Witness Statement Ref. No. 291/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: ANDERSON

Title: Doctor

Present position and institution:

Retired

Previous position and institution: Clinical Director of Women and Children's Services, Erne Hospital, Enniskillen 2000-2004

[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – August 2012]

Nil.

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

17/07/2000 "Review of Lucy Crawford Case" (addressed to Mr Fee)
11/05/2005 "Statement of Dr Trevor Anderson" ref 115-054
4/05/2005 "Summary of Tape Recorded Interview with PSNI " ref 116-038 and 116-039

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

Ref:	Date:	

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

I. QUESTIONS RELATING TO YOUR QUALIFICATIONS, EXPERIENCE AND CAREER BACKGROUND

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of April 2000:

(a) State your medical and professional qualifications, and the date on which they were obtained.

MB,BCh,BAO(1968)
D(Obst)RCOG (1970)
MRCOG (1973)
FRCOG (1986)

(b) State the date of your appointment to the post of Clinical Director of Women and Children's Services, and provide a description of all of the professional posts held by you before and since that date, giving the dates of your employment in each case.

See "Statement of Dr. Trevor Anderson" dated 11/05/2005 and also ref - 116-038

(c) Describe your duties and responsibilities in the role of Clinical Director of Women and Children's Services and provide a copy of your job description.

I have no record of a job description

My duties and responsibilities were to co-ordinate the organization and running of the Obstetrics and Gynaecology department, to see that there was organization and running of the Paediatrics department and to report to Mr Eugene Fee, the Director of Acute Hospital Services.

(d) Please explain what responsibility, if any, you had for clinical governance at the Erne Hospital and/or within the Sperrin Lakeland Trust, and if applicable, outline how you exercised this responsibility?

Clinical Governance was still a newly developing concept and was not yet formally developed, introduced or structured at that time.

(e) In any case where a patient had died at the Erne Hospital, and where that death was unexpected and unexplained, what were your particular responsibilities, and where did those responsibilities derive from?

My role was to gather information, to determine if any lessons should be learned or remedial action taken.

(2) Have you ever received any form of advice, training or education in order to inform you of the appropriate approach to fluid management in paediatric cases and if so please state,

No.

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

(3) Have you ever received any form of advice, training or education in order to inform you of the issues relating to hyponatraemia in paediatric cases and if so please state,

No.

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

(4) Prior to April 2000, describe in detail your experience of dealing with cases of hyponatraemia, including the

No experience.

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children.

(5) Since April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

None.

(a) **Estimated total number of such cases, together with the dates and where they took place.**

(b) **Nature of your involvement.**

(c) **Outcome for the children.**

II. STEPS TAKEN BY YOU FOLLOWING THE DEATH OF LUCY CRAWFORD

(6) **Fully describe the key features of the Trust's arrangements for clinical governance as they applied in 2000, provide any documentation which recorded those arrangements, and state,**

I was Clinical Director but my experience of clinical governance was limited to Perinatal Mortality meetings in my own discipline of obstetrics.

(a) **Did those arrangements apply in Lucy's case, and if so, why did they apply?**
No.

(b) **If applicable, how were those arrangements applied in Lucy's case? In particular, what steps were to be taken pursuant to the arrangements for clinical governance?**

None.

(c) **Were any arrangements in place by which incidents (such as the death of Lucy) would be examined by or within the Trust's management processes? If so, please explain those arrangements and how they operated in relation to the death of Lucy.**

Arrangements were made on an ad hoc basis. Clinical Incident reporting was just in its infancy.

(7) **Starting from the time at which you were first informed about the death of Lucy, outline chronologically all of the steps that you took in the exercise of your responsibilities in order to address any matter associated with the treatment and death of Lucy. For the avoidance of doubt you should refer to all discussions, investigations or inquiries which you raised or undertook, as well as any steps taken by you to obtain any relevant documentation.**

I was told the next morning of the death and I advised the clinicians to make comprehensive notes. I was then approached by Mr. Fee who had been in contact with Mr. Mills. We were asked to analyze the case and write a report.

(8) **State precisely your understanding of why the Sperrin Lakeland Trust decided that it was appropriate to carry out a Review in respect of Lucy Crawford's death?**

Because this was a tragic and unexplained death.

(9) **Describe your role and responsibilities in the conduct of the Review?**

Jointly conducting it with Mr. Fee.

(10) **Describe the role of Mr. E. Fee in the conduct of the Review? Identify any differences between his role and your role?**

Mr. Fee took the primary role and I was his assistant during the review.

(11) **Did you or any colleague seek advice or guidance in relation to how to conduct the Review, such as through the British Association of Medical Managers, or any other source?**

I did not.

(12) **Was the Review carried out by following (or by reference to) any guidance, instruction or protocol, whether written or unwritten? If so, please describe the guidance, instruction or protocol that was followed or which was referred to, and if it was contained in a written document, please provide a copy.**

Not that I was aware of.

(13) **Ms. E. Millar completed a Critical Incident Report form in which she recorded that she spoke to you and Mr. Fee after a Nursing Sister had contacted her to report concerns about the fluids prescribed/administered to Lucy. [Ref: 036a-045-096]**

Please address the following questions arising out of the Critical Incident Report:

(a) **When Ms. Millar spoke to you did you seek to establish more precisely the nature of the concerns that had been expressed to her by the Ward Sister? If so, what did you establish?**

I cannot recall.

(b) **Were you able to establish through Ms. Millar or otherwise who it was that had expressed concerns about the fluids that had been prescribed/administered to Lucy?**

I cannot recall.

(c) **What steps did you or any colleague take as part of the Review to investigate the concerns that had been expressed to Ms. Millar?**

We wrote to medical and nursing staff involved asking for a factual report [see 033-102-299]

(d) **What were the specific concerns that had been expressed?**

Prescription and administration of fluids. The responses are contained in the Appendices to the Review Report of 5th July 2000 [033-036-068]

(e) **Were those concerns documented in the Review report or elsewhere? If so, please refer to the relevant document where those expressions of concern can be found. If they weren't documented, please explain the omission to do so.**

Yes, see (d)

(14) **Between the 17 and 18 April you and Mr. Fee met with various members of the nursing and medical team which had cared for Lucy. You also met with Sister Edmunson [Ref: 033-102-285].**

(a) **What did you tell staff during these meetings?**

I do not recall meeting the staff. The documents record that Mr Fee met with Sr Trainor and Staff Nurse Swift and spoke by telephone with Staff Nurse McManus.

(b) **At those meetings did you learn any more about the circumstances of the deterioration in Lucy's condition, and what might have caused it? If so, what did you learn?**

I do not recall.

(c) **It would appear that Sister Edmunson was not part of the team that treated Lucy in the Erne Hospital? If that was the case, what was the purpose of meeting with her on the 17/18 April?**

I do not recall meeting her.

(15) **It was recorded that you would meet with Dr. O'Donohoe *"and request that he share with staff concerned, in confidence, the verbal report of the cause of death received"* [Ref: 033-102-285.**

Arising out of that record please address the following matters:

(a) **Identify the person who received the verbal report of the cause of Lucy's death, and who did that person receive that verbal report from?**

I do not recall.

(b) **What was the cause of death which had been reported verbally, and was a record made of what had been reported? If a record was made please refer to it.**

I only recall being made aware that Cerebral oedema was found.

(c) **Did you discuss with Dr. O'Donohoe the cause of death that had been reported verbally? What did he say to you about this?**

Probably, but I do not recall this discussion.

(d) **Did you approach Dr. O'Donohoe to ask him to speak to staff, in confidence, about the verbal report of the cause of death, and if so, did he agree to speak to staff?**

I do not recall.

(e) **Did Dr. O'Donohoe speak to staff about the verbal report of the cause of death, and if so, name the staff who he spoke to?**

I do not know.

(16) **It would appear that on the 19 April that you and Mr. Fee met to review the case notes and to agree an action plan [033-102-285 &-286].**

Arising out of that process please address the following:

(a) **Please clarify whether each of the steps which you recorded as forming part of that action plan were in fact carried out?**

1 and 2 were completed.

3 was probably carried out but I cannot recall.
4 was addressed through the health visitor.
5 was addressed .
6 was actioned by appointing an external paediatrician.

(b) **Please outline how you carried out any that was taken as part of the action plan, and state the date by which each such step was taken and completed.**

I actioned numbers 2 and probably 3.
I do not recall being specifically involved in the others.
I was not involved in 7.
I was not involved in 8.

(c) **If any particular step of the action plan wasn't carried out, please explain the omission to do so.**

I cannot assist further.

(d) **What conclusions did you and Mr. Fee reach from the review of the case notes?**

We agreed there was poor documentation of the fluids ordered and poor documentation of their administration.

(e) **Did you or Mr. Fee take any particular action following upon your review of the case notes?**

Yes, we sought expert paediatric advice externally.

(17) **Mr. Mills recorded in a note dated the 20 April 2000, that Mr. Fee was of the view that he required a Paediatrician (to assist with the Review) [Ref: 030-010-017].**

Arising out of this note please address the following:

(a) **Were you also of the view that input from a Paediatrician was required**

Yes

(b) **If so, please explain why you felt that you needed input from Paediatrician?**

We did not have expertise in this field.

(18) **Describe your understanding of the role and responsibilities of Dr. Quinn within the Review process?**

I understood he was to review the notes to determine if any obvious mistakes had been made.

(19) **The briefing letter that was sent to Dr. Quinn on the 21 April 2000 can be found at [Ref: 033-102-296]. Please address the following:**

(a) **Who drafted this briefing letter?**

Mr. Fee

(b) Insofar as you are aware, what was meant by the phrase "initial review of events"? In particular please explain whether you and/or Mr. Fee envisaged that some further steps would be taken after an initial review of events?

I did not draft the letter and cannot comment.

(c) Insofar as you are aware, identify the person(s) who considered that it was relevant to raise for Dr. Quinn's attention the issues set out at 1, 2 and 3 of this briefing letter?

I was not involved in drafting the letter.

(d) Please explain your understanding of why those particular issues (1, 2 and 3) were isolated and raised for Dr. Quinn's consideration.

Fluid management was identified as an area of concern.

(20) Did Dr. Quinn indicate to you or any colleague that he was not prepared to perform any of the following tasks as part his involvement with the Review:

I did not communicate with Dr. Quinn.

(a) Prepare a report for a complaints procedure;

(b) Prepare a report for medical/legal purposes;

(c) Interview the doctors involved;

(d) Interview the nurses;

(e) Interview the family.

If he did raise with you any of these restrictions around his involvement, please state when he did so, state what reasons he gave and indicate what response, if any, you made to him.

(21) Dr. Quinn told the Police Service of Northern Ireland that he recommended to the Trust that it should obtain an opinion from a Consultant Paediatrician from outside the Western Health and Social Services Board area [Ref: 115-041-002], if it required a Paediatrician to interview staff and prepare a medico-legal type report.

Was this view expressed to you?

No

(22) Please clarify what steps, if any, were taken as part of the Review to establish the following information and to provide it to Dr. Quinn, and if applicable, refer to the document from which Dr. Quinn could have extracted that information:

I was not involved in communication with Dr. Quinn nor in preparing the papers provided to him.

(a) The time when the infusion of Solution 18 commenced

(b) The rate at which the Solution 18 was administered

(c) The time at which Solution 18 was stopped

(d) The total volume of Solution 18 that had been given

(e) The time at which Normal Saline commenced

(f) The rate at which Normal Saline was administered

(g) The total volume of Normal Saline that had been given

(h) Whether Lucy was 'shocked'

(i) The time at which Lucy's pupils were first found to be fixed and dilated

(j) The time at which bloods were taken for electrolyte analysis and sent to the lab

(k) The time at which biochemistry results were available on the ward

(23) Nurse Swift wrote to Mr. Fee on the 18 May 2000 [Ref: 033-102-320] in relation to the entries that were made on the Daily Fluid Balance Chart. Please explain whether Nurse Swift's report satisfactorily clarified for you and Mr. Fee the volume of fluid administered to Lucy? If not, did you or Mr. Fee take any further steps to clarify the position with Nurse Swift or any other member of the nursing or the medical teams?

The record was inaccurate. I cannot recall our further discussions with nursing staff in response to this.

(24) In a note of a meeting which took place between Mr. Fee and Dr. Quinn on the 2 May 2000, it is recorded,

"10. How much normal saline was run in?" [Ref: 033-102-287]

In his report Dr. Quinn expressed the view that he could not be certain how much normal saline had been run in [Ref: 033-102-273].

Arising out of these records please address the following matters:

(a) Did you attend the meeting between Dr. Quinn and Mr. Fee on the 2 May 2000?

I did not attend the meeting.

(b) Please explain whether you or Mr. Fee took steps to clarify for Dr. Quinn, his question about how much normal saline was run in?

I was not involved.

(c) Can you explain why Dr. Quinn continued to be uncertain about the amount of normal saline run in, at the time he wrote his report?

No

(25) In a note contained at [Ref: 033-102-287] Mr. Fee has recorded:

"Nursing Staff advise that Normal Saline was commenced at 3.15am and 250 mls had been administered by 4.00am. The dose then was reduced to 30ml/hr for the next two hours."

(a) Do you know which member(s) of the nursing staff provided this information?

No

(b) When was it provided?

I do not know.

(c) Did you or Mr. Fee or any other colleague obtain a written report/statement from the nurse(s) who provided this information? If so, please refer to the document. If not, please explain the omission to do so.

I can find no record or written statement.

(d) Did you or Mr. Fee any other colleague take any steps to ascertain the accuracy of what nursing staff had said about the use of normal saline? If so, what steps were taken?

I do not recall.

(e) Did you or Mr. Fee any other colleague inform Dr. Quinn that nursing staff had said that 250 ml of Normal Saline had been given by 4.00am? If so, when was he informed of this? If he was not informed, please explain the omission to do so.

I do not know.

(26) During the review statements/reports were obtained from a number of doctors and nurses, some of whom were involved with Lucy's care on the 12/13 April 2000. Nursing staff involved in Lucy's care received a written request to provide a report [Ref: 033-102-302]. Mr. Fee also wrote (in different terms) to Sister McManus [Ref: 033-102-300].

Arising out of the foregoing please address the following:

(a) Did you or Mr. Fee enter into correspondence with the medical staff involved in Lucy's care, similar to that which was sent to the nursing staff? If so, please provide copies of this correspondence.

We obtained reports from Drs. Malik, O'Donohoe and Auterson.

(b) If you or Mr. Fee did not write to the medical staff involved, please explain why this didn't happen.

N/a

(c) Whether or not medical staff were written to in similar terms to nursing staff, please clarify whether you or Mr. Fee asked the medical staff to address the issues relating to the fluids received by Lucy in their reports for the Review? If they weren't asked to address the fluids issues, please explain the omission to do so.

I do not know.

(27) Dr. J. O'Donohoe produced a report for the Review apparently at your request [Ref: 033-102-292]. Reports were also provided by Dr. Malik [033-102-281] and Dr. Auterson [Ref: 033-102-316]. None of the reports addressed the issues surrounding Lucy's fluid management.

(a) Did you or any colleague consider it important to obtain from the doctors involved, information on the issues surrounding Lucy's fluid management and the fluids actually received by Lucy, and their views on the appropriateness of the fluids that were given? Please provide reasons for the answer that you give.

This matter was being addressed, I understood, by Dr. Quinn.

(b) Did you or any colleague take any steps to ask the doctors to address these issues, whether before they had produced their reports, or after they had submitted them? If so, please explain the steps that were taken.

I do not recall.

(c) Why was the Review concluded without receiving from the doctors any written account in relation to the issues surrounding Lucy's fluid management and the fluids she actually received?

We had obtained an expert analysis from Dr. Quinn.

(28) At any time, whether as part of the Review or otherwise, did you or any colleague ask the medical staff involved in Lucy's care (in particular Doctors Malik, O'Donohoe or Auterson) to explain ,

(a) The fluids which were in fact administered to Lucy

I do not recall doing so.

(b) Their view of why she was given those fluids and the appropriateness of the fluid regime which was in fact administered to her

I do not recall.

(c) Their view of the possible implications of the fluid regime which was used?

I do not recall.

In the case of each doctor mentioned above, if you or any colleague did ask them these questions, please address the following matters

I do not recall asking these questions.

(i) When were these questions asked?

(ii) In what form were these questions asked (whether in writing or orally)?

(iii) What was the response to these questions?

(iv) Was their response recorded? If so, please refer to the document where the response is recorded. If the response wasn't recorded please explain the omission to do so.

(29) If you or any colleague did not ask the doctors to explain to you the fluids administered, their view of the appropriateness of the fluid regime which had been applied to Lucy, and the possible implications of the fluid regime which was used, please explain the omission to do so?

I do not recall if the question was asked.

(30) At any time, whether as part of the Review or otherwise, did you or any colleague ask the medical staff involved in Lucy's care (in particular Doctors Malik, O'Donohoe or Auterson) to explain their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000?

I have no specific recollection of such questions.

In the case of each doctor mentioned above, if you or any colleague did ask them this question, please address the following matters:

See above

(a) When was this question asked?

(b) In what form was this question asked (whether in writing or orally)?

(c) What was the response to this question?

(d) Was the response recorded? If so, please refer to the document where the response is recorded. If the response wasn't recorded please explain the omission to do so.

(31) If you or any colleague did not ask the doctors to explain to you their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000, please explain the omission to do so?

I do not recall

(32) Why did you conclude the Review without receiving from the doctors any written account in relation to their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000?

I do not recall.

(33) Did you or any colleague carry out an interview with any of the doctors mentioned above after they submitted statements/reports for the purposes of the Review?

I do not recall doing so.

If interviews were carried out with any of the doctors please address the following matters:

(a) Who was interviewed?

(b) When did the interview take place?

(c) What was the purpose of each interview?

(d) What was discussed at each interview?

(e) Did you or a colleague make a record of what was discussed at each interview? If so, please refer to the document in which the record is contained. If a record was not made of each interview please explain the omission to do so.

(34) If you or any colleague did not carry out interviews with each of the doctors referred to above when they submitted statements/reports for the Review, please explain the omission to do so?

I cannot recall any interviews.

(35) Dr. O'Donohoe wrote to Dr. J. Kelly (Medical Director) to provide a comment in relation to the autopsy report:

"I don't quite know what to make of the bronchopneumonia and particularly the suggestion it may have been of some duration." [Ref: 036a-051-114]

(a) Were Dr. O'Donohoe's views in relation to the autopsy report brought to your attention at any time before or after you had concluded the Review?

No.

(b) If so, how were these views made known to you, and did you take any steps to speak to Dr. O'Donohoe about his views?

See above.

(36) As appears from Appendix 11 of the Review of Lucy Crawford's Case, there is a record of a discussion apparently between Mr. Fee and Sister Traynor [Ref: 033-102-295]. Please address the following matters:

(a) Did you attend this discussion with Sister Traynor?

I do not recall attending.

(b) If you did not attend this discussion with Sister Traynor, did Mr. Fee apprise you of the views which she had expressed to him?

I do not recall.

(c) Did Mr. Fee explain to you why he considered it relevant to interview Sister Traynor in relation to the care which had been provided to Lucy?

I do not recall.

(d) **Did Mr. Fee explain to you why he considered it relevant to seek the views of Sister Traynor in relation to fluid management?**

I do not recall.

(e) **Insofar as you are aware, did Sister Traynor have any particular expertise in the area of fluid management?**

She was ward sister and would have general experience but no particular expertise.

(f) **To what extent did Sister Traynor's opinions inform your overall conclusions in the Review?**

I do not recall being influenced by her opinion.

(37) **Having obtained statements/reports from those involved in Lucy's care, please clarify whether this material was provided to Dr. Quinn?**

I was not involved with Dr. Quinn.

If the material wasn't provided to Dr. Quinn, please explain why it wasn't?

(38) **What steps were taken to involve Lucy's parents in the process of the Review and to obtain information from them? If no steps were taken, please explain why this omission occurred?**

Liaison was arranged through the Health Visitor.

(39) **At the time of carrying out the Review were you or Mr. Fee provided with any of the following materials in respect of Lucy:**

(a) **A discharge letter from the Royal Belfast Hospital for Sick Children;**

I did not see this.

(b) **Autopsy request form;**

I did not see this.

(c) **A death certificate?**

I did not see this.

(40) **Please clarify whether any of the following persons/organisations were notified that a Review was taking place, and explain any omission to do so:**

I have no knowledge of (a) - (e) being informed.

(a) **The Department of Health and Social Services;**

(b) The office of the Chief Medical Officer;

(c) The Coroner's Office;

(d) Clinicians or management at the Royal Belfast Hospital for Sick Children;

(e) The pathologist who performed the autopsy (Dr. Denis O'Hara).

(41) During the Review what steps were taken to ask the treating clinicians at the Royal Belfast Hospital for Sick Children for their views in relation to the cause of the deterioration in Lucy's condition and the cause of her death?

I was not involved and do not know.

If no steps were taken in these respects, please explain why this omission occurred?

(42) In your interview with the PSNI you referred to your knowledge of Dr. Asghar and the allegations which he made in relation to Dr. O'Donohoe's clinical management of Lucy [Ref: 116-038-004], and the steps that you took.

(a) State precisely what you discussed with Dr. Halahakoon?

See page 4 of statement [116-038-004]

(b) What did Dr. Halahakoon say by way of a response?

See page 4 of statement.

(c) You have referred to an informal report provided by Dr. Halahakoon [Ref: 116-038-004]. Please identify the document containing this informal report.

Verbal report.

(d) What consideration, if any, did you give to interviewing Dr. Asghar in relation to his views on the treatment afforded to Lucy, or seeking a report from him for the purposes of the Review?

He was interviewed by the Medical Director

(e) Please explain why you/Mr. Fee did not interview Dr. Asghar or seek a report from him for the purposes of the Review?

It was done by the Medical Director.

(43) Mr. Fee sent you a copy of a draft report written by him under cover of letter dated 5 July 2000 [Ref: 033-102-261].

Please address the following matters:

(a) Did you and Mr. Fee conduct any analysis of the material which the Review had received, before he produced a draft report for your attention? If so, please outline how this analysis was conducted.

I cannot recall.

(b) Please explain why you and Mr. Fee on did not write a joint report?

I was asked by Mr. Fee to write my own report.

(44) You wrote to Mr. Fee on the 17 July 2000 to comment on the draft Review report [Ref: 033-102-262].

(a) Please clarify whether you and Mr. Fee conducted any analysis of the information received as part of the Review before the final report was published?

I cannot recall.

(b) If you did meet for this purpose please state when you met, what was discussed and what conclusions were reached. If you did not meet, please explain why you did not meet.

I cannot recall.

(45) In your letter to Mr. Fee dated 17 July 2000 you stated:

"I found that the report by Dr. Quinn, whilst helpful in the sense that it ruled out any obvious mis-management on the part of our medical/nursing staff at the hospital, was also evidence of the fact that there was no clearly obvious explanation for the child's sudden deterioration...

"There was also a mistake in the calculation of the ongoing cumulative fluid which the patient received" [Ref: 033-102-262]

(a) Having recognized the absence of a "clearly obvious explanation for the child's sudden deterioration" did you consider what further steps the Trust should have been taking to clarify the position? If so, what consideration did you give to this issue and what conclusions did you reach?

I had no further involvement after completion of the report.

(b) In particular, in that the death of Lucy continued to be unexplained after the Review, did you give any consideration to seeking advice and guidance from the Confidential Enquiry into Stillbirths and Deaths in Infancy, or any similar organization or body? If so, what consideration did you give to this and what steps, if any, did you take?

No.

(c) Did you discuss with anyone at the Sperrin Lakeland Trust or elsewhere, the absence of an obvious explanation for the child's deterioration? If so, who did you discuss this with and what did you discuss? If you did discuss this issue with anyone was any action taken on foot of those discussions?

No.

(d) You identified a mistake in the calculation of the ongoing cumulative fluid. Did you consider taking steps to obtain clarification of the exact amount of fluid that had been given to Lucy? If so, what consideration did you give to this issue, and please outline any steps that were taken. If you did not give consideration to taking steps to obtain clarification, please explain why you didn't.

Obtaining further clarification was difficult because of the poor quality documentation and two conflicting accounts from Dr. O'Donohoe and Nurse Swift.

(46) Having completed the Review report, please explain what steps were taken by the Sperrin Lakeland Trust to examine its findings, and state:

(a) Who was the report sent to?

I was not involved at this stage.

(b) Was the report considered at Trust Board level?

I do not know.

(c) What action was taken by Trust management in relation to the findings of the Review and its recommendations?

I do not know.

(d) Were you involved in any discussions with regard to the findings of the Review to the extent that they concerned the cause of the deterioration and death of Lucy?

No.

(e) If so, who did you discuss these findings with, what was discussed, and was any action taken on foot of these discussions?

No.

(47) Did the Trust consider the report of Dr. Quinn to determine whether it contained any factual inaccuracies?

I do not know.

If so, what steps were taken in relation to this? If no steps were taken, please explain the omission to do so.

(48) As appears from the report of Dr. Quinn,

"[he] found it difficult to be totally certain as to what occurred to Lucy in and around 3.00am, or indeed what the ultimate cause of her cerebral oedema was."[Ref: 033-102-273]

(a) In circumstances where Lucy's death remained unexplained, as at the start of the Review, did the Trust give any consideration to carrying out a further investigation to determine what caused the cerebral oedema?

I do not know.

(b) If so, what consideration was given to this, and what conclusions were reached?

I do not know.

(c) What consideration did you or any colleague give to reporting Lucy's death to the Coroner in circumstances where the cause of the cerebral oedema could not be established?

I did not report the death to the Coroner.

(d) Did anyone at the Trust check with the Coroner's Office or with clinicians at the Royal Belfast Hospital for Sick Children to ascertain whether an inquest would be held? If no check was made, please explain why.

I do not know.

(49) Were the objectives of the Review as explained at [Ref: 033-102-264], satisfied in all respects? Identify any objective that wasn't satisfied, explain why it wasn't satisfied, and state whether any remedial action was considered or taken to address this.

I considered the core objectives to have been fulfilled. I refer to my report to Mr. Fee 003-012-202

(50) Please refer to the following documents:

- The report of Dr. M. Stewart on behalf of the RCPCH [Ref: 036a-025-052]
- The notes of a meeting between Dr. Kelly and the report's author, Dr. Stewart [Ref: 036a-027-067]
- The report of Dr. John Jenkins [Ref: 013-011-038]
- The report of Dr. M. Stewart and Dr. Boon on behalf of the RCPCH [Ref: 036a-150-312]

(a) Were you provided with a copy of any of these documents?

No.

(b) If so, please identify which of the documents you were provided with and state when you received them.

I was not provided with them.

(c) Whether or not you received a copy of any of these documents, were the conclusions in these documents with regard to the treatment and death of Lucy Crawford discussed with you at any time?

No.

(d) **If so who discussed these matters with you, and when were these matters discussed?**

No.

(e) **If you were aware of the conclusions reached in any of these documents with regard to the treatment and death of Lucy Crawford, did you express any opinion to colleagues about what action the Trust should be taking? If so, what opinion did you express and who did you express it to?**

I do not recall.

(f) **Did you take any action on foot of receiving any of these documents or when you were apprised of their contents? If so, what action did you take?**

I did not receive them.

III. OTHER MATTERS

(51) **Are you now satisfied with the Review which you and Mr. Fee conducted and the conclusions which were reached? Please fully explain the answer that you give.**

The review left certain questions unanswered. We did not feel we could progress the matter further.

(52) **Have you learned any lessons or changed any practice arising out of your experience of involvement in the processes of inquiry into the treatment and death of Lucy Crawford, or any other matter related to her death? If so, fully describe the lessons that have been learned or the changes in practice which have occurred.**

The lessons learned were not directly relevant to my obstetric practice. As Clinical Governance developed new lessons were being learnt in relation to this.

(53) **How would you categorize the quality of care which was provided to Lucy Crawford at the Erne Hospital? In addressing this question please refer to each of the factors which have caused you to reach this view.**

We identified poor record keeping and poor communication between staff which contributed to the the failings in her treatment. At the time of our review the word "hyponatraemia" had not yet been mentioned nor was "solution 18" recognized as being a causative factor.

(54) **Provide any further points and comments that you wish to make, together with any documents, in relation to:**

(a) **The cause of Lucy's death;**

(b) **The role performed by you, the Sperrin Lakeland Trust or any other body when reviewing or investigating issues relating to the cause of Lucy's death;**

(c) **The procedures which were followed when reviewing or investigating issues relating to the cause of Lucy's death;**

(d) **Lessons learned from Lucy's death and how that affected your practice or your approach to management;**

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

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

Signed: Trevor Anderson **Dated:** 2nd November 2012