Witness Statement Ref. No. 338/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Elaine Hicks

Title: Doctor

Present position and institution:

Retired

Previous position and institution:
[As at the time of the child's death]

Consultant Paediatric Neurologist

Clinical Director Paediatrics Royal Hospitals Trust

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since the date of your last statement]

Nothing More

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

None

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

Ref:	**Date:**	
WS-244/1	17 May 2012	Witness Statement (Adam Strain)
WS-264/1	25 Sept 2012	Witness Statement (Claire Roberts)

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.

YOUR QUALIFICATIONS, EXPERIENCE, RESPONSIBILITIES

(1) Please specify any changes occurring in the period from October 1996 to June 2001 in respect of

(a) Your professional and or medical qualifications:

Fellow Royal College of Paediatrics and Child Health, 16 April 1997

Your job, role and functions:

On becoming Clinical Director Paediatrics, my job underwent the following changes:

I reduced clinical sessions to the Paediatric respite Unit, Belvoir Park Hospital and Neuro developmental At Risk Follow-up Clinic at The Royal Maternity Hospital, and these clinical sessions were replaced by work in clinical management.

I became the clinical lead in the Paediatric Directorate.

(b) Your responsibilities and accountability, including to whom.

As (b) above. As CD I was responsible for the staff employed in the directorate, for the budget, and for implementing Trust Policy as it affected the Paediatric Directorate. I was managerially accountable to the Chief Executive.

(2) Confirm that you were Clinical Director Paediatrics in the period between October 1996 and 2002.

Yes

(3) State the date on which you ceased to be Clinical Director Paediatrics

I believe it was 31 March 2002

(4) Describe your responsibilities as Clinical Director Paediatrics in 2000?

I do not have a copy of the job description and cannot remember the full details. I was responsible for the management of the Paediatric Directorate according to the policies in place at that time.

THE DEATH OF LUCY CRAWFORD

(5) **Lucy Crawford died in the RBHSC on 14 April 2000, following treatment at the Erne Hospital. When and how did you first learn of her death?**

As far as I recall it was around the time that the television programme was broadcast and the investigation established. I believe that was in 2004 However if her case was presented to the Paediatric Mortality meeting referred to at (13) below, I will have heard the presentation. I have no memory of any of that meeting.

(6) **Did you personally give consideration to the cause of her death? If so, provide full details.**

Not as far as I can recall

(7) **Was her death reported to you as Clinical Director Paediatrics?**

No

(8) **If her death was reported to you as Clinical Director, please state:** N/A

(a) **Who reported it to you?**

(b) **When was it reported to you?**

(c) **Give full details of what was reported to you?**

(d) **What was your understanding of why her death was reported to you?**

(e) **What action did you take?**

(9) **Would you have expected a child death in the RBHSC to be reported to you as Clinical Director Paediatrics in 2000 in any or all of the following circumstances:**

(a) **Where the death followed treatment at another hospital and where the cause of death was not clear?** No

(b) **Where the death following treatment at another hospital and was sudden and unexplained?** No

(c) **Where the death followed treatment at another hospital and clinicians in the RBHSC had concerns about her fluid management in the referring hospital?** Possibly, although as far as I recall there was no requirement to do so and no system or process for reporting of such situations at that time.

(d) **Where the death followed treatment at another hospital during which IV fluids were administered and the child became hyponatraemic?** As at (c) above

(e) **Where all of the circumstances at (a) to (d) above applied?** No

(10) **Did Dr Hanrahan discuss Lucy's case with you at any stage, whether or not in the context of a report to you as Clinical Director Paediatrics?**

At no stage did he discuss the details of the case with me. In 2004 around the time of the television programme and investigation, he spoke to me about the situation as it was affecting him.

(11) **If Dr Hanrahan did discuss the case with you please state:**

(a) **When did he discuss it with you?** As above

(b) **Give full details of the discussion.** It was a personal discussion relating to his reaction to the situation.

(c) **What action did you take?** I gave him personal advice.

(12) **Was Lucy's death and/or the cause of her death the subject of discussions between you and your medical colleagues in the RBHSC, or between you and those clinicians in the Erne Hospital responsible for treating Lucy?**

I have no recollection of being involved in any such discussions.

CLINICAL AUDIT MEETING 10 AUGUST 2000

(13) **Please look at the documents attached [Ref: 319-023-003 to 319-023-005]. These are said by the Trust to comprise copy attendance sheet for a paediatric audit meeting of 10 August 2000, copy minutes of the 10 August meeting, and copy redacted audit list for the meeting. The redacted audit list indicates that Lucy's death was one of those discussed at that meeting. Arising from this, please answer the following:**

(a) **Please confirm that your name/signature is on the attendance list.** Yes

(b) **Confirm that you attended the audit meeting on the 10th August 2000.** Yes

(c) **Why did you attend this audit meeting?** It was part of my job plan to do so

(d) **Describe fully your understanding of the purpose of the presentation and discussion of paediatric mortalities at audit meetings in 2000.** I understood the purpose of the mortality presentation and discussion to be to review the cases wherein children had died in RBHSC in a forum which included most of the clinicians working there.

(e) **Describe the form such presentations and discussions usually took in 2000.** As far as I can recall, the meeting would be chaired by the Audit Coordinator and each case would be presented usually by the lead clinician responsible for their care, on occasion with additional input from other clinicians involved eg a Radiologist might review the imaging (XRays). If there had been an autopsy the findings would then be presented by the Pathologist. The case would then be open for discussion by those present. On occasion a listed case would not be presented, eg if the lead clinician was unable to attend the meeting or if information was incomplete.

(f) **Who presented Lucy's case at the meeting?**

I do not know. I have no memory of the meeting

(g) **Please give details of the presentation and discussion of Lucy's case at the meeting.**

As at (f) above

(h) **Please give details of any follow up action in relation to Lucy's case following the presentation and discussion of her case at this meeting.**

I have no knowledge of this

CLINICAL GOVERNANCE IN PAEDIATRICS IN 2000

(14) **Please describe the arrangements for clinical governance in the Paediatric Directorate in 2000.**

I have no memory of the details. It would have been according to Trust Policy.

(15) **Describe what your responsibilities, if any, were for clinical governance in the Paediatric Directorate in 2000.**

As at (14) As Clinical Director I would have been responsible for implementing the policy in the Paediatric Directorate

PAEDIATRIC MEDICAL GUIDELINES-AUTOPSY PROCEDURES FOR CHILDREN DYING IN THE RBHSC

(16) **Please refer to the attached extracts from the document "Paediatric Medical Guidelines Second Edition July 1999 ("the Guidelines") [Ref 319-067a-001 to 319-067a-006 and 319-067a-030 to 319-067a-031]. At Ref: 319-067a-031 there is this:**

"For a hospital autopsy, the pathologist requires the written consent form and the clinical summary on a completed request form. When it is complete, the pathologist will telephone the ward with the result and a death certificate can be issued if this has not already been done."

Arising from this, please address the following:

(a) **What was the purpose of the Paediatric Medical Guidelines?**

To guide medical practice.

(b) **Were the Guidelines subject to a process of approval within the Paediatric Directorate? If so please describe that process.**

I cannot remember

(c) **Who contributed the section on autopsy procedures in the Guidelines?**

I do not know.

(d) **Was it considered acceptable practice in the Paediatric Directorate, in cases where a consent autopsy had been requested, for clinicians to await the result of the autopsy before issuing a death certificate?**

It would not be acceptable practice to await the full result as that would take many weeks and delay burial. What was usually done was that the clinician would speak to the pathologist immediately after the initial procedure to ascertain what had been found at that stage and then complete the death certificate accordingly, including initialling the box on the reverse of the form to indicate that further information might be available at a later date.

This is my memory and understanding of what occurred at that time.

If this was considered acceptable practice, what were the reasons for the practice?

N/A

OTHER MATTERS

(17) **Please provide any further points and/or comments you wish to make, together with any documents in relation to:**

(a) **Lucy's death and/or the causes of Lucy' death.**

(b) **Lessons learned from Lucy's death and how that affected your practice.**

(c) **Any other relevant matter.**

I have nothing further to add.

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

Signed: [signature] **Dated:** 13.05.13