Witness Statement Ref. No. 283/2

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.
- March 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:	
WS-283/1	29-11-2012	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) You have indicated that you were a Member of the Critical Incident Review Group (RBHSC, January 2000-August 2012): WS-283/1, page 1. Please address the following additional matters:

Correction to the dates above when I served as a member of the Critical Incident Review group in RBHSC, it was from about March 2000 to August 2010.

(a) Describe your role as a member of the Critical Incident Review Group, and indicate the responsibilities which you exercised as a member of that Group.

The personnel that made up membership of the Critical Incident Review group in the RBHSC included representatives from medical (me), nursing and pharmacy departments. My role in the group was to bring a medical perspective to the deliberation on critical incidents, with a view to learning lessons. My responsibilities included:

- following up incidents involving medical personnel;
- sharing the findings with the individual(s) involved; and
- every 3 months to take turns with the other members of the review group to present critical incidents and lessons learnt at audit meetings held in RBHSC.

(b) What was the function of the Critical Incident Review Group?

This Multi-disciplinary group reviewed most of the critical incidents reported weekly in RBHSC, with a view to identifying lessons learnt and disseminating these lessons in RBHSC, and the rest of the Trust via Risk Management Directorate.

(c) When was the Critical Incident Review Group established, and when did it first commence its work in relation to a critical incident?

I am not sure of the exact date, but I think it may have been in March 2000, and the group met weekly to review the critical incidents reported.

(d) If a critical incident occurred, explain the process by which it was referred to the Critical Incident Review Group for review, and who was responsible for referring it?

When a critical incident occurred in any part of the RBHSC, an incident form (IR1 form), was completed in triplicate. A top copy went to the risk management and occupational health directorate, while a second copy went to the Nurse Manager in RBHSC, and the last copy was retained in the area where the incident occurred. The Incident Review Group reviewed all the incidents reported via the second copy to the

Nurse Manager in RBHSC. Hence there was no one individual responsible for referring the critical incident to the Review Group.

(e) What were the criteria which determined whether an incident was referred to the Critical Incident Review Group?

There were no criteria which determined whether an incident was referred to the Critical Incident Review Group, other than the necessity for an IR1 form to be completed. All cases, in which an IR1 was completed, were reviewed.

(f) How did the Group go about its work of reviewing critical incidents?

The Group met weekly. The incidents received that week were discussed; if an incident required further information, a designated member of the Group followed up the incident and fed back to the Group at the next Review meeting; and lessons to be learnt were formulated.

(g) Having reviewed a critical incident, who did the Group report its findings to?

Depending on the type of incident, the findings from that critical incident were reported to:

- the individual involved in the incident;
- the consultant responsible for a Trainee;
- the Sister in-charge of ward;
- the Line manager; and
- Risk Management Department.

Every three months a summary of the incidents received and lessons learnt were presented at an audit meeting by one of the members of the Critical Incident Review Group.

(h) Should Lucy's death have been treated as a critical incident?

It was not our role in the Critical Incident Review Group to decide what constituted a critical incident. If the Inquiry is asking my opinion, which is outwith my role as a factual witness, this might be more appropriately directed to one of the Inquiry's experts. I would observe however that it appears that if there was a "critical incident" in this case, it might be deemed to have happened in the Erne Hospital rather than the RBHSC, so that might have affected whether or not it was treated as a critical incident within the RBHSC. This is speculation on my part though.

(i) Should Lucy's death have been referred to the Critical Incident Review Group?

Had a critical incident form been completed on Lucy's death, the Critical Incident Review Group would have reviewed the incident. Please also refer to my comments at 1 (h) above.

(j) Was Lucy's death referred to the Critical Incident Review Group? If not, please explain why it wasn't reviewed?

No. There had been no critical incident form completed.

(k) **If Lucy's death was referred to the Group, please outline all of the steps that were taken as part of the process of review?**

Please see the response above in 1(j).

(2) **In answer to question 6(d) of WS-283/1 you have said that Lucy's death was "sudden and unexplained". Please explain what you mean by this – in what sense was her death *sudden* and *unexplained*?**

The clinical notes from the Erne Hospital (061-017-046 and 061-017-047) indicate that Lucy's clinical condition changed suddenly with fixed dilated pupils and requiring her breathing to be mechanically supported. In the clinical notes from the Erne Hospital (061-017-047) there is an entry following discussion with Dr McKaigue, that "? cause of respiratory arrest". Also, Dr Hanrahan had stated in the clinical notes (061-018-063) after examining Lucy on the 13 April 2000 and finding signs indicating no brainstem function that "there was no cause that was clinically evident as yet".

(3) **In answer to question 6(e) of WS-283/1 you have set out in general terms the information which should have been shared with HM Coroner's Office following Lucy's death?**

Should the Coroner's Office have been advised of the history of hyponatraemia in Lucy's case? Please fully explain the answer which you give.

Is the Inquiry seeking my opinion on this? That seems to me to be outwith my role as a factual witness. Perhaps it should be directed to one of the Inquiry's experts.

(4) **In answer to question 6(h) of WS-283/1 you have said that Dr. Hanrahan informed you of his contact with the Coroner's Office, and that it was your understanding that the Coroner's Office was not going to investigate Lucy's death.**

Did Dr. Hanrahan explain to you why the Coroner's Office was not going to investigate? If so, what were you told?

No, I do not remember being given an explanation as to why the Coroner's Office was not going to investigate Lucy's death.

(5) **In answer to question 6(h) of WS-283/1 you have described Lucy's death (following Dr. Hanrahan's contact with the Coroner's Office) as "sudden and unexpected" (as opposed to "sudden and unexplained").**

In this context please explain what you mean by this – in what sense was her death *sudden* and *unexpected*?

In the sense outlined at (2) above.

(6) **In answer to question 6(h) of WS-283/1 you have indicated that you and Dr. Hanrahan decided that a hospital post mortem should be arranged in order "to get some answers."**

Please explain why you thought a hospital post mortem was necessary, and in particular state the questions or the issues which you felt required to be answered.

As stated in the answer to Q. (2), Dr Hanrahan noted that Lucy exhibited signs suggestive of no brainstem function when he examined her on morning of 13 April 2000 while in the PICU (061-018-063). In the absence of Her Majesty's Coroner investigation of Lucy's death, we thought a hospital post mortem would shed some light as to the possible cause for Lucy's loss of brain stem function.

(7) **Did you consider the findings of the hospital post mortem? If so, did it satisfactorily answer for you the questions/issues which you felt required to be answered? Please fully explain the answer you provide. If the post mortem report did provide the answers required, explain how it did so.**

I have no recollection of seeing the findings of the hospital post mortem.

(8) **In answer to question 6(i) of WS-283/1 you have indicated that throughout the course of your clinical involvement in Lucy's care you gave consideration to the cause of her condition.**

Fully describe the factors that you took into account when you were giving consideration to the cause of Lucy's condition, and specify the conclusions which you reached.

I took into account her clinical history, condition and the views of the others involved. I agreed with Dr Hanrahan firstly, that the case be referred to the Coroner, and secondly that a hospital post mortem would be helpful. I would not have been in a position to reach "conclusions" as such but please see Q. (10) below.

(9) **When you gave consideration to the cause of Lucy's condition, did you take into account any of the following factors:**

(a) **The presence of hyponatraemia;**

Yes, I did.

(b) **The rate of fall of serum sodium from 137 to 127, within a short period, while Lucy was a patient at the Erne Hospital;**

Yes, I did.

(c) **The way her fluids were managed.**

Yes, I did.

If you did give consideration to any of these issues, please outline the conclusions which you reached.

I did not reach conclusions per se, but please see Q. (10) below.

If you did not give consideration to these issues, please explain why you did not do so.

(10) In answer to question 14(a) of WS-283/1 you have said that "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."

Please explain by reference to the notes and any other relevant factors why you believe that you would have been agreeing with the working pathogenesis set out by Dr. Stewart.

This is speculation since I have already said I do not recall a discussion. From the medical clinical notes faxed to the PICU from The Sperrin Lakeland Health and Social Care Trust, Lucy had clinical symptoms and signs of dehydration for which she was prescribed intravenous fluids (061-017-044 to 061-017-046).

She seems to have received intravenous fluids (061-017-049 to 061-017-050).

The serum sodium level was noted to have decreased from 137 mmol/l (measured at 8.30 pm on 12/04/00) (061-017-049) to 127 mmol/l (measured around 03.20 am on 13/04/00) (061-017-050), a condition referred to as hyponatraemia.

During the stress of illness, the body produces a chemical called Anti-diuretic hormone, which causes the kidneys retain the water. This also might have contributed to an increase in body water. In this situation, water tends to move from outside the cells into the cells causing them to swell up, a condition called oedema. When this happens to the brain cells, it is referred to as cerebral oedema.

Cerebral oedema can lead to coning and brain stem death.

This sequence of events seems to me to fit Lucy's case, so I speculate that if there was a discussion with Dr Stewart as has been suggested, that I would have been agreeing with her working pathogenesis

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

No, I do not recognize this document.

(12) 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?

I am not aware of any arrangements being in place at RBHSC in April 2000 for receiving patient notes by fax from another hospital and for delivering them to the relevant clinicians in PICU. The Belfast Trust might have an answer. However, the fax machine in the PICU is located in the PICU secretary's office.

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

Signed: [signature] **Dated:** 22/1/13.