Witness Statement Ref. No. 278/1

NAME OF CHILD: LUCY CRAWFORD

Name: JARLATH O'DONOHOE

Title: Doctor

Present position and institution: Retired.

Previous position and institution: Consultant Paediatrician at Erne Hospital, Enniskillen
[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]

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

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 in Relation to your Career Background and Training

(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.

(a) MB, BAO, BCh; University College Dublin, 1978
(b) MRCPCH 1986, FRCPCH 1995

(b) State the date of your appointment to the post of Consultant Paediatrician in the Erne Hospital.

Appointed Erne Hospital June 1987

(c) List all of the professional posts held by you before and since the date of your appointment as Consultant Paediatrician at Erne Hospital, and provide the dates of each such appointment and its duration.

CV attached

(2) At any time prior to your involvement in Lucy's case, had you 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,

(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?

As an undergraduate issues of fluids and electrolytes were introduced in the pre-clinical years, particularly as a part of physiology. It included information on hormonal mechanisms involved. It was generally provided in didactic form. In the later (clinical) years there were rotations through different departments and there would have been some further discussion of these issues, again mainly in a didactic form. There was no practical application of these ideas in this context.

On qualifying the first year was spent rotating through different units. Many practical techniques were acquired from standard handbooks and from earlier occupants of these posts. Practices varied from ward to ward and from consultant to consultant even in the same ward. Much of the learning was on the basis of the usual practice within the different units, often relayed by nursing staff.
In subsequent years most of my information was acquired from standard textbooks, journal reading and attending clinical meetings.

(3) At any time prior to your involvement in Lucy's case, had you 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,

(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?

Education in hyponatraemia generally and in paediatrics in particular followed much the same process as above.

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

(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.

Hyponatraemia is a serum sodium below the reference range (135 – 145mmol/l). Values below the reference range would have occurred every few weeks.
I am only able to recall two specific cases where there were symptoms attributable to hyponatraemia. In one case in Saudi Arabia a child presented with a failure to thrive with a serum sodium of 113. He was referred for further investigation in a specialist metabolic unit. I have seen a further case in a surgical patient with burns in the Childrens' Ward in the Erne Hospital – a child who had a convulsion when I was on the ward. As the first person on the scene I initiated treatment and investigation. When the surgical team arrived I recommended a discussion with and a transfer to the Burns Unit.

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

(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.**

Since April 2000 I can only remember one specific case. This was a child who had been attending a colleague at Erne Hospital with a condition called contiguous gene deletion syndrome. He presented with vomiting and his serum sodium was 118. This was due to adrenal insufficiency (a recognised part of his disorder) and he was treated in line with advice from the paediatric endocrinologist in Belfast and subsequently transferred there for further treatment.

II. Issues Relating to the Efforts that Were Made to Establish the Cause of Lucy's Death

(6) **In April 2000, what was your understanding of the procedures which were applicable in the Erne Hospital or Sperrin Lakeland Trust in circumstances where an adverse incident had occurred leading to an unexpected death?**

I was not aware of any specific procedures in place.

(7) **Please outline the steps that you would have expected to have been taken pursuant to those procedures in such circumstances?**

I was not aware of any specific procedures in place.

(8) **In Lucy's Erne Hospital notes you made the following entry:**

"14/4/00 Yesterday Dr. Peter Crean rang from PICU RBHSC to enquire what fluid regime Lucy had been on. I told him a bolus of 100 mls over 1 hour followed by 0.18% Na Cl / Dextrose 4% at 30 ml/hr. He said he thought it had been NaCl 0.18% Dextrose 4% of 100 ml/hr. My recollection was of having said a bolus over 1 hour and 30 ml/hr as above..." **[Ref: 027-010-024]**

(a) **Did you ask Dr. Crean to explain how he had reached the view that Lucy had received the fluids at a rate of 100 ml/hr? If so, what did he say?**

I have no specific recollection now of the contents of that conversation.

(b) **Did Dr. Crean's report to you in relation to the fluids he thought had been given to Lucy cause you any concerns? If so, please outline what those concerns were.**

Yes. Dr Crean's report suggested that the fluids and the quantities given were different from those that I had instructed to be given.

(c) **Having received this report from Dr. Crean what steps, if any, did you take to establish what fluids had actually been given to Lucy, and to clarify the actual position for Dr. Crean? If you did not take any steps to investigate this issue please explain your omission to do so.**

I located Lucy's notes and I faxed a copy of the fluid administration sheet to Dr Crean.

(d) **If you took any steps to establish what fluids had actually been given to Lucy, what did you discover?**

On reading the fluid administration sheet I saw the fluids were recorded as 100 mls per hour as suggested by Dr Crean.

(e) **Did you read Lucy's notes after receiving the call from Dr. Crean and at or about the time of making your note? If you did read the notes, what conclusions did you reach in relation to the fluids that had been given to Lucy?**

I read and re-read Lucy's notes as I was concerned about the quantity of the fluids actually infused.

(f) **Did you report Dr. Crean's call or any steps taken by you after this call to any of your colleagues in the Erne Hospital or Sperrin Lakeland Trust? If so who did you report to and what did you report?**

I reported Dr Crean's call to Dr J Kelly, Medical Director, with whom I discussed the circumstances of Lucy's treatment and I requested that the episode be examined under the heading of a Critical Incident.

(9) **In an interview with the PSNI on 6 April 2005, Dr. James Kelly provided the following account of a discussion which he said took place with you [Ref: 116-043-002]:**

"Dr. O'Donohoe contacted me by telephone on either Thursday 13th of April....or on the morning of the Friday 14th of April 2000. Dr. O'Donohoe explained he wanted to apprise me of the events surrounding a child who had been admitted to the Paediatric Ward of the Erne Hospital on 12th of April. Dr. O'Donohoe outlined that he was raising this under Critical Incident Reporting. Dr. O'Donohoe informed me that the child had been admitted with diarrhoea and vomiting and had subsequently suffered an unexplained collapse requiring resuscitation and incubation (sic)....Dr. O'Donohoe said he was not sure what happened stating there may have been a misdiagnosis, the wrong drug had been prescribed or the child had an adverse drug reaction. Dr. O'Donohoe explained that there had been some confusion over fluids...."

(a) **Please confirm that you contacted Dr. Kelly on the 13 or 14 April under critical incident reporting to advise of events surrounding the treatment of Lucy Crawford.**

I did contact Dr Kelly.

If you did contact him as aforesaid please address the following matters:

(b) **State the reasons why you contacted him under critical incident reporting?**

Lucy had deteriorated and subsequently had died unexpectedly.

(c) **Confirm whether or not you told Dr. Kelly that there might "have been a misdiagnosis, the wrong drug had been prescribed, or the child had an adverse drug reaction" and that "there had been some confusion over fluids"? In event outline your recollection of what you told Dr. Kelly in relation to Lucy.**

I have no specific recollection now of the contents of that conversation.

(d) **Regardless of what you told Dr. Kelly, at that time or subsequently, did you suspect that there may have been some confusion over the fluids which had been administered to Lucy?**

I was concerned about the quantity of the fluids actually given to Lucy.

If so, please address the following:

(i) **State precisely the nature of the confusion that you suspected. In particular state whether you were concerned that Raychel had been given the wrong fluid and/or too much fluid?**

I was concerned that Lucy had been given more fluid than that I had instructed to be given.

(ii) **When did you become suspicious that there had been confusion over the fluids?**

When Dr Crean telephoned.

(iii) **What factors caused you to become suspicious that there had been confusion over the fluids?**

Dr Crean's telephone call.

(iv) **Were you concerned about the fluids which had been given to Lucy? If so, fully describe the concerns that you had.**

My concerns were that Lucy had been given a larger volume of fluid than intended.

(10) Lucy's Erne Hospital notes contain the following entry made on the 18 April at 0910:

"PM – verbal report via PICU R.V.H.

"ROTA gastroenteritis + cerebral oedema." **[027-010-025]**

(a) **Please clarify whether you made this entry.**

I made this entry.

(b) **If you did make this entry, please address the following:**

(i) **Who made the verbal report to you?**

I do not now recall.

(ii) **Were you told that the post mortem was a consent/hospital post mortem?**
Yes, by Dr Donncha Hanrahan (Paediatric Neurologist, RBHSC) who told me in a telephone call that he had notified HM Coroner that Lucy had died and that HM Coroner had agreed that a hospital Post Mortem could be carried out with the Parents' consent.

(iii) **Were you told whether or not a Coroner's Inquest was being considered?**
Dr Hanrahan told me that a Coroner's Inquest was not being considered.

(11) Did you give any consideration to reporting Lucy's death to the Coroner? If so, please explain the consideration that you gave to this matter and explain why you didn't report her death to the Coroner?

Dr Hanrahan told me that he had notified HM Coroner.

(12) You provided a report to Dr. Anderson [Ref: 033-102-293]. Please address the following matters arising out of the provision of that report:

(a) **Who asked you to provide the report?**
Dr Anderson requested this report by letter.

(b) **What were you told about the purpose of furnishing this report?**
I cannot now find the letter setting out the request for a report. I cannot now remember the reason for the report.

(c) **What were you told should be included within the report?**

My recollection is that I was asked to set out the facts as I believed them then to be.

(d) **Did anyone assist you in compiling the report? If so, please identify the person who assisted you.**
No.

(e) **Before submitting your report to Dr. Anderson, were you interviewed by anyone at the Sperrin Lakeland Trust and about your role in treating Lucy, and the cause of or the reasons for her deterioration? If so, who interviewed you and what did you tell that person about any of these issues.**
No.

(f) **After submitting your report to Dr. Anderson, were you interviewed by anyone at the Sperrin Lakeland Trust in relation to the contents of your report? If so, who interviewed you, what were you interviewed about, and what information did you give?**
No.

(13) **In the report prepared for Dr. Anderson you made the following comment:**

"While strapping the cannula in situ I saw Dr. Malik writing as I was describing the fluid regime i.e. 100 mls as a bolus over the first hour and then 30 mls per hour." **[Ref: 033-102-293]**

Arising out of your report to Dr. Anderson, please address the following matters:

(a) **Did you know when you wrote your report for Dr. Anderson that Lucy had not received the fluid regime which you say you described to Dr. Malik? If you did not know please state when you discovered this fact.**
Yes.

(b) **State precisely how you realized or discovered that Lucy had not received the fluid regime which you say you described to Dr. Malik?**
During and following Dr Crean's telephone call to me.

(c) **Did you ever make a report to anyone at the Erne Hospital or Sperrin Lakeland Trust that Lucy had not received the fluid regime which you say you described to Dr. Malik? If so, who did you make this report to and when?**
I notified Dr Kelly, Medical Director of Sperrin Lakeland Trust.

(d) **If you knew at the time of writing your report for Dr. Anderson that Lucy had not received the fluid regime which you described to Dr. Malik, why did you omit to mention this in your report?**
I cannot now remember why I omitted any reference to the fluids Lucy actually had received.

(e) **Why did you omit to state in your report for Dr. Anderson the fluids (amount and type) that Lucy actually received in the period between her admission to the Erne Hospital and her transfer to the Royal Belfast Hospital for Sick Children?**
I cannot now remember why I omitted any reference to the fluids Lucy actually had received.

(f) **Why did you omit to express any view in your report about the appropriateness of the fluid regime actually received by Lucy between her admission and transfer?**
I cannot now remember why I omitted to express any view.

(g) **Why did you omit to express any view in your report about the possible reasons for Lucy's deterioration and death?**
I cannot now remember why I omitted to express any view.

(h) **When you wrote the report for Dr. Anderson did you have any concern that the treatment received by Lucy in the Erne Hospital may have been relevant to the deterioration in her condition? If so, please outline those concerns. Whether or not you had this concern please fully explain and give reasons for your answer.**
When I wrote my report I did have concerns about Lucy's treatment in light of Dr Crean's telephone call.

(14) **In the hospital notes and records compiled by clinicians at the Royal Belfast Hospital for Sick Children, Dr. Donncha Hanrahan made the following entry relating to a conversation with you on the 14 June 2000:**

"Contacted Dr. O'Donohoe who will see Lucy's parents again, but he would rather wait for the post mortem report." **[Ref: 061-018-069]**

(a) **Please confirm that you had a telephone conversation with Dr. Hanrahan on the 14 June 2000.**
Yes.

(b) **Outline your recollection of the matters that were discussed during this conversation.**
My recollection is as noted by Dr Hanrahan.

(c) **If you discussed with Dr. Hanrahan any matters relating to the cause of Lucy's death, please outline as fully as possible what was said by you and Dr. Hanrahan and any conclusions which were reached.**
I have now no specific recollection.

(15) **You provided a report to Mr. Kevin Doherty in preparation for the Inquest into Lucy's death in which you said the following:**

"I was next called at approximately 03.00 because Lucy had had what sounded like a convulsion. My initial presumption was that this was a febrile convulsion. However, since she showed no signs of recovering by the time I arrived and since there was a history of profuse diarrhoea I took a specimen for repeat urea and electrolytes. My recollection is that Dr. Malik had started the intravenous normal saline before calling me and that the 500 mls given was virtually complete before I arrived. Her repeat urea and electrolytes measurement showed the sodium had fallen to 127..." **[Ref: 013-018-066]**

Arising out of the foregoing please address the following:

(a) **Over what period of time was this quantity of normal saline given?**
I have now no specific recollection of the time over which normal saline was given.

(b) **Did you provide this information (in relation to the quantity of normal saline given) to the clinicians at the Royal Belfast Hospital for Sick Children, when Lucy was transferred there? If so, please indicate how this information was given, and who you gave it to? If you did not provide this information please explain why you omitted to do so.**
I have now no specific recollection of providing this information to the clinicians at RBHSC.

(c) **Did you provide this information (in relation to the quantity of normal saline given) to Mr. Fee, Dr. Anderson or anyone else at the Sperrin Lakeland Trust at the time when a Review was being conducted in relation to Lucy's treatment? If so, please indicate how this information was given, and who you gave it to? If you did not provide this information please explain why you omitted to do so.**
I have now no specific recollection of providing this information to Mr Fee, Dr Anderson or anyone else at Sperrin Lakeland Trust. Likewise, I have now no specific recollection for this omission.

(16) **In an interview with the PSNI on 2 March 2005, Dr. Donncha Hanrahan provided the following account of a discussion which he said took place with you on the 3 December 2004:**

"Yes, there's an annual study day in the Children's Hospital, I was chatting to Doctor O'Donohoe after that. He said later on that it did occur to him that the sequence of events...would suggest that the sodium was actually lower." **[Ref: 116-026-016]**

Please consider the interviews with police given by Dr. Hanrahan starting at [Ref: 116-026-001] and address the following:

(a) **On or about the 3 December 2004, did you have a conversation with Dr. Hanrahan in relation to whether the sodium was actually lower than 127 before normal saline was administered?**
I do recall having such a discussion with Dr Hanrahan although I do not recall the date.

(b) **If so, what information did you give him, and what opinion did you express?**
I said that the serum sodium might have been lower than 127 before the normal saline had been given. I suggested this might provde an explanation for why the cerebral oedema was so severe.

(c) **Did you reach a view, before or after Lucy's death, that the sodium could have been lower than 127 before the normal saline had been run in? If so, please address the following:**

(i) **When did you reach that view?**
I did not reach any specific conclusion.

(ii) **Please explain in detail the view that you reached and the factors that you took into account when reaching it?**
I had raised this possibility with Dr Hanrahan after I had read the expert opinions obtained by HM Coroner for Lucy's Inquest. I had also read widely on the issue of hyponatraemia after Lucy's death.

(iii) **Did you explain your view to anyone at the Sperrin Lakeland Trust, or elsewhere? If so, who did you explain it to and when?**
I cannot now recall whether I discussed this matter with anyone at the Sperrin Lakeland Trust.

(iv) **If you did not explain your view to anyone else (apart from Dr. Hanrahan), please explain your omission to do so?**
As I recall that Dr Hanrahan did not support the idea I did not pursue the matter any further.

(17) **Please describe in detail all steps which were taken by you after Lucy's death to inform yourself of the causes or the potential causes of her deterioration and death.**
I have read extensively on the issues of fluid management and hyponatraemia, including a paper published in the British Medical Journal in 2001 from Halberthal at the Hospital for Sick Children, Toronto. I also chaired Review Meetings where the subject of fluid management was discussed albeit many of the cases under review came from casualty and surgery and not from paediatric medicine.

(18) **Please describe in detail all steps taken by you in order to assist others in understanding the cause of Lucy's deterioration and death, and outline what was said or done by you to assist this understanding.**

I instructed my juniors, at the time of their induction into the department, of the dangers of hyponatraemia. I also added a section to the admission sheet in which the fluid requirements were to be calculated for every child admitted to the ward.

(19) **Did anyone at the Sperrin Lakeland Trust ask you to assist the Trust in understanding the cause of Lucy's death, and/or whether medical treatment received at the Erne Hospital may have contributed to her death? If so, please outline the following:**

No.

(a) **Who asked you to assist?**

(b) **When were you asked to assist?**

(c) **What assistance were you asked to provide?**

(d) **What assistance were you able to provide?**

(20) **At any time before or after speaking to Dr. Kelly or writing the report for Dr. Anderson did you discuss with medical or nursing colleagues at the Erne Hospital or the Royal Belfast Hospital for Sick Children, whether formally or informally, the possible reasons for Lucy's deterioration and death?**

I only now recall specifically talking to Dr Crean and Dr Hanrahan.

If so, please address the following matters:

(a) **Who did you discuss these issues with?**

(b) **When did you discuss these issues?**

(c) **What conclusions did you reach?**

(d) **What conclusions did others reach?**

(21) **In a letter to Dr. Kelly dated 26 June 2000 you commented on the post mortem report in the following terms:**

"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]**

Please address the following matters:

(a) **What did you mean to convey to Dr. Kelly by this reference to the post mortem report?**

I meant exactly what I said in my letter.

(b) **Was bronchopneumonia present when you treated Lucy?**
No.

(c) **Did you discuss the post mortem report with anyone associated with Sperrin Lakeland Trust? If so, who did you discuss it with, when did you discuss it, what did you discuss and did you or anyone else take any action on foot of those discussions.**
I have now no specific recollection of discussing the contents of the Post Mortem report with any medical or nursing colleagues.

(22) **When you were interviewed by the PSNI on 26 April 2005 you made/gave the following statement:**

"When I arrived at the hospital I was surprised to find that a saline drip was running freely. I was surprised because I had not instructed that this should be set up and I reduced the flow to 30 mls." **[Ref: 116-008-003]**

(a) **Did you take any steps to establish why the saline drip was running freely? If so, what steps did you take, and what information were you given?**
Yes. I asked Dr Malik why there was an infusion of normal saline running freely. Dr Malik informed me that it was because Lucy had passed a lot of diarrhoea.

(b) **If you obtained any information to explain why the saline drip was running freely, did you pass that information on to anyone at the Sperrin Lakeland Trust or elsewhere? If so, who did you pass the information on to, and was any action taken on foot of this?**
Yes. I informed Dr Auterson when he attended Lucy. Whilst I made no specific reference in my letter of transfer to Dr McKaigue (043-051-098 / 99) I relied on the entries in the Fluid Balance Chart (027-019-062) to inform the receiving Clinicians as to the nature, quantities and timings of any fluids administered to Lucy.

(c) **Did you give any consideration to whether it was appropriate for the saline drip to be running freely, and whether this had any impact on Lucy's condition? If so, what consideration did you give to this issue and what conclusions did you reach?**
I did not consider it to be appropriate for a drip containing normal saline to be running freely. However I did not see how this could have caused or contributed to Lucy's condition.

(d) **Please explain why you decided to reduce the flow of normal saline to 30mls?**
I had requested at the time when I had placed a cannula into Lucy that Lucy be given normal saline at the rate of 30 mls/hour be given. Therefore I was resetting the infusion to that rate.

(23) **When you were interviewed by the PSNI on 26 April 2005 you made/gave the following statement:**

"After her transfer Doctor Crean from the Royal Victoria Hospital rang and queried to the fluids given. As I had no role in the actual administration of the fluids of (sic) completion of the fluid balance charts, it is impossible for me to comment on what actually transpired during the hours when I was absent from the hospital." **[Ref: 116-008-004]**

(a) **Were you suggesting in this statement that it was impossible for you to clarify for Dr. Crean or for the police just what fluids had actually been administered to Lucy?**
Yes

(b) **Could you have clarified or estimated what fluids had been administered to Lucy by examining her notes? If so, clarify whether you carried out this exercise at any point before or after her death? If you did not carry out this exercise, please explain your omission to do so.**
No. It was impossible to be certain which fluids had been given as there was a lack of clarity in the recording of Lucy's fluids in her notes.

(c) **Could you have determined what fluids had been administered to Lucy by speaking to nursing or medical colleagues who cared for her during your absence? If so, clarify whether you carried out this exercise at any point before or after her death? If you did not carry out this exercise, please explain your omission to do so.**
When I arrived I asked Dr Malik and the nursing staff present for an update. I cannot now recall if I got a clear answer. I believed at that time that Lucy had been receiving the fluids I had earlier requested. I discussed the matter with Dr Kelly after Lucy had been transferred to Belfast.

(24) **When you were interviewed by the PSNI on 26 April 2005 you made/gave the following statement:**

"I also met with the parents but had no explanation as to why Lucy died as I did not have her record at the time of the meeting because I had given the notes to Doctor Kelly when I reported the death of Lucy Crawford to him." **[Ref: 116-008-004 & -005]**

(a) **When did you meet Lucy's parents?**
May 2000 although I cannot now recall the specific date.

(b) **Who asked for the meeting?**
Mr and Mrs Crawford requested the meeting.

(c) **What was the purpose of the meeting?**
I believe Mr and Mrs Crawford wanted a better understanding as to what had happened to Lucy.

(d) **Did you advise anyone at the Sperrin Lakeland Trust that you were meeting with Lucy's parents? If so who did you advise, and what did you tell them about the purpose of the meeting?**
I have now no recollection of informing anyone at the Trust.

(e) **Had you read the notes before passing them to Dr. Kelly?**
Yes.

(f) **Knowing that a meeting was to take place, why did you fail to take steps to arrange to obtain a copy of Lucy's notes from Dr. Kelly?**
I tried unsuccessfully to retrieve Lucy's notes. I looked in the usual places where I would have expected to find Lucy's notes. I asked the paediatric secretaries to help to find them.

(g) **What were you able to tell Lucy's parents in relation to the circumstances of Lucy's deterioration or why Lucy died?**
I told Mr and Mrs Crawford that as I did not then have a clear understanding of what had happened to Lucy I had given Lucy's notes to Dr Kelly for further investigation. I was concerned that Mr and Mrs Crawford had not received any answers.

(h) **Did you meet with Lucy's parents after receipt of the post mortem report?**
No. I told Dr Hanrahan (on 14th June) that I was willing to see Mr and Mrs Crawford again on receipt of the Post Mortem report. However I had no further contact with Mr and Mrs Crawford.

(i) **If so, what were you able to tell Lucy's parents at that point, in relation to Lucy's deterioration or why Lucy died?**

III. **Other Matters**

(25) **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.**
I would now categorise Lucy's care at the Erne as inadequate. As Lucy's Consultant, I should then have written out the prescription for Lucy's fluid management and I should then have ensured that my junior medical staff and my nursing staff understood that prescription.

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

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

(b) **The role performed by you, the Sperrin Lakeland Trust or others when considering issues relating to the cause of Lucy's death;**

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

(d) **Lessons learned from Lucy's death and how that affected your practice at the Erne Hospital or elsewhere;**

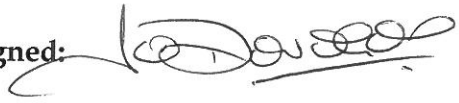
(e) **Any other relevant matter.**

I had reported Lucy's death to Dr Kelly as a Critical Incident (036e-003-004/6). I expected there then to be a thorough/independent review of Lucy's management and that any failings/lessons to be learned would be made known.
Speaking for myself, I reviewed my own practice and, in particular, I tried to ensure that I wrote out my prescriptions for fluid management. Furthermore, I tried to ensure that my juniors were instructed, on their induction, as to the dangers of hyponatraemia (067K-

095-182-185). I also ensured that this was included in the training for junior doctors as part of my role as Foundation Programme Director. Furthermore, I wrote modules on the topic for on-line training.

I wanted to ensure that there was no repetition of the events leading to Lucy's death, which I much regret. To that end, I wish to express my sincere condolences to Mr and Mrs Crawford and their immediate families.

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

Signed: 

Dated: 16/1/13