

S17

STATEMENT OF WITNESS

STATEMENT OF:

DOCTOR T AUTERSON

Name

Rank

AGE OF WITNESS (If over 18 enter "over 18"): OVER 18

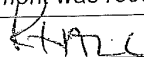
To be completed
when the statement
has been written

I declare that this statement consisting of 3 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 4th day of FEBRUARY 2005



SIGNATURE OF MEMBER by whom
statement was recorded or received



PRINT NAME IN CAPS



SIGNATURE OF WITNESS

I was the on-call anaesthetist on the night of Wednesday 12 April 2000. At approximately 0340 hours on Thursday 13 April I was phoned by switchboard and told I was needed urgently in the Children's Ward – no reason was given. I arrived in Children's Ward shortly after 0350 hours to find a child in a side ward being manually ventilated by Doctor 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 0300 hours 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 Doctor 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 4.5 mm uncuffed endotracheal tube which was secured with tape and manual ventilation resumed with 100% O₂. The child had been given rectal diazepam 2.5 mg after the "fit" so I asked for 100 microgram of Flumazenil (Anexate) to be given intravenous – there was no

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improvement in neurological status or level of unconsciousness. Throughout all this the BP was stable at between 80/50 and 90/60 and there was a sinus tachycardia of 130 – 135/min. SaO₂ was 98 – 100%. U&E Na127, 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 approximately 9 kgs, but with some difficulty I was able to ventilate the child on a Puritan Bennett adult ventilator (VT200-f20, FiO₂ 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. None of my colleagues were available to cover me in the event of my going to RBHSC with the child. Fortunately, Doctor Ashgar, Staff Grade Paediatrics, was available to cover Doctor O'Donohue, Consultant Paediatrician, who travelled with Lucy to Belfast. The child remained haemodynamically stable and at no point during the above became hypoxic. The ambulance arrived at approximately 0610 hours. The ambulance left the Erne with Lucy, Doctor O'Donohue, who provided manual ventilation with an Ambu Bag, and an ICU nurse at approximately 0630 hours. At approximately 0830 hours 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 no improvement in neurological

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status and this persisted until approximately 1200 hours the next day (Friday 14 April) when brain stem death was confirmed and ventilation was discontinued. This is as accurate a description of events that I can remember.

Certified a true copy of original

38/36a
11/03

SIGNATURE OF WITNESS

T. N. Auterson