Witness Statement Ref. No. WS-298/3

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Moira Stewart
Title: Doctor

Present position and institution:
Senior Lecturer Queens University Belfast/ Consultant Paediatrician, Belfast health and Social Care Trust

Previous position and institution:
[As at the time of the child's death]
Senior Lecturer Queens University Belfast/ Consultant Paediatrician, North and West Belfast HSC Trust

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-July 2012]
Chairman Paediatric Training Committee 1999-2002
Regional Advisor to Royal College of Paediatrics & children 1999-2002
Advanced Paediatric Life Support Instructor 1999-2006
External Assessor SpR Training Programme RCPI 2004 -
Regional Academic Advisor, RCPCH 2006 -
Lead Clinician (NI) Confidential Enquiry into Maternal and child Deaths - 2005 -
NI Representative on Council RCPCH 2001-2004
Principal Regional Examiner RCPCH 2006-2012
Officer for Ireland RCPCH 2007-2012
President Ulster Paediatric Society 2011-

Children and Young People's service framework- Acute and Long term conditions subgroup lead 2010-

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

Report to Sperrin Lakeland Trust on management of four clinical cases including LC -sent 26-04-2001. The review followed a request to Royal College of Paediatrics and Child Health for a general paediatrician to review clinical care provided by one consultant, to four children in Sperrin Lakeland Trust, across a range of presenting symptoms and signs.

External professional competency review of the practice of one individual - report sent to Sperrin Lakeland Trust July 2002

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

Ref:	Date:	
WS-298/1	19-11-2012	Inquiry Witness Statement
WS-298/2	18-Jan -2013	Supplemental 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 answer to Question 15 (d) of WS-298/1 (page 13) you have stated as follows:

"The External review report does state that "more attention to the detail of the fluid therapy might possibly have avoided this girl's cerebral oedema and fatal outcome.""

Arising from this please identify, and provide a copy of, the full document from which this quotation is taken together with all drafts of the external review report and all correspondence concerning the external review in your possession and answer the following questions:

The only documentation I have from the external review is a draft (undated) – full copy enclosed – and two letters, one from Dr Boon to me and another from me to Dr Boon, following individual telephone conversations with sister Treanor who was not available when we visited Erne Hospital (letters enclosed). I have to spoken to Dr Boon and can confirm that when he retired from the Royal Berkshire Hospital in June 2011 he arranged for all the confidential papers in his filing cabinet to be shredded, including brief notes he had made relating to our joint enquiry.

(a) Explain fully the circumstances in which this statement (that more attention to the detail of the fluid therapy might possibly have avoided Lucy's cerebral oedema and fatal outcome) was not contained in the versions of the External review report sent to Dr Kelly [Ref 036a-049-303 to 036a-053-323].

From memory Dr Boon and I discussed the draft report. We took account of our knowledge that a medico-legal case regarding Lucy Crawford's management in the Erne Hospital was underway and that we had not been asked to contribute to the process . We decided that we should not exceed the remit of the external review which was to examine the professional clinical competency of an individual consultant. There were other professionals involved in Lucy's management but their actions were outside the scope of the review.

(b) If the statement that more attention to the detail of the fluid therapy might possibly have avoided Lucy's cerebral oedema and death was disclosed to anyone please identify to whom it was disclosed and in what circumstances.

Not to my knowledge.

(c) Explain fully your reasons for concluding that more attention to the detail of the fluid therapy might possibly have avoided Lucy's cerebral oedema and death.

The documentation of events which occurred on the night of Lucy's death was very poor. It did appear that the prescribing and administration of fluids fell short of accepted good practice, but extended beyond the care delivered by the consultant who was the subject of the review.

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

Signed: **Dated:** 21.03.13

PRIVATE AND CONFIDENTIAL

DRAFT

RCPCH External Review - Dr Jarlath O'Donohoe

Introduction

The Royal College of Paediatrics and Child Health was contacted by Sperrin Lakeland Health and Social Care Trust to look into professional concerns about the clinical competency and professional performance of Dr O'Donohoe. Although the terms of reference were to deal with professional matters, we were aware of other matters which had been raised and previously investigated by Sperrin Lakeland Trust.

Most of the professional issues were raised by Dr Ashgar, a Staff Grade Paediatrician at Erne Hospital. Dr Ashgar had written three letters relating to a number of patients to Mr Mills, Chief Executive of the Sperrin Lakeland Trust citing cases where he alleged clinical mismanagement by Dr O'Donohoe.

Review Process

Documents relating to the professional competency review were made available to us before the visit to Erne Hospital. These included copies of correspondence between Dr Ashgar and Mr Mills, details of a report by an investigation team at Erne Hospital and an RCPCH assessment carried out in 2001 of four of the cases raised by Dr Ashgar. Additionally at the time of the external review we were provided with the medical notes of the cases which had not previously been assessed by the RCPCH.

On the 24th June 2002 we interviewed the following individuals:

- Mrs Esther Miller, Women & Children's Services Director
- Dr C Halahakoon, Consultant Paediatrician
- [redacted]
- Dr M Ashgar, Staff Grade, Paediatrics
- [redacted]
- Mr T Anderson, Clinical Director, Women & Children's Services Directorate
- Dr J Kelly, Medical Director
- [redacted]
- [redacted]
- Mr Eugene Fee, Director of Acute Services
- Dr O'Donohoe, Consultant Paediatrician

Sister Treanor, Paediatric Sister, was on leave but interviewed by telephone independently by Dr Boon on the 16th July and Dr Stewart on the 17th July 2002.

We were given background information about Sperrin Lakeland Trust and we also visited the children's ward and outpatient department.

Allegations of Clinical Incompetence

Dr Ashgar raised the following cases in which he alleged clinical incompetence by Dr O'Donohoe:

1. Lucy Crawford

   Lucy was a child admitted with vomiting requiring IV fluids who suffered a convulsion followed by a respiratory arrest and subsequently died of cerebral oedema in Belfast.

2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]

[redacted]

2. [redacted]

3. [redacted]

4. [redacted]

[redacted]

5. Specific Cases of Alleged Clinical Incompetence

All of the cases cited by Dr Ashgar were looked at in detail. The following areas were identified where Dr O'Donohoe's clinical competency fell below what would normally be expected of a Consultant Paediatrician:

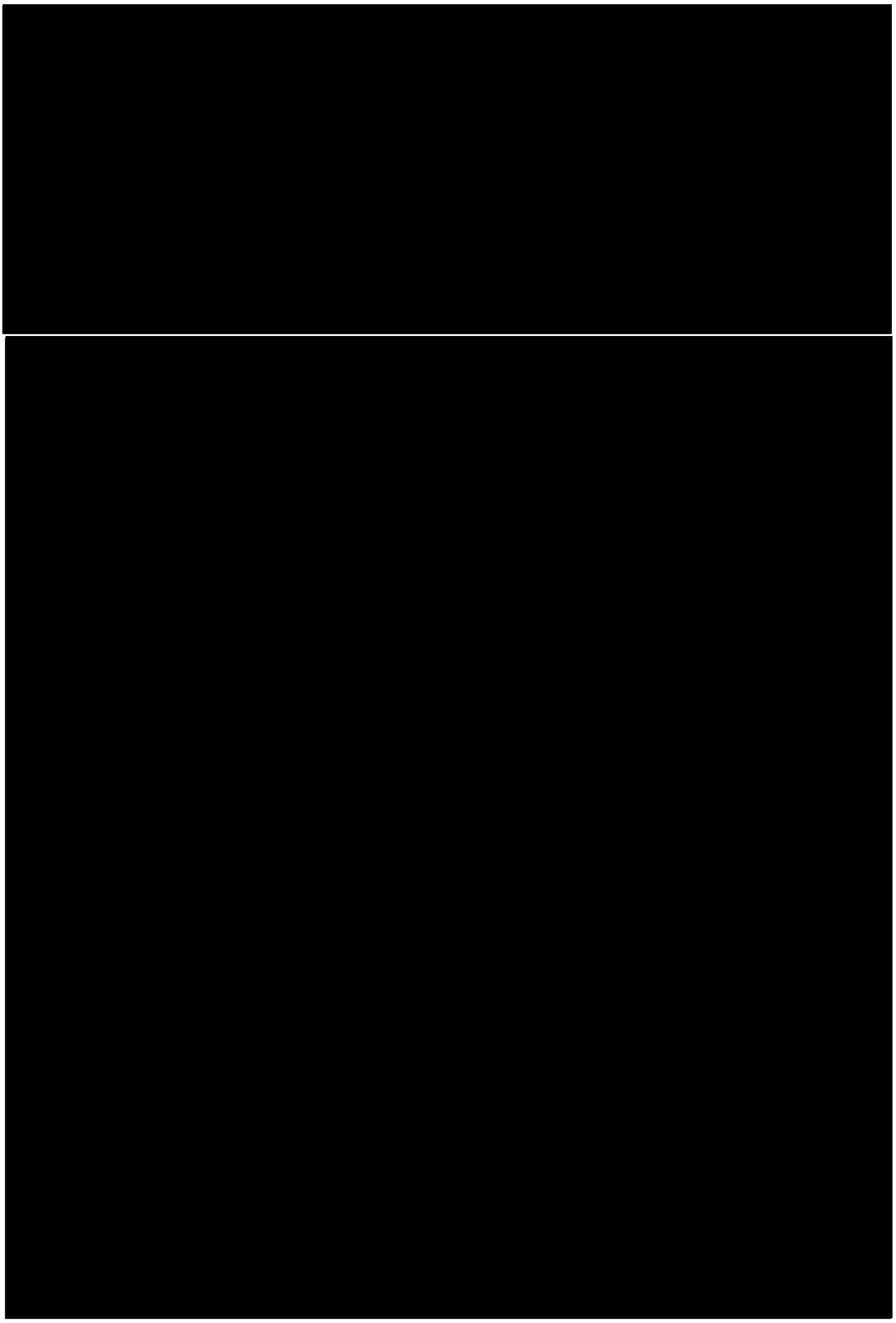
(i) [redacted]

(ii). [redacted]

(iii) *Poor documentation*

The prescription for the fluid therapy for LC was very poorly documented and it was not at all clear what fluid regime was being requested for this girl. With the benefit of hindsight there seems to be little doubt that this girl died from unrecognised hyponatraemia although at that time this was not so well recognised as at present. More careful attention to detail of the fluid therapy might possibly have avoided this girl's cerebral oedema and fatal outcome.

(iv) [redacted]



Conclusion

Sperrin Lakeland Trust is a geographically isolated unit. The ability of paediatric services to provide the optimum care, the babies and children must depend on a high level of interpersonal communication, mutual respect for the knowledge, skills and competencies of other professionals, and a willingness to listen to and learn from the experiences of all members of the paediatric team. It appears that, irrespective of the professional issues raised, the wellbeing of children is compromised by the interpersonal relationships in the paediatric department. The focus needs to shift back to patient care.

Yours sincerely

Dr A W Boon
CONSULTANT PAEDIATRICIAN

Dr M C Stewart
CONSULTANT PAEDIATRICIAN/SENIOR LECTURER IN CHILD HEALTH

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22 July 2002

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23 July 2002
Dictated 23.7.02

PRIVATE AND CONFIDENTIAL

DRAFT

Dear Moira

Interview with Sister Treanor 16.7.02 – Dr Jarlath O'Donohoe

[redacted] At first she sometimes felt a little uneasy with the way in which he practised paediatrics but felt that he was never unsafe. An example of this was that sometimes he prescribed oral rather than intravenous fluids but always with a good outcome.

I then discussed the specific allegations of clinical incompetence that had been made by Dr Ashgar:

1. Lucy Crawford

   Although Sister Treanor was not on call when this child was admitted she was on duty the following morning. The nurses who had been looking after Lucy did not express any concern. She reported a conversation with Dr O'Donohoe when he said to Sister Treanor "what are you going to do about the IV fluids your staff got wrong?" In response Sister Treanor said "who prescribed the IV fluids?". Sister Treanor admitted that there had been a nursing error in totalling the fluids. Sister Treanor felt that Dr O'Donohoe was trying to instil a blame culture relating to this particular case.

[redacted]

[redacted]

Yours sincerely

Dr A W Boon
CONSULTANT PAEDIATRICIAN

THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Chairman: O'Hara J

CHRONOLOGY OF MATERIALS AND CONTACT BETWEEN DR KELLY AND DR STEWART

Key:	**Bold**	**Dr. Kelly's chronology contained in WS-290-01**
	Normal	Dr. Stewart Additional documents

16.07.2001	**Post 16.07.00: Telephone contact with Dr. Moira Stewart, Regional College Advisor in NI for the RCPCH to seek independent external assistance in assessing the competence and conduct of Dr. O'Donohoe**
14.09.2000	
(036a-009-016)	**Letter to Royal College of Paediatrics &Child Health (RCPCH) requesting external assistance on professional competency and professional conduct of O'Donohoe**
09.11.2000	
(036a-010-019)	**Initial Response from RCPCH nominating Dr. Stewart, NI Regional Advisor on Paediatrics to carry out review**
December 2000	**Formal request to Royal College of Paediatrics for assistance in assessing competence and performance issues**
03.01.2001	Tel. contact by Dr. Stewart with Lead Clinician Dr. Crishanti Halahakoon who said she would speak to Dr Kelly
	- see handwritten note on letter of 09.11.2000
15.01.2001	Letter to Dr. Halahakoon

24.01.2001	**Phone discussion with Dr. Stewart outlining how she wished to carry out the review on these cases including Lucy Crawford's. Dr. Quinn's report provided.**
25.01.2001	
(036a-015-030)	**Letter from Dr. Stewart confirming how she was undertaking the review**
26.01.2001	
(067D-002)	**Letter from Dr. Kelly to Dr. M. Stewart**[1]
06.03.2001	Letter from Patricia Hamilton (RCPCH) re Denis Carson (Paediatric Endocrinologist)
28.03.2001	Letter from Dr. Stewart to Dr. Kelly
10.04.2001	
(035-006)	**Letter from Dr. Carson to Dr. Moira Stewart enclosing report**
24.04.2001	Letter from Dr. Stewart to Dr. Kelly
28.04.01	
(036A-022-039)	**First draft of report from Dr. Stewart with invitation to meet if further clarification** (sic.)
31.05.2001	
(036a-027-067)	**(notes typed 01.06.01) Meeting with Dr. Stewart to finalise and clarify aspects of report (short notes of prepared questions and answers**
01.06.2001	Diary entry by Dr. Stewart indicating meeting with Dr. Kelly was on this day and not 31.05.2001

[1] Disclosed on 7 June 2013