Witness Statement Ref. No. 283/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Anthony Chisakuta

Title: Doctor

Present position and institution: Consultant in Paediatric Anaesthesia and Intensive Care, RBHSC

Previous position and institution: Consultant in Paediatric Anaesthesia and Intensive Care RBHSC
[As at the time of the child's death]

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

- January 2000 – August 2012: Education Committee for Anaesthetic Training, Royal Group of Hospitals
- August 2007 – August 2012: Member of the Northern Ireland School of Anaesthesia Training Committee.
- January 2000 – August 2010: Member of Critical Incident Review Group, RBHSC
- January 2007- December2007: Panel Assessor for Confidential Enquiry into Maternal And Child Health (CEMACH) Child Death Review

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

062 -037-076 : Draft statement of my involvement in the care of Lucy Crawford (deceased) sent to the Litigation Management Office, The Royal Hospitals on request of Her Majesty's Coroner's Office (9/05/2003).

062-047-113: Signed statement of my involvement in the care of Lucy Crawford (deceased).

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 and the dates on which they were obtained.

Bachelor of Medicine and Bachelor of Surgery – 8th December 1984

Fellow of Faculty of Anaesthetists in Royal College of Surgeons in Ireland – 8th November 1991.

(b) State the date you qualified as a medical doctor.

1st June 1984

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

01/08/84 – 31/07/85 House Officer University Teaching Hospital (UTH), Lusaka, Zambia

01/08/85 – 31/07/86 Senior House Officer in Anaesthetics, UTH, Lusaka, Zambia

01/08/86 – 31/07/87 Clinical Attachment in Anaesthetics, Belfast City Hospital, Belfast

01/08/87 – 31/07/89 Senior House Officer in Anaesthetics, Belfast City Hospital, Belfast

01/08/89 – 31/07/90 Registrar in Anaesthetics, Belfast City Hospital, Belfast

01/08/90 – 31/07/91 Registrar in Anaesthetics, Royal Victoria Hospital, Belfast

01/08/91 – 31/07/92 Tutor/Registrar in Anaesthetics, Anaesthetic Department, Queen's University, Belfast

01/08/92 – 31/07/93 Registrar in Anaesthetics, Royal Victoria Hospital, Belfast

01/08/93 – 31/07/94 Registrar in Anaesthetics, Altnagelvin Area Hospital, Londonderry

01/08/94 – 31/10/94 Registrar in Anaesthetics, Daisy Hill Hospital, Newry

01/11/94 – 31/01/96 Senior Registrar in Anaesthetics, Royal Group of Hospitals Trust, Belfast

01/02/96 – 31/01/97 Senior Registrar in Paediatric Intensive Care, Great Ormond Street (GOS) Hospital for Children NHS Trust, London

01/02/97- 31/07/97 Senior Registrar in Anaesthetics, Altnagelvin Area Hospital, Londonderry

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

01/08/97 Consultant in Paediatric Anaesthesia and Intensive Care

(e) Provide a description of all the professional posts held by you since that date, giving the dates and details of your appointment in each case.

Consultant in Paediatric Anaesthesia and Intensive Care

(f) Describe your work commitments to the RBHSC from the date of your appointment at that Hospital to April 2000 stating the locations in which you worked and the periods of time in each department /location.

My work commitment to the RBHSC was divided between the operating theatres and Paediatric Intensive Care Unit (PICU). I anaesthetised children for their various surgical procedures in the operating theatres located mainly in the RBHSC, but also in the Ophthalmology / Ear, Nose & Throat theatre block for their eye operations. Every week on Fridays, from 08:00 hrs to 18:00 hrs, I looked after patients admitted to the PICU. During this period, I also attended to patients requiring admission to the PICU from the Accident and Emergency and the wards.

On one out of six nights when I was on out-of-hours on-call duty, I supervised trainee Anaesthetists giving anaesthesia in the operating theatres, and on occasions I would be the one anaesthetising, if the patient was either very young or very sick. I was, at the same time, looking after patients in the PICU with the help of a trainee Paediatrician. If the out-of-hours on-call included a weekend I had to carry out ward rounds in the PICU, which included examining each patient admitted to the unit, and also to attend to any new admission to the PICU.

(g) Describe your duties in the Paediatric Intensive Care Unit on 14 April 2000.

I do not have a detailed recollection of the 14 April 2000. The following is based on my interpretation of the notes and my general practice.

On this day I would have come to work in the PICU around 08:00 hrs. I would have done a quick ward round visiting all the occupied bed spaces in PICU finding out information about each patient from the nurse looking after that patient. It would have been during this ward round, when I read Lucy's notes, that I would have found out that Brain Stem testing needed to be done on Lucy. I would have then liaised with Dr Hanrahan, the Consultant Paediatric Neurologist looking after Lucy who would have then told me her clinical history and progress thus far. I would have read the clinical notes, looked at the documented clinical observations, and would have satisfied myself about the need to perform Brain Stem tests. The first set of tests was completed at 08:50 hrs. (061-019-070). My usual practice would be to inform parents of the outcome of brainstem death testing and I assume that was done although there is no note to confirm that.

At about 09:00 hrs I would have started a ward round which would have been attended by a Trainee Paediatrician who had been on out-of-hours on-call in PICU, a Trainee

Paediatrician on day duty, and the Sister in-charge of PICU. The second set of Brain Stem tests were completed at 10:30 hrs. My standard practice would be to advise parents of the outcome of brainstem tests and I assume that was done, although there is no note to confirm that. Dr Hanrahan phoned the Coroner's Office. Lucy was disconnected from the mechanical ventilator at 13:00 hrs. I continued carrying out clinical duties on the PICU patients, as necessitated by their medical / surgical conditions, until I finished my working day and handed over the care of the patients to the out-of-hours on-call Consultant in Paediatric Anaesthesia and Intensive Care.

(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 appropriate approach to fluid management in paediatric cases and if so please state:

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

Advice, training or education to inform me on the appropriate approach to fluid management in paediatric cases was provided to me by various sources including:

- Lecturer in anaesthetics as an undergraduate student in Zambia
- the various Anaesthetists (both consultants and senior anaesthetic trainees) who had supervised my training in anaesthesia and intensive care medicine in hospitals in Northern Ireland and England;
- Consultant anaesthetists presenting at national and international anaesthetic conferences and courses I had attended; and
- Authors of anaesthetic, paediatric intensive care and paediatric textbooks and peer reviewed medical and anaesthetic journals I read.

(b) When was it provided?

It was provided on an on-going basis as part of my continous professional development.

(c) What form did it take?

Formally, the advice, training or education was given during the lectures, courses and presentations at conferences / seminars, and informally during discussions with supervising consultants and colleagues in the operating theatres and Intensive care Units.

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

At various times in my professional development, different aspects of fluid management were covered. I don't have a specific recollection of what topics were covered or when or how they were covered but they would, generally speaking, have included:

- Formulae for calculation of fluid requirements;
- Choice of fluid for different clinical situations; and
- Monitoring of electrolytes

(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) (b), (c), (d)

I have incorporated into my answer in relation to hyponatraemia in my above answers at 2(a) to 2(d).

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

I cannot distinguish between my experience prior to April 2000 and thereafter.

(a) Estimated numbers of such cases;

I cannot estimate numbers of cases but it is not uncommon to see children with a low sodium. It is not usually symptomatic.

(b) Nature of your involvement;

Advising Trainee Paediatricians and Anaesthetists working in the PICU prescribing intravenous fluids containing eletrolytes to patients and on occassions I would personally prescribe the intravenous fluid in the operating theatre. I would also regularly review blood electrolytes of these patients on intravenous fluids.

(c) Outcome of the cases.

I cannot recall specific cases but do not recall any specific adverse outcomes.

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

Please see answer to (4) above.

II. QUERIES ARISING FROM YOUR STATEMENT TO THE INQUEST INTO THE DEATH OF LUCY CRAWFORD [Ref: 013-003-005]

(6) ***"On Friday 14th April 2000, I was on duty in the PICU. At 0850 hours and 1030 hours, Dr Hanrahan , Consultant Paediatric Neurologist and I carried out brain stem viability tests on Lucy and sadly they were negative. As a result brain stem death was diagnosed and following consultation with her parents, Lucy was disconnected from the mechanical ventilator at 1300 hours and by 1315 hours she had no heart beat. The Coroner's Office was contacted."*** **[Ref: 013-003-005]**

(a) What was the source of your information, or how were you aware, that the Coroner's Office was contacted?

After we had concluded performing the brain stem death tests on Lucy, Dr Hanrahan informed me that he was going to telephone the Coroner's office.

(b) Who contacted the Coroner's Office, and by what means?

Dr Hanrahan telephoned the Coroner's Office.

(c) **When (in relation to the time of Lucy's death) was contact made, with the Coroner's Office?**

The Coroner was contacted after the second set of brain stem death tests were performed.

(d) **Why, in your understanding, was the Coroner's Office contacted?**

The Coroner's Office was contacted because Lucy's death was sudden and unexplained.

(e) **Were you party to any discussion which considered the information to be given to the Coroner's Office in relation to Lucy's death or the circumstances of her death? If so, who participated in that discussion and what conclusions were reached?**

I have no recollection of any discussion with Dr Hanrahan about information to be given to the Coroner. However, the clinical history and the actions taken by the healthcare professionals, who looked after Lucy, were all documented in the case notes and I would have assumed that information would have been shared with Her Majesty's Coroner's Office.

(f) **Whether or not you were party to any such discussion, what information ought to have been reported to the Coroner's Office?**

See (e) above.

(g) **Were you present when contact was made with the Coroner's Office? If so, please detail, to the best of your recollection, the information given to the Coroner's Office.**

I was in the PICU, but not listening in to the conversation Dr Hanrahan was having with the Coroner's Office. I cannot, therefore, provide details of any information given to the Coroner's Office.

(h) **If you weren't present when contact was made with the Coroner's Office, was the outcome of that contact subsequently reported to you? If so, who reported this matter to you and outline your understanding of the decisions reached and actions taken following that contact.**

Dr Hanrahan informed me of the outcome of the contact with Coroner's Office. My understanding was that the Coroner's Office was not going to investigate Lucy's death and hold a Coroner's post-mortem examination. Since Lucy's death had been sudden and unexpected, Dr Hanrahan and I felt we should get a hospital post-mortem examination to get some answers.

(i) **Did you personally give consideration to the cause of Lucy's death? If so please provide full details of the consideration which you gave to this matter and to the conclusions which you reached. If you did not give consideration to this matter, please explain why not.**

Throughout the course of my clinical involvement in Lucy's care on 14th April 2000 I was giving consideration to the cause of her condition. Please see 14 (a) below.

III. QUERIES ARISING FROM A STATEMENT BY DR G.A. NESBITT TO THE PSNI [Ref: 095-010]

(7) *"Following Raychel's death and after discussion with colleagues in RBHSC, when it became apparent that the cause of death was cerebral swelling due to hyponatraemia, I decided to call colleagues in other hospitals I decided to call colleagues in other hospitals where children could be treated surgically. I believe that I made telephone calls on 13 June 2001... I spoke to Dr Chisakuta, a Consultant in Paediatric Anasthesia and Intensive Care in RBHSC about their use of No.18 Solution in post-operative surgical children and he informed me that they had been using precisely the same regime as Altnagelvin Hospital but had changed from No.18 Solution six months previously because of concerns about the possibility of low sodium levels."* [Ref: 095-010-040]

(a) **Please confirm that you were contacted by Dr GA Nesbitt following the death of Raychel Ferguson. If you were so contacted, please address the following matters:**

I have not been provided with the statement referred to, nor have I seen Raychel Ferguson's clinical notes. I do not have any independent recollection of the phone call Dr Nesbitt refers to above, nor do I have any recollection of being involved in Raychel's care.

(b) **On what date did Dr Nesbitt contact you.**

(c) **Explain your understanding of why Dr Nesbitt contacted you.**

(d) **Provide full details of your recollection of your conversation with Dr Nesbitt.**

(e) **Were you asked by Dr Nesbitt about the use of No. 18 Solution in post-operative surgical children by the RBHSC, or a question(s) to similar effect?**

(f) **Did you tell Dr Nesbitt that the RBHSC had changed from No.18 Solution six months previously or give him information to similar effect? If so please give full details of –**

(i) **What you told him;**

(ii) **The matters known to you at the time which caused you to provide that information.**

(g) **Did you tell Dr Nesbitt that this was because of concerns about the possibility of low sodium levels or give him information to similar effect? If so please give full details of-**

(i) **What you told him;**

(ii) **The matters known to you at the time which caused you to provide that information;**

(iii) **The particular concerns about the possibility of low sodium levels to which you were referring and how they had arisen.**

(8) **Did the RBHSC cease the practice of prescribing No.18 Solution to post-operative children?**

I do not recall a formal protocol or directive requiring clinicians to cease prescribing No. 18 solution to post-operative children. My recollection is that different specialties had different practices. As a Paediatric Anaesthetist I had limited involvement in the prescription of post-

operative fluids which were generally managed by ward medical staff. I do not recall the discussion that Dr Nesbitt refers to, or the scenario that he describes. Solution 18 was available (i.e. physically present) on the wards in RBHSC until around 2008. It is still available for specialised use in PICU and the renal unit.

If so, and insofar as you are aware-

(a) On what date was the practice of prescribing No. 18 Solution to post-operative children ended?

For non-specialised use, the practice of prescribing No. 18 Solution to post-operative children ended around March 2008.

(b) Who took that decision?

Hospital Management

(c) What were the reasons for that decision?

In order to comply with the recommendations from the two publications listed below:

- The National Patient Safety Agency (NPSA) Alert 22: *Reducing the risk of hyponatraemia when administering intravenous infusions to children;* and
- The DHSSPSNI Circular HSC (SQS) 20/ 2007, which informed Health and Social Care Trusts and other independent hospitals about the NPSA Alert 22.

(d) Was the decision taken in response to any particular incident(s) or circumstances? If so, describe the incident(s) or circumstances which brought about this decision.

Please refer to answer provided in (c).

(e) Was any other person or group of persons consulted before the decision was reached to end the practice of prescribing No.18 Solution to post-operative children? If so, identify all of those who were consulted in relation to the decision.

I was not involved in any consultation.

(f) If you were consulted in relation to the decision, did you contribute any view and if so what view did you express?

I was not consulted.

(g) Was the decision by the RBHSC to end the practice of prescribing No.18 Solution to post-operative children communicated to any of the following organisations or bodies:

I have no knowledge of this, and I cannot therefore answer questions (i) to (v).

(i) Any other hospital or trust;

(ii) The Eastern Health and Social Services Board;

(iii) The office of the Chief medical Officer

(iv) DHSSPS

(v) Any other organisation or body

And if the decision to by the RBHSC to end the practice of prescribing No.18 Solution was communicated to any of the above organisations or bodies, please state:

- What were they told about the reasons for discontinuing the use of No.18 Solution with post operative children?
- When were they given this information?

(h) If the decision by the RBHSC to end the practice of prescribing No.18 Solution to post-operative children was not communicated to any of the above organisations or bodies, please explain why the decision was not communicated?

Please refer to the answer given in question (g) above.

(9) If you are unable to answer any of the questions set out at (4) above, please identify any person who may be in a position to address these questions.

I do not know who could address these questions.

IV. OTHER MATTERS

(10) 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;

I had no knowledge or awareness of the cases of Claire Roberts or Adam Strain.

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

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

(11) 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.

My knowledge or awareness of the case of Adam Strain dates back to November 2004 when the Inquiry into Hyponatraemia-related Deaths was announced by the Minister of Health for Northern Ireland, and only became aware of the case of Claire Roberts around June 2008 after her name was added to the deaths to be investigated by the above named Inquiry.

(b) Describe how that knowledge affected your work.

It has raised the profile of the use of types of intravenous fluids and electrolyte disorders, specifically hyponatraemia, in the hospital environment.

(12) **Were you party to any discussion with any of your colleagues in the RBHSC regarding the completion of a medical certificate of cause of death in respect of Lucy? If so, please give full details.**

No, I did not take part in a discussion with my colleagues in the RHBSC regarding the completion of a medical certificate of cause of death in respect of Lucy.

(13) **Were you party to any discussion with any of your colleagues in the RBHSC regarding the referral of Lucy for a consent post-mortem? If so, please give full details.**

After Dr Hanrahan informed me that the Coroner's Office was not going to investigate Lucy's death and hold a Coroner's post-mortem examination, we discussed and agreed that a hospital post-mortem should be carried out.

(14) **Please look at the statement of Dr Caroline Stewart to the PSNI dated 9 April 2005 [Ref: 115-022-001]. At Ref: 115-022-002 she stated: *"I stated on the Autopsy form that the Clinical Diagnosis was Dehydration and Hyponatraemia, Cerebral Oedema, Acute Coning and Brain Death. This information was on the basis of the clinical information available, which was the working pathogenesis agreed by Dr Hanrahan and the anaesthetists, in the absence of a definitive aetiological diagnosis."* Arising from that:**

(a) **Were you involved in agreeing any such "working pathogenesis" in respect of Lucy?**

I looked after Lucy on the 14 April 2000 and conducted the brain stem tests. I do not recall any discussion about the working pathogenesis but I assume there was a discussion and I think I would probably have been involved in it. From reading the notes, I think if there was a discussion I would have been agreeing with the working pathogenesis that Dr Stewart has set out.

(b) **If you were, please fully describe:**

(i) **Who else was involved;**

Please see (a) above. Since I cannot recall this, I cannot assist further with this point.

(ii) **How this working pathogenesis was arrived at.**

Please see (a) above. Since I cannot recall this, I cannot assist further with this point.

(iii) **Whether consideration was given to the possible cause of the cerebral oedema, and, if so, the outcome of that consideration.**

Please see (a) above. Since I cannot recall this, I cannot assist further with this point.

(15) **Did you (or, insofar as you are aware, anyone in RBHSC) write a discharge letter in respect of Lucy to her GP? If so, please confirm the following:**

I did not write a discharge letter to Lucy's GP.

(a) **Provide a copy of the discharge letter;**

(b) **State whether the discharge letter was copied to the Erne Hospital, and if so, to whom.**

(16) **Did you complete or sign off a PICU Coding Form in respect of Lucy? If so, please provide a copy.**

I did not complete or sign off a PICU Coding Form in respect of Lucy.

(17) **Please outline the processes which were available within the RBHSC in the year 2000 to facilitate investigation or review of a death, where that death was considered to have been unexpected, unexplained, or where there might have been concerns that it had arisen out of an adverse clinical incident.**

I cannot provide an exhaustive list of processes. Hospital management would be in a better position to do that. From my own experience the most common forms of investigation were Coroner's investigation and hospital post mortems.

(18) **Was Lucy's death investigated or reviewed under any of the processes set out in your answer at 17 above? If so, outline the nature of any investigation or review which took place and the conclusions that were reached. If no such investigation or review took place, please explain why this omission occurred.**

The case was referred to the Coroner and a hospital post mortem was carried out. I am not aware of any other investigations but hospital management may be able to assist further.

(19) **Please look at Ref: 061-038-123 where it is stated-** ***"2. Lucy's death was discussed in the mortality section of an RBHSC Audit meeting. This meeting was chaired by Dr. R H Taylor, Consultant Paediatric Anaesthetist, Paediatric Intensive Care Unit, Royal Belfast Hospital for Sick Children, 10 August 2000."*** **(Ref: 061-038-123)**

Arising out of the foregoing please address the following matters:

(a) **What, insofar as you are aware, was the function or purpose of the mortality section of Audit meetings in the RBHSC?**

It was to review the full clinical details of a patient's illness leading to his / her death (including review of post-mortem results if available), with a view to learning lessons.

(b) **How often, insofar as you are aware, did mortality meetings take place in the period around 2000?**

It is my assumption that the Mortality and Morbidity meetings took place monthly when the audit meetings took place, unless the audit meeting was cancelled for whatever reason.

(c) **Describe the process, in 2000, by which a particular death was identified for discussion at Audit meetings, and outline the factors that determined that a particular death would be discussed?**

As far as I am aware, the Audit Co-ordinator in the RBHSC would identify all deaths listed in a register kept in the Accident and Emergency department of the RBHSC, and which had not been previously discussed. If the death was not a subject of the Coroner's investigation, the deceased patient's admitting consultant was asked to present the case at the Mortality and Morbidity section of an audit meeting.

(d) **Did you attend the mortality section of the Audit meeting which discussed Lucy's death on the 10th August 2000?**

No I did not attend the mortality section of the audit meeting which discussed Lucy's death on the 10th August 2000.

If so:

(i) **Identify all of those persons who attended that meeting and who were present when Lucy's death was discussed.**

(ii) **Describe the information that was given to the meeting in relation to the death of Lucy, and identify the person(s) who provided that information to the meeting.**

(iii) **Please outline and describe the matters that were discussed in relation to the death of Lucy.**

(iv) **Clarify whether the meeting discussed the relevance of fluid management in relation to Lucy's death? If so, please fully outline the nature of those discussions. If those matters were not discussed, please explain why they were not discussed.**

(v) **Clarify whether the meeting considered the case records from the Erne Hospital. If so, please outline the conclusions, if any, that were drawn from a review of those records.**

(vi) **Clarify whether the meeting made any assessment of the correctness of the treatment which Lucy received at the Erne Hospital? If so, please outline the conclusions if any which were reached following any such assessment.**

(vii) **Clarify whether the meeting reviewed the autopsy report which had been prepared by Dr O'Hara, or the death certificate signed off by Dr Dara O'Donoghue? If either of these documents were reviewed, please outline the conclusions , if any, which were reached following any such review.**

(viii) **Were any conclusions reached in relation to the death of Lucy following this discussion? If so, please outline the conclusions that were reached.**

(e) **Whether or not you attended the meeting, did you know that Lucy's death was discussed at the Audit meeting on the 10th August 2000?**

No I did not know that Lucy's death was discussed at the Audit meeting on the 10th August 2000.

If so please answer the following:

(i) **Did you provide any information or documentation for consideration at that meeting? If so, specify the information or documentation that you provided?**

(ii) **Who identified Lucy's death as one which ought to be discussed at the Audit meeting?**

(iii) **Why was Lucy's death discussed at the Audit meeting?**

All deaths which occur in RBHSC are discussed at one of the audit meetings.

(iv) **Did you delegate any member(s) of your clinical team to attend the meeting? If so identify the person(s) to whom you delegated this task.**

No, I did not delegate any member of my clinical team to attend the meeting.

(v) **Did you receive any information as to the discussion of Lucy's death at the meeting or the outcome of that discussion? If so, please provide full details of that information, and, if the information was in writing, a copy of the document in which it is contained.**

I have no recollection of having received any information as to the discussion of Lucy's death at the meeting or the outcome of that discussion.

(vi) **Insofar as you know, were any follow-up investigations or inquiries conducted after this meeting, or was any action taken on foot of what was discussed at this meeting? If so, fully describe the investigations, inquiries or action which resulted.**

I have no recollection of there being any follow-up investigations or inquiries conducted after this meeting or any action taken on foot of what was discussed at this meeting.

(vii) **Insofar as you know, were the circumstances leading to Lucy's death discussed between the RBHSC and the Erne Hospital/Sperrin Lakeland Trust before the Audit meeting on the 10 August 2000? If so, please outline the nature of those discussions and identify the persons who participated in them.**

I have no knowledge of whether the circumstances leading to Lucy's death were discussed between the RBHSC and the Erne Hospital / Sperrin Lakeland Trust before the Audit meeting on the 10th August 2000.

(20) **Following the Inquest into Lucy's death which took place in February 2004, were the issues relating to Lucy's death revisited by the RBHSC in the context of its audit arrangements or otherwise.**

Not to my knowledge, but hospital management might be able to assist further.

(21) **Apart from the discussion of Lucy's death as part of the mortality section of the Audit meeting on the 10 August 2000, was her death and/or the cause of her death otherwise the subject of discussions between you and any of your medical colleagues in the Royal Belfast Hospital for Sick Children at any time?**

I do not recall any such discussions. That is not to say they did not take place – medical staff often informally discuss cases. Lucy's case may well have been discussed by staff informally in that manner, but it was more than 12 years ago and I could not now speculate on what was discussed, when or by whom.

If her death was otherwise the subject of 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?**

(22) **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.**

Nothing further to add to the answers given above.

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

When teaching junior medical staff I now refer them to this inquiry and emphasise the importance of fluid management and monitoring of electrolytes.

(c) **Current Protocols and procedures**

In 2007 the Department of Health, Social Services and Public Safety produced regional initial management guideline of paediatric parenteral fluid therapy for children aged 1 month to 16 years. This guideline was released in wall chart format and is found in all clinical areas in the RBHSC. It can be found on www.dhsspsni.gov.uk/hsc_sqsd_20-07_wallchart.pdf.

In April 2011 the Belfast Health and Social Care Trust produced a hyponatraemic Guidance Note for Children and Young People (aged 1 month to 16th year birthday) to accompany the DHSSPSNI Regional Parenteral Fluid Therapy Wall chart. This Guidance note gives three important types of information, namely:

- List of triggers for completion of an adverse incident form;
- Availability of crystalloid intravenous fluids for children; and
- Sources of advice regarding fluid therapy for clinicians treating children.

In June 2011, the Belfast Health and Social Care Trust's Standards and Guideline Committee produced a policy for the administration of intravenous fluids to children from 1 month until the 16th birthday entitled "reducing the risk of hyponatraemia". It maps the advice issued in March 2007 from the National Patient Safety Agency (NPSA) and September 2007 from the Northern Ireland Regional Paediatric Fluid Therapy Working Group on how to reduce the risks associated with the administering intravenous infusions to children. The document is aimed at preventing hyponatraemia.

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

None

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

Signed: [signature] **Dated:** 29/11/12.