Appendix 19

Statement: Dr T Auterson re Lucy Crawford

20.04.2000

I was the on-call anaesthetist on the night of Wednesday 12th April 2000. At approximately 03.40 on Thursday 13th April I was phoned by switchboard and told I was needed urgently in the Childrens Ward - no reason was given. I arrived in Childrens 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 intravenous 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° and there was a query 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. The child had been given rectal diazepam 2.5mg after the "fit", so I asked for 100 microgram of Flumazenil (Anexate) to be given intravenous - there was no improvement in neurological status or level of unconsciousness. 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 - Query when sample taken?

A portable chest x-ray and abdominal x-ray 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 manual ventilation earlier.)

This child needed CT scan of brain and a paediatric Intensive Care Unit - a bed in P.I.C.U at the Royal Belfast Hospital for Sick Children (RBHSC) was arranged. In the meantime, I decided to bring Lucy to our Intensive Care Unit for stabilisation etc. prior to transfer.

Unfortunately we had no paediatric ventilator suitable for a 17-month old child who weighed approx 9kgs, but with some difficulty I was able to ventilate the child on a Puritan Bennett adult ventilator (V_T200 -f20, FiO_2 1.0) despite the fact that the BP was 80/50 and heart rate was 80-90. 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 the lack of recent experience with patients of this size - however the peripheral IV line was satisfactory.

At this stage I replaced the oral ETT with a nasal ETT of the same size, without difficulty in order to make the airway more secure during transport to RBHSC. Also 25 mls 20% Mannitol was given slowly intravenous and an intravenous antibiotic was given.

The next problem was that none of my colleagues were available to cover me in the event of my going to RBHSC with the child. Fortunately, Dr Ashgar Staff Grade Paediatrics was available to cover Dr O'Donohue Consultant Paediatrician who kindly agreed to go with Lucy to Belfast. The child remained haemodynamically stable and at <u>no</u> point during the above became hypoxic.

The ambulance arrived at approximately 06.10. The ambulance left the Erne with Lucy, Dr O'Donohue who provided manual ventilation with an Ambu Bag and an ICU nurse, at approximately 06.30. At approximately 08.30 I rang RBHSC P.I.C.U and was informed that Lucy had arrived safely and was being stabilised on a ventilator. Sadly there had been <u>no</u> improvement in neurological status and this persisted until approximately 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.

Dr T.N. Auterson F.F.A.R.C.S