Witness Statement Ref. No. 291/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Trevor Anderson

Title: Doctor

Present position and institution: Retired

Previous position and institution: Clinical Director of Women and Children's Services, Erne Hospital
[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 - December 2012]

Nil

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

17/07/2000 Review of Lucy Crawford case (addressed to Mr Fee) Ref: 033-102-262

11/05/2005 Statement of Dr Trevor Anderson Ref: 115-054

04/05/2005 Summary of tape recorded interview with PSNI, Ref 116-038 and 116-039

02/11/2012 Enquiry witness statement WS291/1

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

Ref:	Date:	
WS-291/1	02-Nov-2012	Inquiry Witness Statement

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. FURTHER QUESTIONS ARISING FROM YOUR STATEMENT 291/1 TO THE INQUIRY

(1) **You are referred to your answer to question 1(d) of WS-291/1. The question asks you to explain your responsibilities, if any, with regard to clinical governance matters. You have not addressed the question asked. Please now do so.**

I was given no instruction or direction as to my role in clinical governance.

(2) **You are referred to your answer to question 6 of WS-291/1. The question asks you to describe the key features of the Trust's arrangements for clinical governance at that time, insofar as you are aware. You have not addressed the question asked. Please now do so.**

I was unaware of the Trust's arrangements for clinical governance at that time.

(3) **You are referred to your answer to question 7 of WS-291/1. The question asks you for a chronology of all of the steps taken by you in the exercise of your responsibilities in order to address any matter associated with the treatment and death of Lucy Crawford. You have not addressed the question asked. Please now do so, setting out chronologically every action you took.**

(i) I was told the next morning of the death
(ii) On same date I invited clinicians to make detailed notes
(iii) Several days later I was approached by Mr Fee who told me that Mr Mills had asked that he and I look into the matter.
(iv) There were several meetings with Mr Fee but I have no recollection of dates.
(v) I submitted my report dated 17 July 2000 [033-102-262]

(4) **In your answer to question 7 of WS-291/1, you indicate that you advised the clinicians to make comprehensive notes. Please address the following matters:**

(a) **Which clinicians did you speak to?**

Dr O'Donohoe and Dr Malik.

(b) **What was your purpose in speaking to the clinicians?**

To ask them to make a record of what happened while still fresh in their memories

(c) **What did you tell the clinicians? If you cannot remember precisely, explain what you told them in general terms.**

I asked them to record what had happened

(d) **What did each of the clinicians tell you? If you cannot remember precisely, explain what you were told in general terms.**

I cannot recollect precisely what they told me but generally it is reflected in the written records. [033-102-292 & 033-102-281]

(e) **Did you ask any of the clinicians to explain what they thought had happened to cause Lucy's deterioration? If you did not ask this question please explain why you didn't.**

I cannot recall specifically asking this question although I am likely to have done so.

(f) **Did any of the clinicians tell you what they thought had happened to cause Lucy's deterioration?**

I cannot recall what they said.

(g) **Why (for what purpose) did you ask the clinicians to make comprehensive notes?**

It was considered good medical practice to have a comprehensive clinical record.

(h) **Did the clinicians make comprehensive notes as per your advice?**

Yes.

(i) **Did you or anyone else receive the notes?**

I do not recall receiving them but there is a letter of 5 March 2000 which indicates that the note by Dr O'Donohoe was sent to me. [044-016-034]

(j) **If the notes were received, what were they used for?**

To assist in preparing an account of the relevant events.

(k) **Please arrange for the Inquiry to be provided with copies of the said notes.**

Copies have been provided. [033-102-292 & 033-102-281]

(5) **In your answer to question 13(c) of WS-291/1 you say that** ***"we wrote to medical and nursing staff involved asking for a factual report."***

Please address the following matters:

(a) **Who drafted the letters that were issued to medical staff?**

Mr Fee

(b) **Why were the letters which were issued to medical staff not appended to the Review report?**

I cannot recall.

(c) **Please arrange for the Inquiry to be provided with copies of the letters which were issued to medical staff.**

See copy letters at Ref: 044-020-040; 044-020-042; 044-020-044.

(6) **The question at number 23 of WS-291/1 erroneously refers to Nurse Swift writing to Mr. Fee on the 18 May 2000, whereas in fact it was Nurse T. Jones who had written to him. The Inquiry apologises for this error. If necessary, please revise the answer which you have provided in light of this clarification, and also address the following:**

(a) **You have said that the record was "*inaccurate*". Please refer to the Daily Fluid Balance Chart, and provide full details of the inaccuracies which you refer to.**

The record of intravenous amounts is not correctly tallied as Nurse Jones states.

(b) **Clarify, insofar as you are aware, whether those inaccuracies were brought to the attention of Dr. Quinn?**

I did not play any role in briefing Dr Quinn.

(7) **Arising out of your answer to question 27(a) of WS-291/1, please address the following matters:**

(a) **Did you personally consider it important for the Trust to obtain from the doctors information on the issues surrounding Lucy's fluid management, the fluids received by her and the doctors' views on the appropriateness of the fluids received by her?**

We received information which was confusing. As neither of us was a pediatrician we sought the views of an appropriately qualified paediatrician.

(b) **You have said that you understood that Dr. Quinn was addressing the matter of obtaining from the doctors involved information on the issues surrounding Lucy's fluid management and the fluids actually received by Lucy and their views on the appropriateness of the fluids that were given. On the basis of your understanding, how was Dr. Quinn going to obtain this information from the doctors concerned?**

I was unaware of Dr Quinn's proposed method of enquiry.

(8) **Arising out of your answer to question 34 of WS291/1 where you state that you do not recall interviews with doctors after they submitted their statements/reports, clarify whether you are saying that no such interviews took place or that you simply don't recall interviews taking place? If the former, please explain why arrangements were not made to interview doctors about the content of their statements/reports.**

I do not recall interviews taking place.

(9) **You are referred to your answer to question 38 of WS-291/1. The question asks you to explain the steps taken to involve Lucy's parents in the process of the Review and to obtain information from them. You have not addressed the question asked. Please now do so.**

I suggested consultation with them but had no further involvement. I have no knowledge of the steps taken to involve Lucy's parents.

(10) Arising out of your answer to question 42(c), of WS-291/1, set out fully what you were told by Dr. Halahakoon as part of her informal report.

To the best of my recollection she was critical of poor record keeping and poor communication but had no other criticism.

(11) Arising out of your answers to question 42(d) and (e), of WS-291/1, please clarify whether it was your understanding that Dr. Kelly interviewed Dr. Asghar for the purposes of the Review.

If so, please explain what consideration you or Mr. Fee gave to the views expressed by Dr. Asghar when carrying out your duties for the purposes of the Review.

I did not understand this interview to be part of the review.

(12) You are referred to your answer to question 45(a) of WS-291/1. The question asks you did you consider what further steps the Trust should have been taking to clarify the position in the absence of a *"clearly obvious explanation of the child's sudden death"*. You have not addressed the question asked. Please now do so.

I gave no further consideration to further steps to be taken by the Trust once I had completed the report and had passed it to the Trust.

(13) Arising out of question 45 of WS-291/1, please address the following additional matters:

(a) Indicate by reference to Dr. Quinn's report how you reached the view that mismanagement on the part of medical/nursing staff at the hospital had been ruled out?

Dr Quinn did not identify any specific mis-management.

(b) Did you subsequently become aware that mismanagement by staff at the hospital may have contributed to the cause of Lucy's cerebral oedema?

Yes

(c) If so, state the date on which you first became aware of this, and explain how you became aware of this?

I was unaware of the inappropriateness of solution 18 until it was implicated in the deaths of other children.

(d) If applicable, what specific steps did you take when you became aware that mismanagement by hospital staff may have contributed to the cause of her cerebral oedema?

I do not consider this to be applicable.

(14) **Arising out of your answer to question 51 of WS-291/1, please address the following matters:**

(a) **Specify the questions which the Review left unanswered.**

We could not be definitive about the root cause of the death in the light of the evidence we considered.

(b) **Fully explain why you and Mr. Fee felt that the matter could not be progressed any further.**

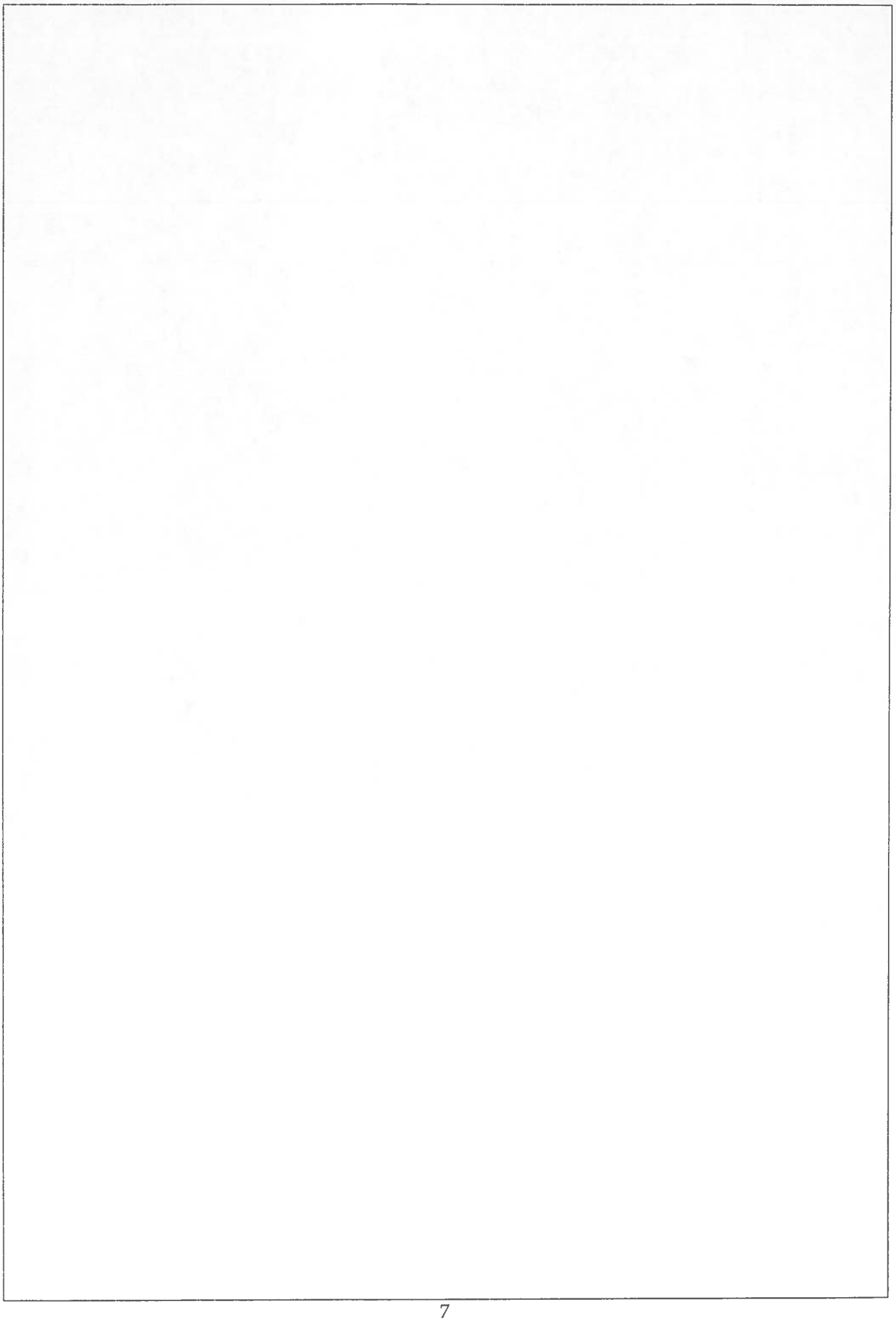
We were reliant on the paediatric expertise of others and could not progress it ourselves.

(c) **What consideration was given to taking further steps to address the issues raised by Lucy's treatment and death, following the Review? If there was a meeting to discuss this issue, for example, please give details.**

I had no further involvement after completion of the report.

(15) **Arising out of your answer to question 53 of WS-291/1, clarify whether you are intending to suggest that those conducting the Review did not appreciate that hyponatraemia was a feature of Lucy's case during the period of her treatment in the Erne Hospital? If this is not what your answer was intending to suggest, please clarify the position.**

That is correct. We did not appreciate that hyponatraemia was a feature of her case.



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

Signed: Tonia Anderson Dated: 31/01/2013