Witness Statement Ref. No. 281/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: CAROLINE GANNON

Title: Doctor

Present position and institution:

Consultant paediatric pathologist
Northern Ireland Regional Paediatric Pathology Service
Royal Victoria Hospital, Belfast

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

April 2000: Specialist registrar in paediatric pathology, Hammersmith and Queen Charlotte's Hospital, London

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

Group B Streptococcus working group, 2011-2012

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

No previous statements made

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

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of 17 February 2004:

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

I am a registered medical practitioner having qualified from Queens University Belfast in 1991 (full registration with GMC 1992, number: 3475157). My qualifications are MB, BCh, BAO. I am a Fellow of the Royal College of Pathologists (2000). I have a Masters degree in Health Care Law and Ethics (MA 2009, Swansea University). I am accredited with the General Medical Council as a specialist histopathologist with sub specialization in paediatric pathology.

(b) Specify the post which you held on that date and the name of your employer.

Regional consultant paediatric pathologist in the Northern Ireland Regional Paediatric Pathology Service based at Royal Victoria Hospital in Belfast. My employer is the Belfast Health and Social Care Trust.

(c) State the date of your appointment to that post, 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.

August 1991-July 1992: Junior house officer in general medicine and general surgery, Whiteabbey Hospital, Newtownabbey, Northern Ireland

August 1992-July 1993: Senior house officer in general medicine at Mid-Ulster Hospital, Magherafelt, Northern Ireland

August 1993-May 1998: Senior house officer, registrar and specialist registrar in general histopathology and cytology, Royal Victoria Hospital, Belfast

June 1998-October 2000: specialist registrar in paediatric pathology at Hammersmith and Queen Charlotte's Hospital, London

October 2000-January 2001: Locum consultant in paediatric pathology, Hammersmith and Queen Charlotte's Hospital, London

February 2001-June 2003: consultant paediatric pathologist at St James's University Hospital, Leeds, West Yorkshire.

July 2003-present date: consultant paediatric pathologist, Royal Victoria Hospital, Belfast

(d) **Describe the duties which you were required to undertake in the post you held on the 17 February 2004.**

I am one of two consultants in the Northern Ireland Regional Paediatric Pathology Service. This is based at the Royal Victoria Hospital in Belfast, and the service provides a regional paediatric autopsy service undertaking autopsy examination of all babies greater than 12 weeks gestational size where parental consent for examination has been obtained: this includes miscarriages, stillbirths, babies with abnormalities, babies with genetic or chromosomal disorders, babies who die in the neonatal period, and infants and children who die of natural causes in hospital. The service undertakes approximately 250-260 cases per annum.

I also provide a service to HM Coroner: this includes cases of infant and child death in the community and deaths in hospital where the case of death is not known. These may be held in conjunction with a forensic pathologist from the State Pathologist's Department.

I also examine and report on surgical biopsies from children up to the age of 16, including paediatric tumours and malignancies, and obstetric pathology cases (first trimester pregnancy losses, uteri and placentae).

(e) **Did you work with Dr. O'Hara? If so, please outline the nature of your working relationship and specify the periods when you worked with him.**

Dr O'Hara's post was a 'joint appointment' with responsibilities via Queens University Belfast for undergraduate teaching as well as consultant histopathologist duties for the Royal Victoria Hospital. When I was a medical student at Queen's University (1986-1991), he was one of the lecturers responsible for delivering the curriculum lectures on histopathology to my undergraduate cohort.

When I was a trainee general histopathologist in the Royal Victoria Hospital pathology department, Dr O'Hara was one of my senior colleagues responsible for providing training and guidance. All of the consultants in the department at that time shared the responsibility for providing training for the junior staff.

The consultant post to which I was appointed in July 2003 was intended to be a third specialist paediatric pathology post to support Dr O'Hara and his colleague Dr Claire Thornton: Dr O'Hara was a general pathologist with a subspecialty interest in paediatric pathology and Dr Claire Thornton is a regional paediatric pathologist. At the time of my appointment, Dr O'Hara was gravely ill and was confined to hospital for extended periods of time. Although technically we were colleagues, we spent little working time together. He died in September 2004.

(2) *"On the instructions of HM Coroner for Greater Belfast, Mr. J L Leckey, I Dr Caroline Gannon reviewed the pathological findings of a Post Mortem examination carried out by Dr Denis O'Hara into the death of the late Lucy Crawford.*

I now produce a copy of Dr O'Hara's report as exhibit C." (**[Ref: 047-133-289]**

Arising out of the foregoing please address the following matters:

(a) On what date (approximately) were you instructed by Mr. Leckey to review the pathological findings of the Post Mortem examination.

I do not recall the exact date. Dr O'Hara was absent due to ill health for considerable periods of time over the latter half of 2003. Mr. Leckey, HM Coroner, had requested a copy of Dr O'Hara's report and there was discussion between myself and Dr Thornton as to who would take over the case should Dr O'Hara be unable to do so. In the event, Dr O'Hara was well enough to provide a written report and a commentary on his findings to the Coroner, but he was not well enough to later attend the inquest. It is my recollection that my instructions from HM Coroner were at short notice due to the fluctuating state of health of Dr O'Hara, and I was possibly instructed sometime in early January 2004.

(b) Did you receive a letter or any other form of written communication containing your instructions? If so, please provide a copy?

I do not recall receiving written communication or instructions. To the best of my recollection, the Paediatric Pathology Service received a telephoned verbal request for a pathologist to stand in Dr O'Hara's stead at the inquest to provide an explanation of the pathology findings if required.

(c) Fully outline the instructions which were given to you by the Coroner.

See above

(d) To the best of your understanding, explain why you were instructed to review the pathological findings of the Post Mortem examination, and the purpose of that review.

I was asked to attend the inquest into the events surrounding the death of Lucy Crawford as Dr O'Hara, the pathologist who had undertaken the autopsy, was too unwell to attend. The Coroner requested that a paediatric pathologist attend to give evidence regarding the autopsy findings and explain any pathological features. I was not asked to review Dr O'Hara's work in a critical manner, or to provide a separate written pathological report, only to be available to present his report and explain any pathology.

(e) What did you understand by the instruction to *"review"* the pathological findings of the Post Mortem examination?

To 'review' the pathological findings of a post-mortem examination means to systematically examine the written report; evaluate the macroscopic and microscopic descriptions of the organs and tissues and evaluate and critically appraise the conclusions reached by the original pathologist. It involves the re-examination of tissue sections, photographs, genetic testing and other investigations such as microbiology. My understanding at the time was that Dr O'Hara's pathology report was not being contested or challenged, but that I was to familiarize myself with the autopsy report and the pathological findings, and be available to present the pathology findings that Dr O'Hara had recorded.

(f) Did you hold a discussion with anyone about the instruction which you had been given by the Coroner before commencing your review? If so, please address the following matters;

My colleague, Dr Claire Thornton, was aware that there an inquest was due to be held, but I do not recall any detailed discussion. However, it is our working practice to discuss any complex or unusual cases so I assume that I may have done so.

(i) **Whom did you discuss the instruction with?**
See above

(ii) **When did you hold that discussion(s)?**
See above

(iii) **What did you discuss?**
See above

(iv) **What conclusions or views were reached on foot of this discussion(s)?**
Not applicable

(v) **Outline any steps that were taken on foot of this discussion(s)?**
Not applicable

(g) **Describe each of the steps taken by you in order to review the pathological findings of the Post Mortem examination.**
I asked Mrs. Claire Preshaw, the paediatric pathology office manager, to provide me with a copy of Dr O'Hara's report and I obtained the histological sections from the departmental storage. At the time, there was no formal recording of when glass slides were removed from file so I do not know the date that this occurred. I examined the histological sections microscopically.

(h) **What conclusions did you reach after reviewing the pathological findings of the Post Mortem report?**
I concluded that Dr O'Hara's report was a detailed and comprehensive examination and that based on the clinical history provided, and the histological appearance of the tissues, I would have reached the same conclusion as he did about the cause of death.

(i) **Did you hold a discussion with anyone about the review which you conducted? If so, please address the following matters;**
At the time the inquest into Lucy Crawford's death was due to be held, Dr Ciaran O'Neill, a trainee pathologist in the Histopathology Department at the Royal Victoria Hospital, was attached to the paediatric pathology service for two weeks (this is a routine attachment that all junior pathologists undertake as part of their professional training in their first three years). I would have discussed the case with him briefly as he was due to attend the inquest with me, again as part of his professional training. I do not recall the specifics of the discussion.

(i) **Whom did you discuss the review with?**
See answer to (2) g (i) above

(ii) **When did you hold that discussion(s)?**

See above

(iii) **What did you discuss?**
See above

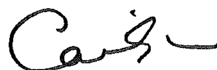
(iv) **What conclusions or views were reached on foot of this discussion(s)?**
See above

(v) **Outline any steps that were taken on foot of this discussion(s)?**
See above

(j) **Did you give evidence before the Coroner at the Inquest into the death of Lucy Crawford? If so, does the deposition appearing at Ref: 047-133-289, accurately reflect all of the evidence that you gave at the Inquest?**

The deposition appearing at 047-133-289 indicates that I presented a copy of Dr O'Hara's report as evidence (exhibit C). However, the report was accepted without discussion. I was not asked to provide a verbal statement or give evidence under oath: Dr O'Hara's commentary, report or any the pathological evidence therein were not discussed. To the best of my recollection, the Coroner, Mr. Leckey, made a statement indicating that the death had been accepted as being due to hyponatraemia.

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

Signed:  **Dated:** 11th Oct 2012