Witness Statement Ref. No. 290/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: James Kelly

Title: Doctor

Present position and institution:

Consultant Geriatrician

South West Acute Hospital

Western Health & Social Care Trust

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

Medical Director and Consultant Geriatrician, Erne Hospital, Sperrin Lakeland HSS Trust

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

WHSSB Cancer Unit Development Group (2002 – March 2005)

WHSSB Managed Clinical Networks Group (1999 – March 2005)

Management Board Local Health and Social Care Group (2002 – 2007)

Western Area DBS Project Board (June 2004 – 2007)

Chairman Sperrin Lakeland Local Task Force Group (1999 - 2007)

DHSS Specialty Advisory Committee - Advisor Internal Medicine (1996 - 2007)

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

Statement to PSNI –05th April 2005 ref: 015-016 – 001-013

WS – 290-1 – 6th November 2012

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

Ref:	Date:	
WS-290/1	06-Nov-2012	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.

I. SUPPLEMENTARY QUESTIONS ARISING FROM YOUR STATEMENT WS-290/1

(1) Arising out of your answer to question 6 of WS-290/1, please address the following matters:

(a) On what date did you receive a copy of the post mortem report from Mr. Fee, and who did he receive the report from?

I believe that Mr. Fee received the report in Mid-June 2000 and that he provided me with a copy shortly before the meeting with Dr. Quinn on 21st June 2000. I do not know who provided Mr. Fee with the Post Mortem Report.

(b) In August 2001 the Paediatric Unit received a copy of the RBHSC Fluid guidelines. Who in the Paediatric Unit received these guidelines, and who in the RBHSC sent them?

I was informed by E. Millar that the Paediatric Unit had received a copy of the RBHSC Fluid Guidelines. I do not know who received these Guidelines or from whom they were sourced.

(2) Arising out of your answer to question 8 of WS-290/1, please explain the basis for your assumption that the post mortem had been conducted at the request of the Coroner's Office?

The assumption is based on my, and the Review Teams', belief that any child dying from presumed gastroenteritis, and the manner of the acute deterioration, would automatically be a Coroner's case and any Post Mortem arising from discussions would be at the direction of the Coroner.

(3) Arising out of your answer to question 12(d) of WS-290/1, apart from obtaining assurances, did you take any steps to ensure that the recommendations were in fact implemented? If so, fully outline the steps that you took.

No. I relied on the assurances received from the Service Director and the Clinical Director. I expected that the changes to practice and learning were being enacted.

(4) Arising out of your answer to question 22(c) of WS-290/1 where you refer to the recommendation relating to the issue of fluid prescription, fully describe the steps that were taken to implement the other recommendations contained in the Review. If any of the recommendations weren't taken forward please explain how this omission occurred.

I am unable to answer this question, as these matters were addressed by the Directorate and Paediatric Department. I was not made aware of any failure or problem in addressing the recommendations.

(5) In your answer to question 23(c) of WS-290/1, you have set out the factors which at the time the Review report was produced you considered relevant to the cause of the cerebral oedema.

Arising out of your answer please address the following matters:

(a) Did you subsequently become aware that the hypotonic fluids administered to Lucy did or may have contributed to the cause of her cerebral oedema?

Yes I did subsequently become aware that the hypotonic fluids administered to Lucy may have contributed to the cause of her cerebral oedema.

(b) If so, state the date or approximate date on which you became aware that the hypotonic fluids administered to Lucy may have contributed to the cause of her cerebral oedema?

In or around June 2001 was when I became aware that the hypotonic fluids administered to Lucy may have contributed to the cause of her cerebral oedema.

(c) If applicable, how did you first become aware that the hypotonic fluids administered to Lucy may have contributed to the cause of her cerebral oedema?

My first awareness of any possibility of Hypotonic Fluids being an issue in paediatric practice and potentially causing cerebral oedema was following the meeting with Dr. Moira Stewart on 31st May 2001 (036a-027-067) and the discussion that occurred at the Medical Directors' Group meeting on 18th June 2001.

(d) If applicable, what specific steps did you take when you became aware that the hypotonic fluids administered to Lucy may have contributed to the cause of her cerebral oedema?

This lead to me, along with Dr. Raymond Fulton, to ensure the matter was raised with the office of the CMO for consideration of Regional Guidance. I also issued an alert letter on 21st June 2001 to the Trust paediatric staff asking them to consider reviewing the practice of using hypotonic fluid for rehydration (036a-055-141).

Further, more definitive, statement that hypotonic fluids may have caused the cerebral oedema and subsequent death of Lucy was April 2002 upon receipt of the Medico-Legal report from Dr. John Jenkins (ref: 036c-041-099) in preparation for the Scrutiny Committee meeting on 12th April 2002.

(6) Arising out of your answer to question 31(b)(v) of WS-290/1, please address the following matters:

(a) On each occasion (November 2001 and April 2002) identify the person(s) in the DLS from whom you sought clarification in relation to the holding of an Inquest and the reason for the delay;

At the Scrutiny Committee meeting on 15th November 2001, DLS were asked to contact the Coroner re the Inquest. Donna Scott from DLS was present at this meeting, along with Mr Kevin Doherty, Ms O'Rawe and myself.

At the Scrutiny Committee meeting on 12th April 2002, DLS were asked to confirm the position regarding an Inquest. Meeting attendees were myself, Mr Kevin Doherty, Ms O'Rawe and Miss Finnegan.

(b) On each occasion what advice did you receive in relation to these matters.

The advice received following the November 2001 request for clarification was that the Inquest was not yet scheduled. I was also informed that this time delay was not unusual. Arising from the inquiries made at the April 2002 Scrutiny Committee, I learned later in 2002, through Scrutiny Committee discussions, that 'the Belfast coroner's office knows about this case and no Inquest is planned'.

(c) On what date did you become aware that a Coroner's Inquest was not being arranged.

I learned later in 2002 through the Scrutiny Committee discussions that no inquest was planned. At that stage I sought a meeting with Counsel for the Trust to discuss the case – this took place in April 2003 (ref: 036c-043-101)

II. OTHER MATTERS

(7) Please refer to the report sent to you by Dr Jarlath O'Donohoe dated 24 August 2003 [Ref: 047-053-148 to 047-053-149]in which he advised you (paragraph 4) that he recalled Dr Malik had started the intravenous normal saline before calling him and the 500mls given was virtually complete before he arrived. At paragraph 6 of the report he informed you that *"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 address the following matters.

(a) Did you ask Dr O'Donohoe to provide this report to you? If so please state whether you asked him to address any specific matters in the report and if so what were those matters.

As requested by the Coroner, (ref: 036c-050-109) (ref: 36c-053-119) I asked Dr. O'Donohoe, and other relevant clinical personnel, to provide a witness statement needed by the Coroner in the preparation for the planned inquest. The list was compiled in May 2003 with direct assistance from Mr. Fee (ref: 034-097c-285) who lead the original Case Review and Esther Millar, Service Director (ref: 034-097c-284a) & (ref: 047-178-385).

I provided Dr. O'Donohoe with a copy of the letter from the Coroner and the attached report from Dr. Sumner (ref: 036c-051-11).

In accordance with my customary practice, I would have requested an accurate and factual witness statement and advised that the statement, along with others, would be forwarded to the Trust's legal team managing the preparation for the Inquest.

(b) **Did you request the report in writing. If you did please provide the Inquiry with a copy of your request.**

I believe that I requested this in writing but I do not have a copy of the request.

(c) **For what purpose(s) did he provide this report?**

As a witness statement / deposition for the Coroner.

(d) **Identify the document you understood Dr O'Donohoe to be referring to as *"the version I sent to you previously"* and provide a copy of that document to the Inquiry.**

I believe Dr. O'Donohoe is referring to his previous or original statement of Yr 2000 (ref: 036-040-079). I am not aware of any other statement version.

(e) **Describe what steps you took on receipt of this report from Dr O'Donohoe. In particular;**

(i) **Did you discuss this report with Dr O'Donohoe? If so please give details of the discussion.**

I understood my role to be to gather and forward statements from identified staff to the Trust's legal team. The statements were forwarded to Mr. Kevin Doherty, and I believe were then forwarded unaltered to the Trust's Legal Team (see reference 047-038-118) I did not discuss the Witness Statement of Dr. O'Donohoe either with him or any other parties.

(ii) **In so far as you are aware, was Dr O'Donohoe at any stage asked to account for his failure previously to mention that almost 500mls of normal saline had been administered before he arrived and that this was a much larger volume than he would have used, and if so what did he say? If not, please explain why not.**

As stated, I considered my role was to forward the statements of the clinicians with direct involvement in Lucy's care. I had no discussions with individuals on their statements. It would be inappropriate for me to attempt to alter either by interrogation or suggestion any prepared witness statement.

(iii) **In so far as you are aware, was Dr O'Donohoe asked at any stage to explain the basis for his belief that the infusion of normal saline was commenced following the first episode of diarrhoea and before the convulsion? If so what did he say? If not, please explain why not.**

No discussion took place between Dr. O'Donohoe and myself re this matter. I perceived these to be matters for the Inquest.

(iv) Did you share this report with anyone else? If so, please identify the person(s) with whom the report was shared.

As identified previously these statements were all forwarded to the Trust's legal team via Kevin Doherty Westcare Business Services Litigation Manager. (ref 047-038-118).

(8) Please refer to the undated report of Dr O'Donohoe which appears to have been faxed to Mr Kevin Doherty on 12 December 2003 [Ref: 047-026-102] and subsequently forwarded to the Coroner [Ref: 013-018-066]. This differs from the report from Dr O'Donohoe to you 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 sent to Mr Doherty. Arising from this:

(a) Are you aware of the circumstances in which these paragraphs were omitted? If so please explain the circumstances and reasons for the omissions.

I have no knowledge of the circumstances of these changes. I believe any changes to Dr. O'Donohoe's statement would have been through advice from the Trust's Legal Team. This most likely explanation for this was via direct contact between Dr. O'Donohoe and Kevin Doherty on behalf of the Trust's Legal Team and explains the direct faxed statement (ref: 047-155 -333, 047-155-334).

(b) In particular explain (in so far as you are aware) the circumstances in which Dr ODonohoe'statements

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

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

were omitted from the report to Mr Doherty which was forwarded to the Coroner, and the reasons for those omissions.

I have no recollection of any involvement in changes to Dr. O'Donohoe's statement.

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

Signed: Pam Hall Dated: 21st Jan 2013