Witness Statement Ref. No. 278/2

**NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)**

**Name: Jarlath O'Donohoe**

**Title: Doctor**

**Present position and institution:**

**Retired**

**Previous position and institution:**
*[As at the time of the child's death]*

Consultant Paediatrician Erne Hospital

**Membership of Advisory Panels and Committees:**
*[Identify by date and title all of those between January 2000 - December 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:**

| Ref: | Date: | |
|---|---|---|
| WS-278/1 | 16.01.2013 | Inquiry Witness Statement |

*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 to your statement.*

**(1) In your answer to question (1)(b) of WS-278/1 you state that you were appointed to the post of Consultant Paediatrician at the Erne Hospital in June 1987. This is clearly an error. Please confirm the date of your appointment to this post.**

I started work in the Erne Hospital in June 1997

**(2) In your answer to question 8(c) of WS-278/1 you state that after your conversation with Dr Crean you faxed a copy of the fluid administration sheet to Dr Crean. Arising from this please answer the following:**

**(a) On what date and at what time (approximately) did your conversation with Dr Crean take place?**

The telephone conversation took place on the morning of Thursday 13th April 2000.

**(b) When did you fax a copy of the fluid administration sheet to Dr Crean?**

On the same morning.

**(c) For the avoidance of doubt identify the document which you refer to as the fluid administration sheet, which you faxed to Dr Crean.**

It is included in Folder 15 as Document 015-012-089

**(d) Why did you fax a copy of the fluid administration sheet to Dr Crean?**

To confirm and to ensure that Dr Crean had the fullest information.

**(e) Did you fax any other documents to Dr Crean at this time or subsequently?**

I do not now recall exactly what else I faxed. It would have been common practice to fax the bulk of the relevant notes in such circumstances in case there were any other questions Dr Crean might have had.

**(f) Did you send any accompanying communication (in the form of a fax cover sheet or otherwise) to Dr Crean with the copy of the fluid administration sheet? If so, please provide a copy of the communication to the Inquiry.**

It would have been my normal practice to add a covering sheet with the name of the intended recipient.

**(g)Did you take any additional steps to ensure that clinicians in the RBHSC were aware of the fluids actually received by Lucy?**

No.

**(3) In your answer to questions 10(b)(ii) and (iii) of WS-278/1 you state that Dr Hanrahan told you *"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"* and that *"a coroner's Inquest was not being considered"* Arising from this please answer the following:**

**(a) When did this conversation take place? If you cannot remember the precise date please give your best estimate of when it occurred.**

I believe it was on the afternoon of Friday 14th April 2000.

**(b) Did you inform anyone else in Sperrin Lakeland Trust that a coroner's inquest was not being considered? If you did please give details of;**
**(i) The information which you provided;**

I cannot now recall whether or to whom when I may have relayed such information.

**(ii) The persons to whom you provided it;**

**(iii) When you provided the information.**

**If you did not tell anyone else in Sperrin Lakeland Trust that a Coroner's inquest was not being considered please explain your omission to do so.**

I cannot recall specifically whether I told anyone in Sperrin Lakeland Trust.

**(4) In answer to question 20 of WS-278/1 which asked whether you discussed with any colleagues at the Erne Hospital or Royal Belfast Hospital for Sick Children, whether formally or informally, the possible reasons for Lucy's deterioration and death, you have answered *"I can only now remember specifically talking to Dr Crean and Dr Hanrahan."* Arising from this, please answer these questions:**

**(a) Is it your evidence that you did discuss the possible reasons for Lucy's deterioration and death with Dr Crean and Dr Hanrahan? If so please answer questions 20 (b) (c) and (d) of WS-278/1 in respect of your discussions with Drs Crean and Hanrahan respectively.**

My conversations are as previously indicated. My conversation with Dr Crean was during a telephone call he had made and which was largely confined to the issues mentioned, ie the fluid records. Dr Hanrahan called me. I was aware that Dr Hanrahan had carried out and / or instigated a number of investigations to look for various causes of the deterioration. However I believe the results of many of these investigations were not expected for some days.

**(b) Is it your evidence that you did not discuss with any colleagues at the Erne Hospital, whether formally or informally, the possible reasons for Lucy's deterioration and death? Please clarify. If you did discuss the possible reasons for**

**Lucy's deterioration and death, whether formally or informally , with any colleagues at the Erne Hospital please address the following:**

**(i) Whom did you discuss those issues with?**

I did not discuss Lucy's deterioration and death with any colleagues at the Erne Hospital other than Dr Kelly, the Medical Director.

**(5)**

**(i) When did you discuss those issues?**

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

**(iii) What conclusions did other reach?**

**(6) In the Erne hospital notes [Ref: 027-010-023] you recorded repeat electrolyte results showing Lucy's sodium level as 127 (a fall from 137 on admission), and her potassium level at 2.8 (a fall from 4.1 on admission). You then recorded that you discussed the case with *"Dr McKeague "*(sic). Arising from this please answer the following:**

**(a) Why did you arrange a repeat electrolyte test for Lucy?**

This is a usual investigation in the case of deterioration, particularly in the presence of diarrhoea. Dr Malik had given me an account of profuse diarrhoea and this might have produced abnormalities of the electrolytes.

**(b) Who informed you of the results of that test?**

I do not now recall.

**(c) When were you informed of the results of that test?**

I do not now recall.

**(d) Did you consider the changes to be significant?**

Yes

**(e) What conclusions if any did you reach from the results of the repeat electrolyte test?**

I believed that the results did not help to explain the cause of Lucy's deterioration.

**(f) Did you inform Dr McKaigue of the repeat electrolyte results when you discussed the case with him? If you did, please give details of the discussion. If you did not, why did you not?**

I do not now recall the discussion with Dr McKaigue in any detail.

**(g) Why did you not include details of the repeat electrolyte results in the transfer letter which you wrote to Dr McKaigue? [Ref: 061-014-038 to 061-014-039]**

I do not remember when I wrote the transfer letter in relation to receiving the electrolyte result.

**(h) Did you inform any of the clinicians in the Royal Belfast Hospital for Sick Children of the repeat electrolyte results at the time of Lucy's transfer to the RBHSC? Please give details.**

I believe I relayed the repeat electrolyte results in the verbal hand over on arrival.

**(7)Did you discuss the repeat electrolyte results with Dr Auterson at any time? If so please give details.**

I do not remember specifically doing so although Dr Auterson has recorded the results in his reports: (0(047-015-074 and 047-086-115) but without indicating who told him.

**(i) Did you discuss the repeat electrolyte results with Dr Kelly at any time? If so please give details.**

Yes, when I notified Dr Kelly of the case.

**(j) Did you discuss the repeat electrolyte results with Dr Malik at any time? Please give details.**

I do not recall discussing the results with Dr Malik.

**(8)Please refer to the document at Ref: 030-007-012 which records:**
***"16/06/00 JO'D had informal meeting with Dr Hanrahan, Paediatrician (sic) in Belfast and discussed the PM report"***

**Arising from this please address the following matters:**

**(k) Did you meet with Dr Hanrahan on 16th June 2000 to discuss the PM report? If so,**

I do not recall meeting with Dr Hanrahan to discuss the PM report.

**(i) Who arranged this meeting?**

**(ii) Where did it take place?**

(iii) **Who attended the meeting?**

(iv) **What particular issues were discussed and what conclusions were reached?**

(v) **Was a record made of the meeting?**

(7) **Please refer to your report dated 24 August 2003 [Ref: 047-053-148 to 047-053-149] which you sent to Dr Kelly in which you recalled that Dr Malik had started the intravenous normal saline before calling you and the 500mls given was virtually complete before you arrived. In the 6th paragraph of this report you stated *"this report differs from the previous version ...in respect of the infusion of 500mls of normal saline to which I did not refer in the version I sent to you previously. Since this is approximately 50ml/kg a much larger volume than I would use I believe this had been started following the first episode of diarrhoea ie before the convulsion."* Arising from this please answer the following:**

(a) **Identify the document you were referring to as *"the previous version"* and *"the version I sent to you previously."***

I am now unable to identify and now find a copy of the document to which I was referring.

(b) **Please explain the basis for your belief that the infusion of 500 mls of normal saline had been started following the first episode of diarrhoea but before the convulsion**

My recollection is that Dr Malik told me that he had started the infusion in response to the diarrhoea.

(c) **Explain why you omitted to mention that an infusion of 500 mls of normal saline had been given, or that this was a much larger volume than you would use, or that you believed it had been started following the first episode of diarrhoea and before the convulsion, in the report which you sent to Dr Anderson at Ref: 033-102-293.**

Although Mr Anderson was the Clinical Director for the Womens and Childrens Department, I had perceived him as being reluctant in that capacity to get involved in technical issues in the paediatric section.

(8) **Please refer to your undated report which appears to have been faxed to Mr Kevin Doherty on 12 December 2003 [Ref 047-026-102] and subsequently to the Coroner [Ref: 013-018-066]. This differs from your report which you sent to Dr Kelly on 24 August 2003 [Ref: 047-053-148 to 047-053-149] in that the last three paragraphs of the latter are omitted from the version dated 12 December 2003 sent to Mr Doherty. Arising from this:**

(a) **Why did you omit the last three paragraphs of the report to Dr Kelly when making the report to Mr Doherty?**

I do not remember why I added the extra three paragraphs in my report to Dr Kelly.

(b) **In particular, please fully explain why you omitted from the report to Mr Doherty the statements in your report to Dr Kelly that :**

(i) **500 mls of normal saline was *"a much larger volume than I would use"*; and**

(ii) **You believed the infusion of normal saline *"had been started following the first episode of diarrhoea ie before the convulsion"*.**

I do not now recall why I did not add the extra three paragraphs to the report sent to Mr Doherty.

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

**Signed:** [signature] **Dated:** 4/3/13