered useful in Lucy's case.

My understanding was that the request for a PM was to rule out other pathology, in particular brain abnormalities that had not been detected by previous investigations.

(k) Did you personally obtain the parents' consent for a hospital post- mortem?

I have written in her notes that Lucy's parents gave consent for a hospital PM but I do not recall who they gave their consent to. I was the neurology registrar, and as part of my job remit, I regularly transcribed notes on behalf of the consultants regarding the clinical decisions and management plans they agreed for their patients. Therefore I cannot say if it was me personally who sought their consent for PM, or if it was Dr Hanrahan.

(l) If the answer to (k) is yes-

(i) Describe fully the information you provided to the parents about the post- mortem and its purpose.

(ii) Did Mr and/or Mrs Crawford raise any issues that they wished to have addressed by the post-mortem?

I do not recall any details about the information provided to her parents. I did not record if her parents asked questions about the PM.

(m) Was the parents' consent to the hospital post -mortem obtained in writing? If so, please provide a copy of the consent document.

I do not know if her parents gave written consent as I have not recorded this (page 67) and there is no copy in her medical notes. I do not have a copy of any consent document. It is likely that the normal practice for consent for a hospital PM in 2000 was verbal, not written.

(7) *"Spoke to Pathologist Dr D.O'Hara*

- *Autopsy form*
- *Consent (written by parents)...*"**[Ref: 061-018-068]**

(a) Confirm that you made this entry in the notes.

Yes.

(b) Provide full details of your conversation with Dr O'Hara, and in particular;

(i) What did you tell Dr O'Hara about the circumstances of Lucy's death?

(ii) Did you give Dr O'Hara any information about the fluids Lucy received or her sodium levels? If so what information did you give him?

(iii) Did you discuss with Dr O'Hara the timescale within which the post-mortem was to be carried out and/or the report was to be available? If so provide full details.

(iv) Did you discuss with Dr O'Hara why a hospital post–mortem was to be performed and why it might be considered useful? If so, what did you tell him?

(v) **Did you identify to Dr O'Hara any specific issues which were to be addressed by the post-mortem? If so, provide full details.**

I do not have any recollection of the conversation I had with Dr O'Hara apart from what I have written in the hospital notes and the autopsy request form. I am unable to comment on the specific questions above as I do not remember any details that I have not written down. I recorded the fact that I spoke to the transplant team and then conveyed the message to Dr O'Hara that Lucy's heart was to be retrieved during her PM. On re-reading through her notes, it is clear that the consent referred to on page 68 relates to her parents' consent to retrieve Lucy's heart for valve donation at the time of the PM, which was a separate parental consent from that referred to on page 67 of the clinical notes.

(c) **Did you have any further discussion with Dr O'Hara, or any other pathologist, at any time about Lucy's case. If so, please provide full details.**

I do not remember speaking to any other pathologist about Lucy's case.

(d) **When, insofar as you are aware, was the autopsy carried out?**

It is stated on the autopsy report that her post mortem took place on 14.4.00 and I have no reason to think that it was not carried out at this time.

(8) *"14/05/00 Contacted by -re death certificate- spoke to Dr Stewart- had been waiting for pm result-pm result in front of chart"***[Ref: 061-018-068]**

(a) **Please confirm that Dr O'Donoghue spoke to you on 4th May 2000 about the issue of a death certificate. If so-**

(i) **Provide full details of that conversation.**

(ii) **Were you waiting for the post-mortem result before issuing a death certificate? If so, why?**

I do not recall having this conversation with Dr Dara O'Donoghue and as the registrar I would not expect the result to be coming to me; I would expect it to go to the consultant unless I was specifically asked to action some point on receiving it. There were other Dr Stewarts working in the Children's Hospital in Belfast, some were at consultant level, and I am not sure if this reference to Dr Stewart is me or not.

(b) **Did you consider the "*pm result*" referred to? If so-**

(i) **What exactly did you consider and when did you consider it?**

(ii) **What conclusions did you reach having considered the post mortem result?**

I cannot remember any of the specific details; it is clear that Dr O'Donoghue spoke to Dr Hanrahan about the PM result on 4.5.00.

(c) **Why, insofar as you are aware, had a death certificate not been issued before 4 May 2000?**

I have no recollection of the reasons for the death certificate being issued on 4 May 2000.

(d) **Why, insofar as you are aware, was a death certificate not issued before the autopsy?**

My understanding in the event of having an autopsy, it is not normal practise to issue a death certificate before the preliminary autopsy results are known.

III. QUERIES ABOUT THE AUTOPSY REQUEST FORM [Ref: 061-022-073 - 075]

(9) Please confirm that you compiled this document.

Yes.

(a) Did anyone assist you in compiling this document? If so-

(i) Identify the person(s) who assisted you.

(ii) Provide full details of the assistance which was provided.

I do not recall anyone assisting me with this document. It was part of my role as a registrar to complete this document and I felt that I was relating the relevant clinical facts that were known and understood by the anaesthetists and neurologists looking after Lucy.

(10) Did you discuss with anyone what should be included in the document.? If so-

(a) Identify the person(s) with whom you discussed this.

(b) Provide full details of the discussion.

I cannot remember if I discussed the form with anyone either before or after it was completed.

(11) When stating that Lucy was *"given IV fluids(No.18 +N.Saline)"[Ref: 061-022-073]*

(a) What was your source for this information?

This information was taken from the facts on the fluid balance sheet, medical notes and nursing notes sent from the Erne Hospital when Lucy was transferred to PICU in RBHSC. These IV fluid solutions were widely used at that time and were common practice in paediatric management. I had no part in the prescription of these fluids given in the Erne Hospital.

(b) What significance did you attach to this information?

This was part of the general information documented from her clinical history.

(c) Did you consider the rate and volume of fluids administered? If so, explain what consideration you gave to this. If not, explain why you did not.

I did not include specific details such as rates/volumes of any of the fluids she was given; these were regularly used fluids at that time in paediatric practice and the autopsy form did not request these details.

(12) Why did you draw attention to the fall in sodium from 136 to 126 at the Erne Hospital [Ref: 061-022-073]?

The form asked for investigations therefore I recorded the abnormal results which I considered to be relevant. I included her sodium levels as they had fallen, the results of the CT scan of her head and EEG, which were all very abnormal.

(13) Did you give consideration to the possible cause(s) of the fall in sodium from 136 to 126 at the Erne Hospital. If so explain what consideration you gave to this and what conclusion you reached. If you did not, explain why you did not.

I was stating the facts of her lab results, not concluding what had caused all her abnormal results.

(14) Explain why you included "*hyponatraemia*" in the "*Clinical Diagnosis*" section [Ref: 061-022-073]. In particular-

(a) Did you consider that hyponatraemia had, or might have, caused or contributed to Lucy's death? Whether you did, or did not , please provide your reasons.

(b) Did you consider what had, or might have, caused hyponatraemia?

I included "Hyponatraemia" as it was the biochemical fact of a low sodium level and recorded in both her notes from the Erne Hospital and RBHSC. After Hyponatraemia, I have listed "cerebral oedema, acute coning and brain stem death", which were the sequel of events leading to her death.

In completing this form, I filled it out as accurately as possible to the best of my knowledge at the time and gave a summary of the clinical findings with the facts as presented in her medical notes.

(15) Explain why you listed "*hyponatraemia*" in the "*List of Clinical Problems in Order of Importance.*" [Ref:061-022-075]

I felt that the list was in chronological order as she presented, initially with vomiting and diarrhoea, leading to dehydration, then hyponatraemia and then seizure.

(16) Did you consider what had caused Lucy to suffer a cerebral oedema? If so, please provide full details of your consideration.

I do not remember any details apart from what I have recorded; the fact she was having a PM was to try to ascertain the cause for her cerebral oedema.

(17) Did you raise as a question for Dr O'Hara to discover what had caused Lucy to suffer a cerebral oedema? If so, please identify where this question was raised. If not , please explain why not.

I do not remember speaking to Dr O'Hara about her cerebral oedema; my role in discussing with him about her autopsy was in relation to her heart valve donation on behalf of her family. I was aware that Dr Hanrahan, consultant, had discussed the finding of cerebral oedema with Dr O'Hara.

(18) Did you provide Dr O'Hara with any other documents, or copies of documents, apart from the autopsy request form? If so, identify what additional documents, or copy documents you provided to him.

No other documents were provided to the best of my knowledge; I cannot remember any additional forms.

(19) Why is it stated on the Autopsy form [Ref: 061-022-075] that neither you nor a colleague would be attending the review session on the day of the autopsy? In particular-

(a) What consideration was given to this question and by whom?

(b) If it was decided that none of the clinicians would attend the review session, explain the reason for that decision.

(c) Did you or a colleague attend the autopsy or any subsequent review session with the pathologist? If so please provide details. If not, explain why not.

It was not normal practice for a paediatric registrar to attend an autopsy review session. I do not remember being asked to attend and do not remember ever being at an autopsy review throughout my paediatric career.

(20) Did you give consideration to preparing a death certificate at the time of completing the Autopsy request?

(a) If you did, provide details of the consideration given.

(b) If you did not, explain why you did not.

I do not remember being asked to complete a death certificate. It was considered best practice to have the preliminary autopsy results before completing a death certificate. I do not remember any discussion relating to me writing a death certificate on the day that she died.

IV. QUERIES ARISING FROM YOUR POLICE STATEMENT DATED 7th APRIL 2005 [115-022-001/002]

(21) *"I was on call on 13 April 2000 when Lucy Crawford was admitted to RBHSC. I accepted by telephone her transfer from the Erne Hospital around 6am; she arrived in PICU at approximately 7.45 am. Along with the SHO in PICU and the Consultant Anaesthetist I spoke to Dr O'Donohoe from the Erne Hospital who transferred Lucy. I took a medical history and examined the patient. The anaesthetist and SHO both made admission notes. The staff in PICU contacted the Erne Hospital that morning to request a copy of Lucy's medical notes and to clarify what treatment she had received prior to arrival at RBHSC."*[Ref: 115-022-001]

(a) Identify the SHO and the Consultant Anaesthetist to whom you refer.

The SHO was Dr Louise McLoughlin and the anaesthetist was Dr McKaigue.

(b) Did Dr O'Donohoe give you any information about the type, volume, and/or rate of fluids administered to Lucy at the Erne Hospital?

I do not recall getting specific information about the type or volume of fluids she had been given from Dr O'Donohoe. Information relating to fluid management was not available until her Erne notes were faxed at a later time.

(c) Identify, insofar as you can, who contacted the Erne Hospital to request a copy of the medical notes and to clarify what treatment she had received prior to arrival at the RBHSC.

Dr McLoughlin has written in her notes that Erne notes were requested for further info; but it is not clear which member of staff contacted the Erne to request them.

(d) Insofar as you are aware, what clarification was obtained as to the treatment that Lucy had received prior to arrival at the RBHSC?

The Erne notes (medical and nursing) and the fluid balance chart stated that Lucy had been given both No. 18 solution and Normal saline.

(e) Insofar as you are aware, at what date and time was a copy of the medical notes from the Erne received in the RBHSC?

The copies of Lucy's notes from the Erne were faxed to PICU the morning she was admitted. Dr Crean states in his ward round notes that he is waiting for faxes to be sent from the Erne. The date on the faxed information is 13/4/00 and there are two times stated - 08:53 at the top of the page and 09:51 at the bottom of the page. It is not clear which time relates to the actual time they were received in PICU.

(f) Did you personally read the medical notes copied by the Erne to the RBHSC? If so, when did you first read them?

Yes I read the notes at some point during the morning Lucy was admitted to PICU but I cannot remember what exact time I read them first.

(22) *"I stated on the Autopsy form that the Clinical Diagnosis was Dehydration and Hyponatraemia, Cerebral Oedema, Acute Coning and Brain Death. This was the working pathogenesis agreed by Dr Hanrahan and the anaesthetists, in the absence of a definitive aetiological diagnosis."*[Ref: 115-022-002]

(a) Identify the anaesthetists who agreed this "*working pathogenesis*".

The anaesthetists involved in looking after Lucy were Dr McKaigue, Dr Crean and Dr Chisakuta. There may have been others working in PICU who I cannot remember.

(b) Were you personally present when the "*working pathogenesis*" was agreed with-

(i) Dr Hanrahan

(ii) The anaesthetists.

If so give full details of the discussion(s) and conclusions reached.

I do not recall if I was personally present. From my reading of her notes it is likely I was there as I recorded the clinical facts and the general thoughts about Lucy's condition from Dr Hanrahan and from the anaesthetists. My role as the registrar was to transcribe the conclusions of any discussions between the professionals in whatever notes I made, to the best of my ability and knowledge. These were not my own personal opinions. I do not remember specific detail apart from what I have written.

(23) *"I understand that there has been a suggestion that I was the first Clinician to make reference to the condition of hyponatraemia with regards to Lucy. This is not the case. Hyponatraemia is one of several biochemical abnormalities that Lucy was suffering from at the material time. For example she also had a low potassium level; the medical term for this is Hypokalemia. Any trained medical person would recognise that Lucy was suffering from a range of biochemical abnormalities. There is no significance attached to the fact that I wrote the term "Hyponatraemia" in her medical notes and records."*[Ref: 115-022-002]

(a) Identify any other clinician(s) who, to your knowledge, made reference to the condition of hyponatraemia with regard to Lucy, and state by reference to any relevant notes and records-

(i) When, by what means, and in what circumstances, the other clinician(s) made reference to hyponatraemia?

It has been documented by Dr O'Donohoe in the Erne notes (page 47) that Lucy had a low sodium level and also by Dr McLoughlin in RBHSC notes (page 60), when Lucy was admitted to PICU. As mentioned earlier, hyponatraemia is the medical term for a low sodium level and consequently a reference to a sodium level of 127 is immediately recognised by a clinician as hyponatraemia.

(b)Identify the other biochemical abnormalities from which to your knowledge Lucy was suffering at the material time.

It is stated in the Erne notes that Lucy had a high urea (9.9) when she first had blood tests (page 46), and after her seizure, a second set of blood tests showed a low potassium (2.8; page 47) and a high blood glucose (12; page 47) as well as a low sodium (127; page 47). When she was in PICU it is clear from Dr Crean's notes that Lucy also had a metabolic acidosis (page 65).

(c) Did you draw to the attention of the pathologist any of the other biochemical abnormalities to which you refer? If so, please give details.

I do not remember speaking to the pathologist about any of Lucy's biochemistry results. My conversation with Dr O'Hara was about retrieving her heart for subsequent heart valve donation.

(d)Did you include any of the other biochemical abnormalities either in the "List of Clinical Problems in Order of Importance" section or in the "Clinical Diagnosis" section on the Autopsy Request Form.

(i) **If you did, please identify where you did so.**

(ii) **If you did not, explain why you did not.**

I made a list of problems that I understood to be relevant in chronological order, and did not include all the abnormal biochemical findings in this list. I do not remember specific details about filling in this list.

(e) Explain what you meant when you said that there was "*no significance*" attached to your writing "*Hyponatraemia*" in the medical notes and records.

I have said in my statement that "*there is no significance attached to the fact that I wrote the term 'Hyponatraemia' in her notes*". My emphasis in this statement is the word "I". All the other professionals dealing with her case were aware of her abnormally low sodium. Hyponatraemia was a clinical fact, known from her transfer from the Erne Hospital. It was not an opinion or new diagnosis described by me alone. As stated previously, documentation of her abnormal sodium level was clearly recorded by several others.

(f) If writing "*hyponatraemia*" had no significance, why did you list "*hyponatraemia*" at (3) in the 'List of Clinical Problems in Order of Importance' in the Autopsy request form?

I stated that there was no significance to the fact that ***I wrote the term*** hyponatraemia. I did not mean that hyponatraemia had no significance. The other professionals looking after Lucy, and I, were all aware that she had a low sodium level, which is why I included it in the list of problems.

(g) Do you now maintain that there is no significance attached to the fact that you wrote hyponatraemia in Lucy's medical notes?

As noted in my responses to (e) and (f) above, there is significance to the fact that she had hyponatraemia, but there is no significance to the fact that '*I*' used this term.

V. OTHER MATTERS

(24) When, insofar as you are aware, was Dr O'Hara's post mortem report dated 13 June 2000 [Ref: 061-009-024/25] received by the RBHSC?

I do not know when this report was received by RBHSC.

(25) Did you read Dr O'Hara's post mortem report dated 13 June 2000? If you did not please explain why not. If you did, please answer the following;

(a) **When did you read it?**

(b) **Did it explain to your satisfaction the cause of Lucy's death? Whether it did, or did not, give reasons for your answer.**

(c) **Did you discuss the findings in the report with anyone else? If so, identify the person(s) with whom you discussed it, the date(s) on which the discussion(s) took place, and the substance of the discussion(s).**

(d) **Did you consider whether, in the light of Dr O'Hara's report, Lucy's death should be reported to the Coroner? Whether you did, or did not, give reasons for your answer.**

I do not remember reading the post mortem report at the time it was produced, nor discussing it with anyone else. It would be normal practice for such reports to be sent directly to the responsible consultant and as a registrar I may or may not have seen the report.

I have read through the report along with all her medical notes as a result of being questioned by the Inquiry. I am satisfied with the report and explanation given.

(26) Did you show or send Dr O'Hara's report of 13 June 2000 to anyone else? If so, identify the person(s) to whom you showed or sent the report, and , insofar as you can, the date(s) you showed or sent the report to them.

I do not remember seeing the final report dated 13.6.00 at the time, or indeed showing it to anyone else.

(27) Was Lucy's death and/or the cause of her death the subject of discussions between you and your medical colleagues in the RBHSC, other than those already described elsewhere in this statement?

If her death and /or the cause of her death was the subject of any such discussions please address the following matters:

(a) **Whom did you have such discussions with?**

(b) **When did such discussions take place?**

(c) **What aspects of her death and/or the cause of her death were discussed, and what views were expressed?**

(d) **Were any conclusions reached as a result of such discussions?**

(e) **Was any action taken on foot of such discussions?**

As a trainee paediatrician, any child death was taken very seriously and the circumstances of each individual death were a bitter experience for all the staff involved in the child's care. I felt for Lucy's family very much, losing their child; as did all the other staff that looked after her. It was a very sad experience for the staff in PICU. The events of a child's death in hospital would be typically shared with medical colleagues in a supportive and empathetic way. My main involvement with her family was in ascertaining if she was a suitable candidate for organ transplant donation, which was a new experience for me. I do not remember any specific discussions with other medical colleagues in the weeks and months after Lucy's death in any unusual way.

(28) State your knowledge or awareness, prior to 14 April 2000, of the cases of Claire Roberts or Adam Strain, and the issues arising from those cases and;

(a) **State the sources of your knowledge or awareness and when you acquired it;**

(b) **Describe how that knowledge or awareness affected your work.**

I had no knowledge of these children prior to the death of Lucy Crawford.

(29) State your knowledge or awareness , since 14 April 2000, of the cases of Claire Roberts or Adam Strain and the issues arising from those cases and;

(a) State the sources of your knowledge or awareness and when you acquired it.

(b) Describe how that knowledge affected your work.

Following the set-up of the Inquiry, I have been aware of both these cases, but do not know specific details about their individual development of hyponatraemia.

(30) Please provide any further points and/or comments that you wish to make, together with any documents in relation to:

(a) Lucy's death and /or the cause(s) of Lucy's death.

(b) Lessons learned from Lucy's death and /or the cause of Lucy's death and how that has affected your practice.

(c) Any other relevant matter you may wish to raise.

It is widely accepted that paediatric practice in fluid management has changed in the last 12 years, and is now much more robust with clear guidance and monitoring requirements. Training is formalised and structured and many useful teaching tools have been developed. As a consultant paediatrician now in 2012, I consider it my responsibility to personally review IV fluid charts on a daily basis and offer guidance to junior staff about optimum fluid management. This is different to the general clinical practice in paediatrics that was routine in the year 2000.

Since this event and the development of the Inquiry, my clinical practice has changed in some aspects, as I am more aware of the need for detailed note keeping in medical records.

During the year 2004, I was contacted at home by phone by a reporter who told me about the UTV insight programme about to be broadcast "When hospitals kill". I was shocked to be questioned about my involvement in Lucy's case out of the blue.

At the time, I did not have clear recollection of the details of her case, and had to refresh my memory by re-reading her notes.

My memory of Lucy in PICU is as a beautiful toddler with golden hair and a pretty denim dress, which her family said was her favourite. I remember the deep sorrow of her parents and older siblings when they were told the devastating news that she was brain dead and how they sincerely wanted her organs to be used to help another child or children. It was my first time to be directly involved in liaising with the transplant co-ordinator and I learned a lot from that experience.

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

Signed: C Stewart. **Dated:** 5.11.12