Witness Statement Ref. No. 282/2

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:	
WS-282/1	05-11-2012	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 to your statement.

(1) **At question 13 of WS-282/1 you were asked whether you gave consideration to the possible cause(s) of the fall in serum sodium from 136 to 126. You have not answered this question directly.**

It is understood that you did not address that question in the autopsy request form, but quite apart from this form, did you give consideration to what might have caused the fall in serum sodium? If so what consideration did you give to this issue, and what did you conclude?

If you did not give consideration to this issue please explain why you didn't?

I was the paediatric registrar at that time, not the consultant, and my role was to collate the results and highlight any abnormal findings. I stated the laboratory results in Lucy's notes and autopsy request form. I do not remember, at this far remove, what consideration I gave to the cause of the fall in her sodium level, and I would have felt that it was the consultant's role to conclude what had caused her abnormal results. I remember noting the fact, and simply stating that she had a low sodium level. Low sodium levels were often seen in paediatric practice in ill children. Dr Hanrahan, the consultant neurologist, outlined a list of possible differential diagnosis (including infective, metabolic, hemorrhagic causes) in her notes and a plan of investigations of causes of cerebral oedema.

My personal paediatric practice now as a consultant in a similar case would be to focus on the list of differential causes of cerebral oedema and the relationship of co-existing abnormal blood results. Back in 2000, I was a very busy paediatric registrar covering all the medical problems in the Children's hospital during the night and had many varied patients and problems to attend to. I do not remember any more specific thoughts I had about a cause for Lucy's low sodium and cannot comment further about this.

(2) **In answer to question 14 of WS-282/1 you have explained that you included hyponatraemia in the clinical diagnosis section of the form because it was part of the 'sequel' (presumably, sequence) of events leading to her death.**

You were asked at question 14(a), did you consider that hyponatraemia had or might have caused or contributed to Lucy's death. Please address this question directly. What consideration did you give to this issue, and what did you conclude?

If you did not give consideration to this issue please explain why you didn't?

I felt that Lucy's death was as a result of cerebral oedema. She initially presented with gastroenteritis and was very sick and dehydrated. It was noted that she had low sodium levels, but I do not remember thinking that this in itself had caused her death. I used the term "Hyponatraemia" to mean a low sodium level. I do not remember putting any other significance to this term. I listed it as a clinical finding, not an ultimate diagnosis. I did not infer by using the term "Hyponatraemia" that Lucy had "water intoxication" or "Dilutional Hyponatraemia", and I do not remember ever considering these in Lucy's case.

As I have stated above (question 1) I did not feel it was my role as a registrar to make conclusions about what caused Lucy's sodium to fall or if this had contributed to her death. It was clear she had an acute event in which she collapsed suddenly. At the time I understood this to have been due to acute coning of her brain from cerebral oedema.

(3) **In answer to question 17 of WS-282/1 you have explained that Dr. Hanrahan had discussed the finding of cerebral oedema with Dr. O'Hara. How were you aware of that discussion, and did it take place before or after the post mortem?**

I recall that it was Dr Hanrahan who spoke to Dr O'Hara to request a hospital post mortem when the coroner's office said a coroner's post mortem was not required. Dr Hanrahan informed me he had requested a hospital post mortem but I do not recall hearing his conversation with Dr O'Hara, which took place before the post mortem. I am aware of this as I filled out the autopsy request form after Dr O'Hara agreed to do the post mortem. I did not make a note in her chart about this but I have written in my PSNI statement (dated March 2005) that it was Dr Hanrahan who requested a Hospital post mortem, and my recollection in 2005 would be much better than now of the events in April 2000.

Insofar as you are aware what was discussed between Dr. Hanrahan and Dr. O'Hara in relation to the cerebral oedema?

I do not have any recollection of what Dr Hanrahan and Dr O'Hara discussed in relation to the request for a post mortem or in relation to Lucy's cerebral oedema. I do not remember hearing their conversation and did not make any clinical notes about this.

(4) **In answer to question 18 of WS-282/1 you have explained that it wasn't the normal practice for a paediatric registrar to attend an autopsy review session. Clarify whether it was the normal practice for any treating clinician to attend the review session and if so, who would normally attend in your experience?**

I answered in *question 19* of WS-282/1 that it was not normal practice for a registrar to attend autopsy review sessions. I was not aware of the responsible consultant attending autopsy reviews. I would respectfully suggest that your query about who attended the review session should be directed to the Trust.

(5) **You have explained in answer to question 22 of WS-282/1 how the working pathogenesis came to be recorded by you. Is it your recollection that you recorded the "clinical facts and the general thoughts" about Lucy's condition after a meeting with Dr. Hanrahan and the anaesthetists, or was this information communicated to you through some other means?**

My recollection of this statement was the general thoughts of the team in PICU who looked after Lucy, including Dr Hanrahan and the anaesthetists. They were agreed that she was brain dead as they carried out two sets of brain stem tests together on two occasions and have stated the diagnosis of cerebral oedema on the form. I do not have specific recollection of what conversations took place. However, I did not express my own personal opinion but the

opinion shared by the senior consultants in many of the ward rounds and discussions regarding Lucy's care. I do not recall any other way of communicating information at that time.

(6) **Arising out of your answer to question 22 of WS-282/1, explain precisely what you mean by a 'working pathogenesis' as distinct from a 'definitive aetiological diagnosis'.**

I meant the "working pathogenesis" to mean the sequence of problems that affected Lucy and eventually led to her death. It is a term I have used to describe conditions, symptoms and clinical signs without having the full picture of knowing the underlying diagnosis. "Dehydration" was listed as the first problem in this working pathogenesis as that was the reason she was initially admitted to hospital. There are many causes of dehydration and therefore, in itself, dehydration is not a diagnosis. The working pathogenesis explains what is wrong with the patient, not what caused all the problems.

I meant the "definitive aetiological diagnosis" to be the key problem (or problems) identified which caused the patient's clinical condition. "Definitive" means clearly defined or formulated and "Aetiology" means cause of the disease. I meant looking for a specific cause for the various clinical conditions affecting Lucy which I had listed on the autopsy form. This was the purpose of having a post mortem.

(7) **In answer to question 23(f) of WS-282/1 you have clarified that in your police statement you did not mean to imply that hyponatraemia had no significance. Please explain what you understood was the significance of hyponatraemia in relation to Lucy at the time you completed the autopsy request form.**

When I completed the autopsy form, I attempted to summarize the clinical conditions that Lucy presented with. I listed them as dehydration, hyponatraemia, cerebral oedema, acute coning and brain death. These were listed as problems, not diagnosis. I felt that each problem was linked in the sequence of her illness. I was aware that Lucy had several biochemical abnormalities (low sodium and low potassium) which I felt were linked to her dehydration. At that time, I would have been aware that there were several factors in Lucy's case which could have accounted for these biochemical abnormalities as she had prolonged vomiting and also had a generalized seizure.

I do not recall attaching any particular significance to the term hyponatraemia, and in fact I do not even remember filling in this form. Again, I state that hyponatraemia was listed as a clinical finding, not an ultimate diagnosis. I did not infer by using the term "Hyponatraemia" that I thought that Lucy had "water intoxication" or "Dilutional Hyponatraemia", and I do not remember ever considering this term in Lucy's case. Please also refer to my response at (2) above.

(8) **Insofar as you are aware, did Dr. Hanrahan and the anaesthetists (Drs. Crean, McKaigue and Chisakuta) share your view of the significance of hyponatraemia in Lucy's case?**

As far as I am aware, the responsible consultants all agreed that Lucy had dehydration, hyponatraemia, cerebral oedema and brain death. I do not remember any difference of opinion about this or discussions about the results of her investigations. Dr Hanrahan requested several other tests to look for a cause of cerebral oedema. I do not remember if any of the PICU staff used the term "Hyponatraemia" or not, but it is clear that they all were aware of her low sodium levels and other abnormal results.

(9) **You have said in answer to question 25 of WS-282/1 that having read the post mortem report of Dr. O'Hara dated 13 June 2000, you are satisfied with the report and the explanation given. You are referred to Dr. O'Hara's report starting at Ref: 013-017-054. Please consider**

his report and explain by reference to the specific contents of the report why you have expressed yourself as satisfied with the report and the explanation given.

I feel that I am not qualified to give a professional view on a post mortem report as this is outside my area of expertise and I am not an expert witness in this Inquiry. I am not able to comment further.

Do you recognise the document at Ref: 061-005-012? If so, please explain what it refers to.

I do not recognize this document, and can only confirm that it is NOT my handwriting.

(10) **Please clarify the arrangements which were in place at RBHSC in April 2000 for receiving patient notes by fax from another hospital and for delivering them to relevant clinicians in PICU? Were the notes sent directly to an office within PICU, and did a member of admin staff place the notes on the patient's chart?**

As far as I remember in 2000, we had a fax machine in the PICU unit (clinical area) and requested faxes from both inside and outside RBHSC on a regular basis. It was common practice for both nursing and medical staff to request faxed copies of notes or documents to PICU. There was usually a ward clerk present in PICU for general administrative duties during normal working hours. My understanding was that he or she would have managed the fax machine by sending or receiving faxes on behalf of nursing, medical or technical staff in PICU. If so, a member of staff would have been told when the fax they were expecting had arrived. Outside normal working hours, the fax machine would have been managed by clinical staff working at the time in the unit.

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

Signed: C Stewart **Dated:** 25.1.13.