re LUCY CRAWFORD Appendix 19. 20.4.00

I was the on-call anaesthetist on the night of Wednesday 12th April, 2000. At approx 03.40 on Thursday 13th April, I was phoned by switchboard and told I was needed urgently in the children ward — no reason was given. I arrived in children ward shortly after 03.50, to find a child in a side ward being manually ventilated by Dr. J. O'Donohue. I was told that the child had been admitted the previous evening with vomiting, and had had some offensive diarrhoea — presumptive diagnosis being gastroenteritis. There was a cannula in the right hand or arm, and I.V. fluids were being administered. The child was pale and unresponsive. Apparently, at about 03.00, the child had had some type of "fit" and was noted to have gone rigid. However, I was informed that at no time was the pulse absent, and cardiac arrest had not occurred. The child had had a pyrexia of 38°–39°c — ?? febrile convulsion.

I took over hand ventilation from Dr. O'Donohue, and noted that the pupils were fixed and dilated and unresponsive to light. I then proceeded to intubate the child with a Portex 4.5mm uncuffed endotracheal tube, which was secured with tape, and manual ventilation resumed with 100% O_2 as before

The child had been given rectal diazepam 4.5 mg after the "fit", so I asked for 100 micrograms of flumazenil (Anexate) to be given I.V. — there was no improvement in neurological status or level of consciousness. Throughout all this, the B.P was stable at between 80/50 and 90/60, and there was a sinus tachycardia of 130–135/min. SaO_2 was 98–100. U+E Na^+ 127, K^+ 2.5 — ?when sample taken.

A portable CXR and abdominal XR revealed what I thought was a normal chest and lung fields (no signs of aspiration), but the stomach and bowel were dilated with gas. I passed a small bore oro-gastric tube to deflate the stomach (undoubtedly filled with air due to the mouth ventilation earlier.)

The child needed CT scan of brain and a paediatric ICU. — a bed in P.I.C.U in RBHSC was arranged. In the meantime I decided to bring him to our ICU for stabilisation etc. prior to transfer.

Unfortunately, we had no paediatric ventilator suitable for a 17-month child who weighed approx 10 Kgs., but with some difficulty I was able to ventilate the child on a Puritan Bennett adult ventilator (V_T ~200, f 20, FiO_2 1.0). Despite the fact that the B.P was ~ 80/50 and

Hr. was 80-90 (S.R.), I was unable to palpate any peripheral pulses, and was unsuccessful in cannulating either femoral artery: I did not insert a central line, due to lack of recent experience with patients of this size — however, the peripheral I.V. line was satisfactory.

At this stage I replaced the oral E.T.T. with a nasal E.T.T. of the same size, without difficulty, in order to make the airway more secure during transport to R.B.H.S.C. Also, 25mls 20% Mannitol was given slowly I.V., and an I.V. antibiotic (Claforan if I remember correctly) was given.

The next problem was that none of my colleagues were available to cover me in the event of my going to R.B.H.S.C with the child: Fortunately, Dr. Asghar was available to cover Dr. Donohue, who kindly agreed to go with Lucy to Belfast.

The child remained haemodynamically stable, and at no point during the above became hypoxic.

The ambulance arrived at approx. 06.10. and left the Emc with Lucy, and Dr. O'Donohue provided manual ventilation with an Ambu bag, and an ICU nurse., at approx. 06.30.

At approx 08.30, I rang R.B.H.S.C. P.I.C.U.

And was informed that Lucy had arrived safely and was being stabilised on a ventilator. Sadly, there had been no improvement in neurological status, and this persisted until approx 12.00 the next day (Friday 14th April) when brain stem death was confirmed, and ventilation was discontinued.

This is as accurate a description of events that I can remember.

T.N. Anderson

DR. T.N. ANDERSON F.F.A.R.C.S.I

P.S. I anaesthetised Mrs. May Crawford for the LUSCS to deliver Lucy, approx. 17 months ago. Also, my wife (Dr. Elaine Connor) is the family's G.P.