notes from Inquest.

Adv. Sue ... 10.43.

Dr Han (Thus) [redacted]

Theela [redacted]

Brege [redacted]

① May 11+ times.

② Neville 6 - 10 times

— Dr Gannon —

③ Dr Kirby — 1925 1946 38 R60. (Rapid) 40 normal. Drowsy

④ Dr Curran 1984

H/o Na level 137 → 127 ? Notes — Can't remember

on arrival Na 145 RBHSC

9 - 9pm 13 In 1183 out 680

⑤ Dr Sumner.

⑥ Dr Evans.

* DDAVP — used in diabetes Insipidus

Y 3 doses 10.30 11.30 1320. 131

Arrived 7.45

WERE FAXED!! on 13 8.53 ✓ confirmed

Jacketh

Now use NI Regional transfer form agreed 6.40

Which includes medication times

Obs before tr

RBHSC does state Gastro Enteritis

P.G.

Dr Evans: Is 9.14 or 9.8 consistent — Yes.

: Is record keeping of Fluid out accurate — Yes.

: Not easy patients (toddlers) This is why we have childrens specialists

: Failure to note dehydration. Was considered YES. Not addressed

Mild + life threatening dehydration Mild mod etc + rely on clinical finding

eg ↓ BP mucosa (was moist) Urea 9.9 Mild → Mod. 5%.

in nappy 7.5 dil most generous to keep management.

Type: Dr Jenkins report. Copy report on fluids

043-134-282

LC-SLT

95 Case in Belfast.

Have become more pedantic. Have not had problem in our Unit Nothing new.
Recent years - not accurate statement
Ref DHSS protocol 2002 Dr Evans not aware of it.
Not familiar with NI Contract. Dr Evans has not exp in 21 years
Use of Soln 18 may be 2 schools of thought but my opinion not change my mind
Coroner - Summon said not new science
Even
There may be places it use 18 in other circumstances - dept in this and not
in low large volumes.
- Equip/procedure stated did not affect outcome. ? basis for this
- ? factual basis
Should be a check system to do quick & effective
Is this fact or from parent —— In Nursing Notes. Info not relevant
Pq/ Is it procedure or notes. Read statement Mrs C.
My exp had 1 acute events very vivid recall.
Pq basis is on Mrs C. statement

In Fav Diff Evans v Jenkins - No 18 is Something Absents 18 inappropriate
No 18 as maintenance should not be different - Agree.
Does ? agree with Summon/Coroner as fundamental error - Yes. Rate infusion - Absolutely.
? 3rd fundamental error 0.9 Soln at free flow - Very Serious Phys: Para 64 No record
Record keeping in general and of a clear Prescription - Absolutely Mandatory - to be followed
? Coroner raised publications re steps - Para 37 (1997) 1st edition 93.
How widely used - Does not sit on every childrens Ward. Probably
? Reference 30/3/01 Mr Crawford gov letter re Mills - outcome sentence - Have not seen
[illegible] - If assumed I would still have been
critical of basic errors. 12.10 Pm

✳ Coroner ✳
✳ Ref re Dr Quinn report. - Write to Med Dir Att & CMO re appropriateness of his views
Asked for Copy of Trust letters views.

Dr [redacted] –

Coroner

Why no paed ventil – have no paed ICU Children usually transferred

Make do with adult – Have acquired suitable adult ventilator. ? as recruit don't know

Will you keep have paed ICU – Will have ICU but not aware of paeds

Coroner – comment about lack of services in Wick. not acceptable.

– What would happen if anyone in same ? Delay a die waiting – Yes.

– Distances would be any diff you + Dr O'D. – No difference ; responsible for ongoing

– Ref helicopter use. Not to be undertaken lightly, weather RVH has NO helipad

Would be Alby help from EKN. Car import about no helipad.

Dr A. Process of transfer about Retrieval Service.

Can U say something about information re Dr Crean comment. – Practice in transfer

person given notes letter + given info. In this summary.

When U came on scene were U able to form view + what was wrong – Puzzling Did U consider

hypo – Yes when given lab results – Wasn't favor thoughts

Who responsible for fluids? Anaes – Intro of + in ICU only. On Ward Surgeons / Physicians

Sometimes in Consult + no

Comment about fluids – Too Much wrong fluid.

Mix ? 0.9% Saline on face not wrong – I am not sure how given when I arrived

Volume inappropriate ? Too Low – Should be regulated via pump

Given 3 litres. U would not Standard care given as proper quality – Many heard upset

care not up to standard Iye later letter from Trust No Certain of U.

Many fluids + equipment U frustrated – Yes ? Problem getting tubes – No Catheter from

Can't remember if there any difficulty 2nd page statem No reading ? When taken

Info given orally. Lab results back often likely cause of problem –

Have Trust indicated to family that fluids wrong – Not question for T.A

When Paed ventilator – ? inside you + whether contemplating ? Aware today Yes.

Coroner other big problems

Reason – ? considerable activity – Some Chaos – ? organised chaos yes. Could this appear panic Yes

Dpt of appeared Rude – Hum. Any diff + others – Not really. Not pleasant + take part

in of however. Good manners forgotten.

∴ Dr Smyth

Mr Mughan – U & Dr Malik assessed. Not first one. Initial assess S/N McD

Diff with vein ? at least 11 time → once in my presence Unsuccessful

U are aware had more than 1 unsuccessful.

? How long for Dr O'D to come – Anaes cleared were u present – yes

JOD to run fluids ? Dr Malik – Who was responsible JOD.

Rate instructed & length of time – Certain.

Dr Autterson & Dr Evans :- Med staff prescribe – Yes. Who records – Dr Malik recorded Rx.

Saw Dr Malik write on Fluid chart. Nature Soln for reference rate – At that time

not unusual. Chart asks for rate. Signed chart

When U aware of catastrophe – Did U know – After death

Was asked for statement. Dr Malik there for period before & after – Yes.

Are U aware he was asked for

Pq.

Paracetamol 6pm Lab Closed but 'On Call'. Tests done & reported

Did it affect staff

Sally McM

Is it SC first Completed Kardex. Who gave U info for Kardex. – A range of people & 2 doc.

I.V fluids to encourage output → S/N Smyth Fluids resp of Doctors – Yes.

Panic at Rescus Nurses comfort

P.S. Lot of movement. Yes. They taken – Radiog bleeped & brings. BP monitor on ward.

but brought Drug off ward – from I.CU. people phoning results etc.

Peoples perception can be very different looking on. (Good comment re?)

T Jones U indicated after vomit Dr Malik informed – No instructions

N/Saline run freely BM high Sugar Dr Malik said Saline & run free.

U heard 500mls & 400mls pressure bag What left in bag taken down → 100 ls

Appr 3:30 JOD unsuccess to intubate Present ē Dr Autterson → not with equip

JOD had used tubes & extras had to be got. Characterised activity to organised chaos

P.S. ? Everyone knows role – yes.

043-134-285

T. McCaffrey

No questions

A

S. McNeill Notes - JOO letter + transfer

Has said he had No access to Notes When he seen at 10.30 am

10.50

* Notes faxed 8.53.

Dr Hanrahan

Trans 13 Apr Returned 10.30. No access to notes.

11/4 - 2pm

Dr Curtis on behalf of Coroner.

Seen Parents twice + encouraged them to attend JOO

Coroner

Dr Anderson said Wrong + too much. Heard from Dr Sumner + Dr Evans.

How should cause of death be

1(a) Cerebral Oedem (b) Hyponat (Dilutional) (c) Excess dilute fluid (2) Gastric entritis

Dr Crean said Lucy dead leaving Ward.

2 sets Brain Stem

McGee

No Criticism of RBHSC treatment + gratitude to U personally

Fundamental errors in Soln + amt. Do you agree with these views - Yes but be need. Not an expert on fluid mgt. A more concent soln should This not appl after

Dr Anderson confirming - Coroner stopped questioning on

PG.

U do not consider expert on fluids - Correct.

1st Rtnrn 10[30] - No access to notes. See fax in RBHSC notes from S/L. - It may have come in RBHSC but would appear not to reach me. He confirmed this

#15

Dr Jenkins

obs 19[30] 22[30] 23[30] ↓37[4] (GAP) on observation sheet.

JOD 3.20. TA arrived 350. Pupils fixed dilated

Comments - typical of G. Enteritis.

Soln used is common in Maintain plus dextrose.

Initial finding >2 sec mucosa moist Urea ↑ 9.0 Dugg MILD ± normal electrolytes HOWEVER Replacement should ↑ 0.9 NaCl.

Convulsion more common El 251 app repeated im ↓ 127 K ↓ ↑ glucose

these values raise question on fluid mgt. there appears confusion

other Aspects demonstrate rapid response Both Consultants

2o adult I.CU in absence of Paed ICU transfer.

Recent years concerns about Soln 18. More approp ↑ Na DHSSPS

Must emphasise this recent. Rate rather than Level.

Certainly suggestion death from this. Confusion ± inadequate document

* Mgt fell below standard * Coroner Summer + Evan said same.

Coroner

Cause of death. - Agree with list.

2 other deaths - Death of Rach constituted catalyst for Protocol

Around same time we Removed Antrim.

Publications esp. J Jenkins

Conn Hopefully this will aid prevention

MI Fee

Dr Malik attempted + Called JOD. 3½ hrs for line to be inserted — Depends on skilled [illegible] 5-7% dehy. would not add

inserted I.V. as long as oral tolerated.

If attempt to IV comm 7.30 + achieved 11. - If Junior Doctor attempts + unsuc + either continue trying senior or visit + watch

No details asso of dehydration.

? Agree formal assess should be made. No formal assessment

? after ass + signs noted a call should be made by Dr of extent + plan of treatment

043-134-287

LC-SLT

11.30 Arrive.

? good practice to have recorded Coroner clarify results – Mr Fox to write to Coroner

Col JT – we did not normally write the actual calculation but do not accept necessary in all cases to show calcul plus results

BF – Advantage to have records ? understatement

Prescribing

MF ? In Jenkins deposition P. 3. Coroner intervention.

Mr Fox letter re Q. reference. Mr G. to Coroner.

Mr F U know Trust wrote to family that care was not inadequate ? U agree that Care Lucy received was substandard.

P. 2 deposition – Soln used is common for maintainance ? recent years more away

Sum: Evan said not correct in this case. – JT disagree.

? as only soln – Agree to make up deficit

Sum: Evan strange view that that was old news. J.T. Had not been well clarified in Paed literature.

R u saying confusion in N.T in 2000. – Yes there was a lack of widespread understanding. Not widespread knowledge: why Working Group done Protocol

BF Learned medical school: protocol only reminder – JJ. not the case.

Principles taught school: practical guidelines have not been adequately clear.

(Date 6 Feb 04) 7 Mar 2002 assigned upon. MF

BF Page 2 Comment suggest not common for dificit Est ? delay than single Soln

to was 18. JT In Young infant not necessily delay – Yes.

Coroner More on

JT References on Fluid Mgt → So this IS maintainence Book 1999.

Different views: diff practices were

BF U agree inappropriate to use Sol 18 – Trust Bolus Nacl: follows Soln 18

1st Para.

Fall in Na 137 – 127. Yes no alternative explanation for death.

Death – excessive dilute fluid. – Yes.

If no prescriptn have risk ? confusion about what: what rate. Know 10L

infected 30 hr but staff midwives doc – Agree grave state affairs.

Who resp for prescription Doctor – Yes. To avoid doubt Fluid: Rate – Yes

We know no such record exists. If someone gives script: doesnt write any full book

to avoid, Normally on pres sheet normally nurses put on

fluid sheet i.e 2 sources info.

043-134-288

Are U saying secondary records confusing — Yes diff to interpret & I find it difficult.

Rate of fall Na is crucial — I suggested in literature rate is important

JJ Yes Having heard evidence rapid fall cause of cerebral oedema

BF U speculated if Lucy's death catalyst — suggest unlikely if Trust did not consider lack of quality. Don't agree. Cons in RBHSC & initiated discussion

came to group June 2001

PL.

Were U member of Group - Yes. ? review literature JJ did searched world lit

? literature on ambiguity uncertainty — Found standard texts did not elaborate clarity as today. Were on in jour on routine reading. Had been Areas.

? BMJ 1993 not generalist Paeds. Were range of approaches. ? obj to clarity

Yes - clear statement on how to do but ended c̄ Guidelines — there is still room for differences. Guideline sets framework for decisions & highlights dangers of Hypo. We found commonly used with lack of clarity

? NI or Wider — Dis NI but articles Americ UK in 2003 Suggests still not clear see Oct 2003 Lancet General.

Turn Lucy → Na 137 degree of dehydration 5 - $7\frac{1}{2}$% - Agree. With this how would U approach — Est degree circulatory compromise Refill delay Rx Bolus 100mls 0.9 Saline & continued Water Deficit Na = with Na 137 no evidence of serious deficit so could use Soln 18. Important to address significant ongoing vomiting & included in Fluid prescription

? diff in using c̄ Lucy — Are U surprised this used JJ No. Generality in framework of other research.

P. 41 Dr Evans ? appropriate - This falls in range of opinion diff ways of dealing

[illegible] Calcul [illegible] would be high

? Dr Evans going averaging — Yes

Coroner Prescription was flawed = JJ. inappropriate as should have had bolus NaCl

Coroner Issue not about 18 bad medicine but appropriate No evidence not to use at all.

P.S ? Criticism of ward procedure ? Have you considered this — In context of Enve notes — mainly on Response times & senior available to stabilise.

an info senior staff responded on times etc Yes.

MDU.

Miss Wylie - only received instruction this am. Have Dr D will require his own advice

Cor 9.1. - same post

- proof representation

Coroner - Strongly oppose outrageous at this stage. As part of Trust Team Can be rep by Trust. JOD is not without legal rep.

Wants diff or additional - Expert reports were there with clear indicators No sudden justification Also clear account of fact ongoing nightmare Believe today final of legal investigation

Pg. Seeks to achieve balance on JOD a family. Balance

Coroner 'Books of Rules" Aware 1.35. today JOD had sought different legal Fairness JOD and not agreeing. -

Protection in Coroner legislation Rule 9.1. (1963) (2002)

Para 1. may refuse 'with serious allegats" Para 2. Coroner inform refuse to answer

Not reasonable Not fair to Crawford family

Not in interests of justice So far as Dr D'D

① - proceed to give evidence deposition questns Coron etc o obj to

or ② - to say anything might incriminate

Miss Wylie - Will advise to not give evidence.

Coroner - I can read disposition.

Recd pursuant to Rule 17

Resume 2.30 a Will

Coroner 2.35.

Cause of death

12 Apr 18 months old Case poor oral vomiting dig replacement therapy.

In moribund state trans after 6am. 13.15 14 April

Excess volume Collapse inapp fluid.

Failure to regulate rate of inf.

Errors comp by poor quality medical record.

2.40pm

Rule 23.2 → if delivers actions should be personal authority to take action.

Normally to Minister & CMO.

⇒ CMO is aware of circumstances of Lucy & Ra Feng.

⇒ Writing to her about 3rd body.

Mr Fee + Bodies to consider → ① Clear evidence before U of what is abnormal care. Compounded by Trust not recognising that lessons have been learned. Letter 2001 "No evidence ....."

Persisted to get answer what caused death — No satisfactory answer Door closed in face.

Civil proceedings another opportunity. Almost 4yrs civil case — not contest liability (long short of) Trust admission was in Anderson, first & only admission Aggravated by failure of Jud evidence might have assisted Steps — ① info may be useful to Coroner in relation to future ② ? matter info to GMC. may have an interest & assist in material to practising professionals? ③ Papers to DPP. ? Criminal offence may have been Happy to take advice of Coroner. Feel D not giving evidence not position to judge if should go. Lessons to be learned rather than individual criminal responsibility (Family not asking)

P.G

Comm Trust & family → process shared & info letter & document

Re Rule 23 → CMO corresp 2002 from D.C. No need for Hse

? GMC - to look at this & lessons to be learned. Protocol widely available?

? this will enhance info

? DPP – Cause ∩ death ? Are those omissions as Criminal offence. Errors ∩ Judgement are not Criminality. This verdict does not support.

Coroner Gross negligence ≠ manslaughter. Re not aware of any recent NI. This is not.

A Wylie – not in position. Clarified JOD told not to take stand.

Coroner:

(1) Ref CMO → Protocol disseminated nonetheless concerned both death & if paper to CMO. to consider with w/Party will advance area ∩ medicine ∴ worth effort.

(2) GMC → Reference should be made (Med Dir ∩ Hospital) →

(3) DPP → under 1972 may appear criminal. My view is that threshold not met ∴ not use powers. However PSNI can operate independently & do take different views. Not in decision

- Ack debt of every to SET for inviting & concerns. otherwise there would not have been a proper investigation.
- Hope has gone a long way to answer. Reassuring 3 expert draw same conclusions.
- Grateful to witnesses & candour ∩ the Coleraine ordeal & emotional Hopes no other child die same as Lucy.
- Fluid Pres resp Doctor BUT Nurses Must monitor & adhere.

Conclusion Deep Sympathy