Witness Statement Ref. No. 289/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Donncha Hanrahan

Title: Doctor

Present position and institution: Consultant Paediatric Neurologist, RBHSC.

Previous position and institution: Consultant Paediatric Neurologist, 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]

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

WS-289-1

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

Ref:	Date:	
WS-289/1	01-11-2012	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) **Arising out of WS-281/1, please identify the name of the consultant under whose care Lucy Crawford was admitted to PICU?** I do not know for certain. I was not party to the decision to transfer and admit her to RBHSC.

(2) **Who was in charge of Lucy's care when she was a patient in PICU?** I am unsure. I do not recall formally assuming responsibility.

(3) **Arising out of your answer to question 7(d) of WS-289/1, it is noted that you did not document your concern about the appropriateness of the fluids administered to Lucy at the Erne Hospital. The question at 7(d) asked you whether you gave consideration to this issue. Please answer the question directly.** I cannot recall.

(4) **If you did give consideration to the appropriateness of the fluids administered to Lucy at the Erne Hospital, please address the following matters:** See (3)

(a) **When (approximately) did you give consideration to this issue eg. was it before Lucy's death, was it before you spoke to the Coroner's Office, was it before you spoke to Lucy's parents, or was it at some other time?** I cannot recall.

(b) **If you had concerns about the appropriateness of the fluids administered to Lucy at the Erne Hospital, specify what those concerns were.** I cannot recall specific concerns.

(c) **If you had concerns about the appropriateness of the fluids administered to Lucy at the Erne Hospital, what steps did you take to address this issue?** I cannot recall specific concerns.

(d) **If you had concerns about the appropriateness of the fluids administered to Lucy at the Erne Hospital, why did you not document those concerns?** I cannot recall specific concerns.

(5) **Arising out of your answer to question 10(a) of WS-289/1, please explain why you did not document the concerns of Lucy's parents about how she had been treated in the Erne Hospital?** I cannot recall. While I was clearly appropriately sympathetic towards Lucy's parents during their ordeal, and conversed personally with them on numerous occasions, I may not have considered it necessary to document this as part of her medical records.

(6) **Arising out of your answers to question 11 of WS-289/1, please clarify whether you are saying that you don't remember speaking directly to Dr. Curtis, or are you saying instead**

that while you remember speaking to him you don't remember the details of the conversation? I do not recall speaking with him, although I clearly did so, judging from Dr Stewart's note.

(7) **Arising out of your answer to question 12(d) of WS-289/1, please consider the statement of Dr. Caroline Stewart to the PSNI dated 9 April 2005 [Ref: 115-022-002], when she said,**

> **"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 cannot recall, but I worked closely with Dr Stewart at that time. She was right to detail the above features, including hyponatraemia, since 127 does represent this entity. This differs from my information to the coroner, since a level of 127, while hyponatraemic, is not in my opinion severe enough to result in dilutional hyponatraemia and coning. Dr Stewart specified Lucy's sodium value on the form, but Dr O'Hara, like me, did not identify this as severe enough to be causative of Lucy's demise.

(b) **If you weren't involved in agreeing any such working pathogenesis, would you nevertheless have agreed at that time with what Dr. Stewart had recorded in the Autopsy form?** Yes

(c) **If you were involved in agreeing any such working pathogenesis, please address the following:**

(i) **Who else was involved?** I cannot remember

(ii) **How was this working pathogenesis arrived at?** I cannot remember, but it is most likely that it was arrived at by verbal discussion.

(iii) **Whether consideration was given to the possible cause of the cerebral oedema, and, if so, the outcome of that consideration.** I cannot remember. The post mortem was carried out to try and elucidate this.

(8) **Do you consider it likely that you would have discussed your interest in the post mortem and the reasons for it with Dr. O'Hara before the autopsy was performed?** I do not believe this to be likely.

(9) **In answer to question 13(e) of WS-289/1, you say that you do not recall considering the Post Mortem Report. Do you consider it likely that you did consider the report?** I do not believe this to be likely

(10) **In answer to question 13(f) of WS-289/1, you have said that you do not recall a discussion with Dr. O'Hara about the findings of the post-mortem? Do you consider it likely that you did have such a discussion?** I do not believe this to be likely

(11) **Arising out of question 14 of WS-289/1 and your answer to it, please address the following matters:**

(a) **What did you discuss with the Coroner's Office before interviewing Lucy's parents on the 9 June 2000?** My response to WS-289/1 refers to my conversation with the coroner's office immediately following Lucy's death and not to the 9th June.

(b) **Who in the Coroner's Office did you speak to, and what were you told?** I cannot recall directly, but judging from previous documentation, I believe that I spoke with Ms Maureen Dennison and Dr Curtis immediately following Lucy's death.

(c) **Did you make a record of your discussion with the Coroner's Office?** No.

(d) **At 14(f) you have indicated that you encouraged the parents of Lucy to seek clarification from the Erne Hospital because "the sentinel event occurred" there. At 14(g) you indicate that you have no recollection of attempting to clarify events at the Erne.**

Please address the following matters:

(i) **What particular issues did you think required clarification from the Erne Hospital?** I cannot recall my exact thoughts. Notwithstanding the expressed concern about the IV fluid administered to Lucy, the exact cause of death was not obvious at that stage in view of the seemingly modest drop in sodium measurement.

(ii) **Did you identify for Lucy's parents, the matters which required clarification at the Erne? If you did not do so, please explain why?** See (i) above

(e) **At 14(g) you indicate that you do not recall making attempts to clarify events at the Erne Hospital. At 14(i) you indicate that you do not recall the exact details of your conversation with Dr. O'Donohoe.**

Arising out of those answers please address the following matters:

(i) **Do you consider it likely that you brought to Dr. O'Donohoe's attention your view that fluid management appeared inappropriate?** I do not believe so, in the absence of correct information about the true degree of Lucy's hyponatraemia

(ii) **Do you consider it likely that you sought to obtain from Dr. O'Donohoe clarification of the events which took place at the Erne Hospital which precipitated Lucy's acute collapse?** I do not believe I did.

(f) **At 14(h) you have indicated that the "fluid management did appear inappropriate, both in the amount of Soln18 administered prior to Lucy's collapse and the size of the bolus of normal saline that she subsequently received. Lucy's cerebral complications were, however, due to hyponatraemia (secondary to the Soln 18), the degree of which I was unaware of at the time."**

Please address the following matters:

(i) **Did you advise Lucy's parents that fluid management appeared inappropriate? If you did not do so, please explain why?** I cannot recall.

(ii) **Whether or not you advised Lucy's parents that fluid management appeared inappropriate, did you discuss this issue with anyone else, or seek advice on it whether for the purposes of assessing the implications that it had for Lucy or otherwise?** I cannot recall.

(12) **Arising out of your answer to question 16(a) of WS-289/1, identify the specific information which you did not have which you have described as "the most important link in the chain of events leading to her cerebral oedema".** This refers to the degree of Lucy's hyponatraemia. The lowest sodium level we were provided with was 127, which represents only a modest reduction from normal. I believe that she was markedly more hyponatraemic than we were led to believe since this level was taken following a large bolus of normal saline.

(13) **Please clarify the answer which you have given to question 16(c) of WS-289/1. Is it the case that the reason for Lucy's death was not entirely clear to you so that you could not exclude the possibility that Lucy had died an unnatural death?** To be sure that Lucy's death was unnatural, one would have required the full facts. These were not available to us. I therefore could not confidently have stated that the death was unnatural, which I could have done if the true nature of her hyponatraemia had been revealed.

(14) **Please clarify the answer that you have given in response to question 19(d). You were asked to give reasons for your answer. Why did you consider it appropriate to issue a death certificate?** I cannot recall discussions about her death certificate. I may have felt that the postmortem had given sufficient information to allow the death certificate to be written. I now accept that this was not the case.

(15) **Please clarify the answer that you have given in response to question 19(f)(i), as there appears to be a typographical error. The question asks you to describe in detail the consideration that you gave to the possible causes of the cerebral oedema in the context of certifying the cause of death.** I cannot recall the consideration I gave, but I believe that I suggested using the postmortem report for the completion of the certificate

(16) **In answer to question 19(f)(iii) you have clarified your view that the cerebral oedema was not due to dehydration.**

Please address the following matters:

(a) **Can you explain why the death certificate states that the cerebral oedema was due to or in consequence of dehydration?** No. In retrospect, this is clearly not the case.

(b) **At the time that the death certificate was completed, did you believe that the cerebral oedema was due to or in consequence of dehydration? If so, please explain how you reached that view and if applicable, identify the clinical features which supported that view.** I do not recall my exact thoughts at the time (ie whether the cerebral oedema was related to dehydration). I recognize that it was erroneous and I may have over-relied upon information from the postmortem report.

(17) **Arising out of your answer to question 20 of WS-289/1, please clarify whether it was your understanding that it was the practice of clinicians at the RBHSC to complete a discharge letter in circumstances where a patient has died, and if so, whose responsibility was it to write such a letter in Lucy's case?** It is usually the responsible clinician that completes discharge letters. It was not clear to me that I was the responsible consultant and I may have believed that I was involved only in a consultative role.

(18) **In answer to question 25 of WS-289/1 you have indicated that Lucy's death was discussed at a mortality meeting, but you haven't addressed that part of the question which asked you to outline the conclusions which were reached. Please complete your answer.** I cannot recall the proceedings since the practice at that stage was not to take minutes.

(19) **Arising out of your answer to question 26(iv), please address the following matters:**

(a) **Who made you aware that it was the policy at that time <u>not</u> to take minutes of what was discussed within the mortality section of the Audit meeting?** I cannot recall. Minutes were not circulated at that time but I do not recall an explicit statement being made to that effect.

(b) **Was that policy contained in a document so far as you are aware?** I do not believe so

(c) **What was your understanding of the purpose underpinning this policy of not taking minutes?** To allow learning in a non-judgemental, non-adversarial forum.

(d) **When did that policy change?** I am unsure

(20) **Arising out of your answers to question 26 of WS-289/1, clarify which clinician took the lead in presenting the circumstances relating to Lucy's death to the mortality section of the Audit meeting which took place on the 10 August 2000?** I do not know

If you made a presentation, and if that presentation was committed to writing, identify who that document was given to, or where (to the best of your knowledge) it is now? I do not

recall making the presentation. If I did, my usual practice is to speak directly to the issue rather than committing to writing.

(21) Consider the document at Ref: 030-007-012 which records:

"16.06.00: JO'D had informal meeting with Dr. Hanrahan, Paediatrician in Belfast and discussed the PM report."

Arising out of that document please address the following matters:

(a) **Did you meet with Dr. Jarlath O'Donohoe on the 16 June 2000 to discuss the post mortem report?** I have no memory of this and I do not believe I met with Dr O'Donohoe on 16.6.2000. I am unaware as to where this information came from.

If so,

(b) **Who arranged this meeting?**
(c) **Where did it take place?**
(d) **Who attended the meeting?**
(e) **What particular issues were discussed, and what conclusions were reached?**
(f) **Was a record made of the meeting?**

(22) **Do you recognise the document at Ref: 061-005-012? If so, please explain what it refers to.** I have no memory of this document, although it clearly is in my hand. I do not recognize it from Lucy's casenotes, so I cannot say for certain when I wrote it (although see below).

The first three lines detail, in turn: (a) IV - didn't cry; (b) 10-3 No doctor saw her; (c) Soln. These appear to refer to Lucy's parents' complaints about her treatment in the Erne Hospital. The first line reflects Lucy's unresponsiveness (in turn related to her worsening brain condition) in that she did not cry with the attempts at erecting an intravenous (IV) cannula, although it is unclear as to whether this refers to the previous repeatedly unsuccessful attempts at IV placement, or the successful cannulation by Dr O'Donohoe on his arrival. The second refers to the fact that no medical staff saw her while she clearly remained very ill. The third refers to "Soln". This may refer to the IV solution given, although I did not write Soln 18. I do not know if this was raised by me or by Lucy's parents, although, as mentioned above, including question 4, there was comment made at the time of Lucy's death about the IV fluid prescribed for her, even though by the time of this document being written, I was still unaware of the true severity of Lucy's hyponatraemia.

The last two lines refer to "Put in writing" and "Stanley". The first of these ("Put in writing") reflects, I believe, my advice to Lucy's parents, to formally document their concerns in writing. The second refers to "Stanley", who I believe to be Stanley Millar, who acted as an advocate for patients in the Western Board area. These two entries would imply that this document was written some time after Lucy's death, when Lucy's parents had considered the option of taking their concerns further, having learned about the potential involvement of Mr Millar.

(23) 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 do not recall.

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

Signed: [signature] Dated: 15/1/13