

PRIVATE AND CONFIDENTIAL

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 the 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 the Erne Hospital. These included copies of correspondence between Dr Ashgar and Mr Mills, details of a report by an investigation team at the 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.

We interviewed a range of relevant nursing, medical and managerial staff involved in the delivery of paediatric services in Sperrin Lakeland Trust. We were given background information about Sperrin Lakeland Trust and we also visited the Children's Ward and Outpatient Department.

Allegations of Clinical Incompetence

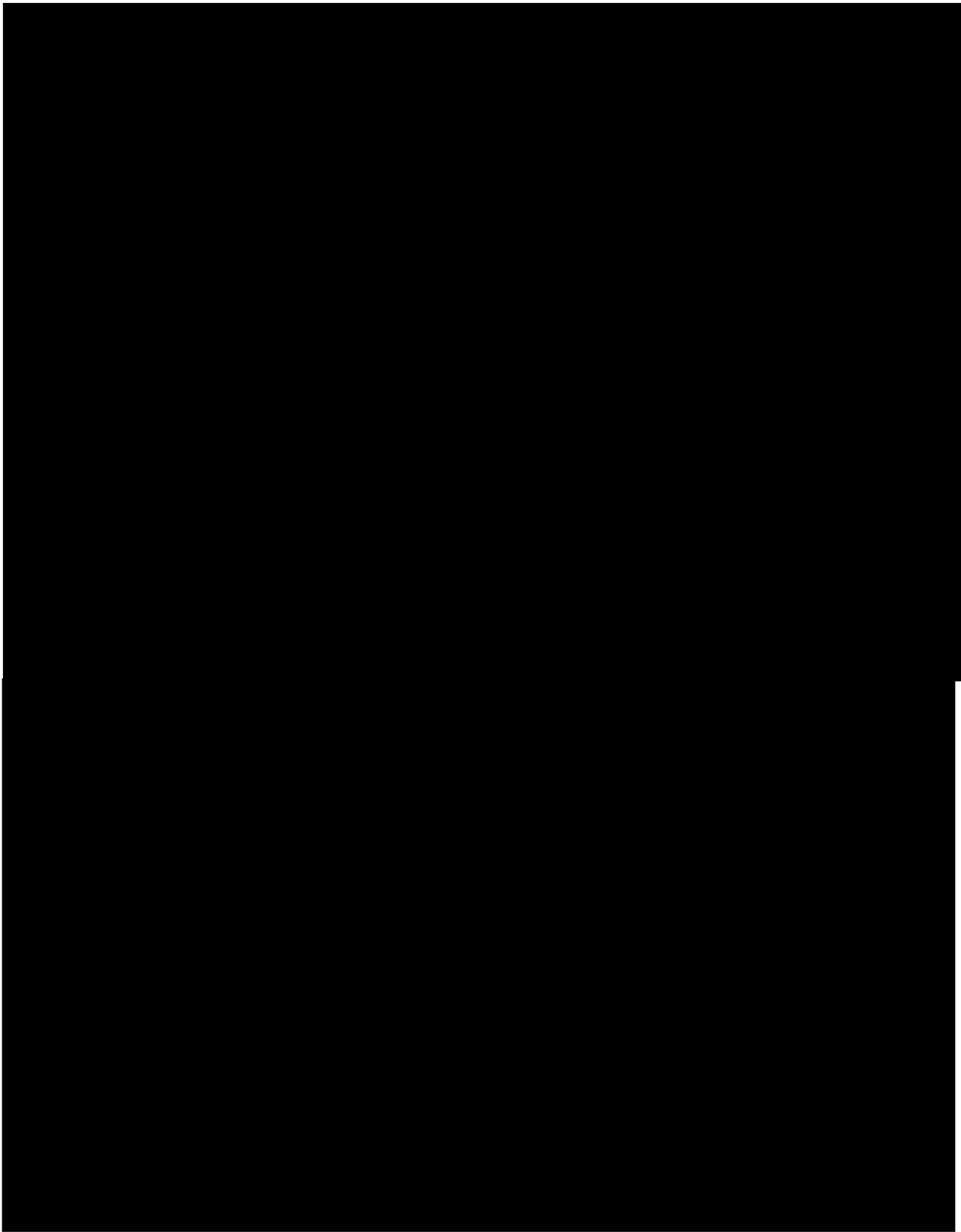
Dr Ashgar raised the following cases in which he alleged clinical incompetence by Dr O'Donohoe:

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.

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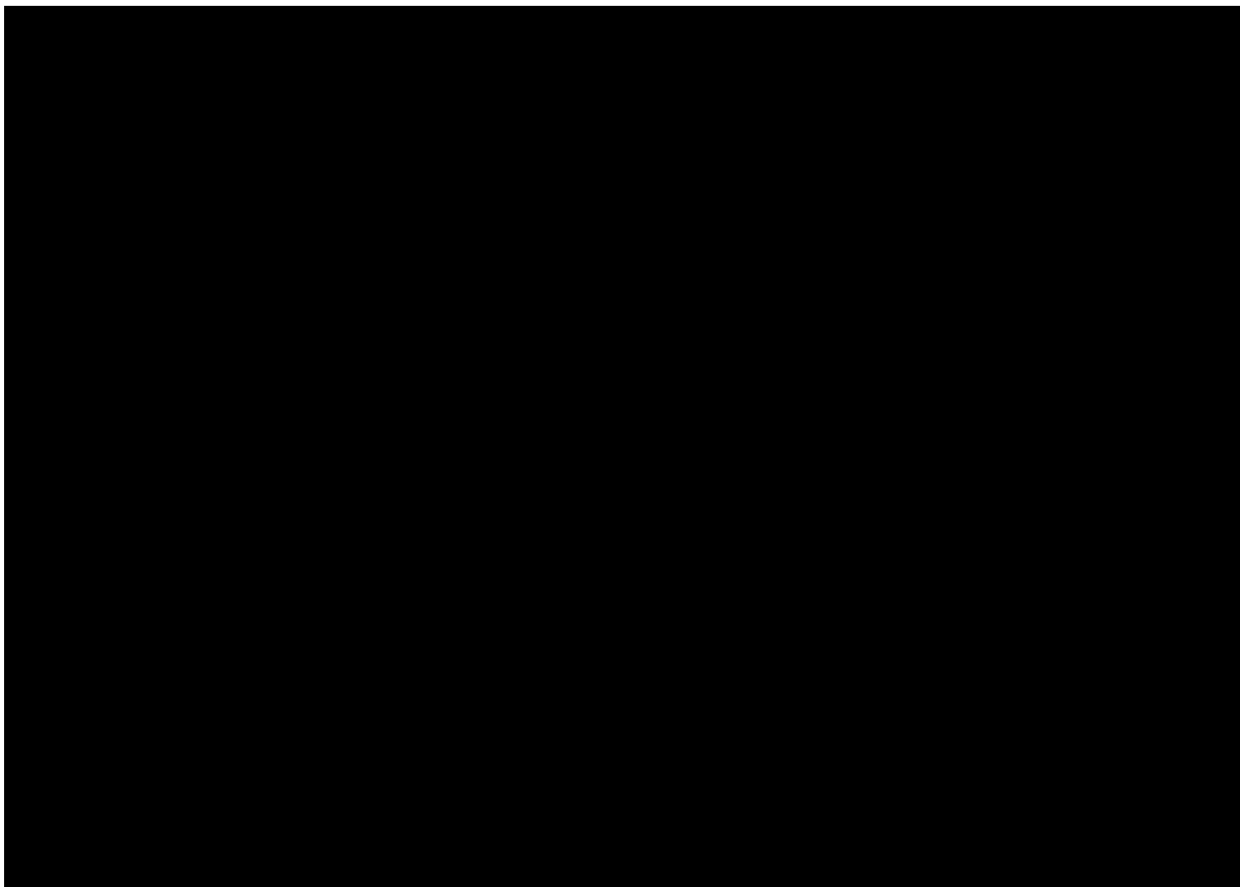
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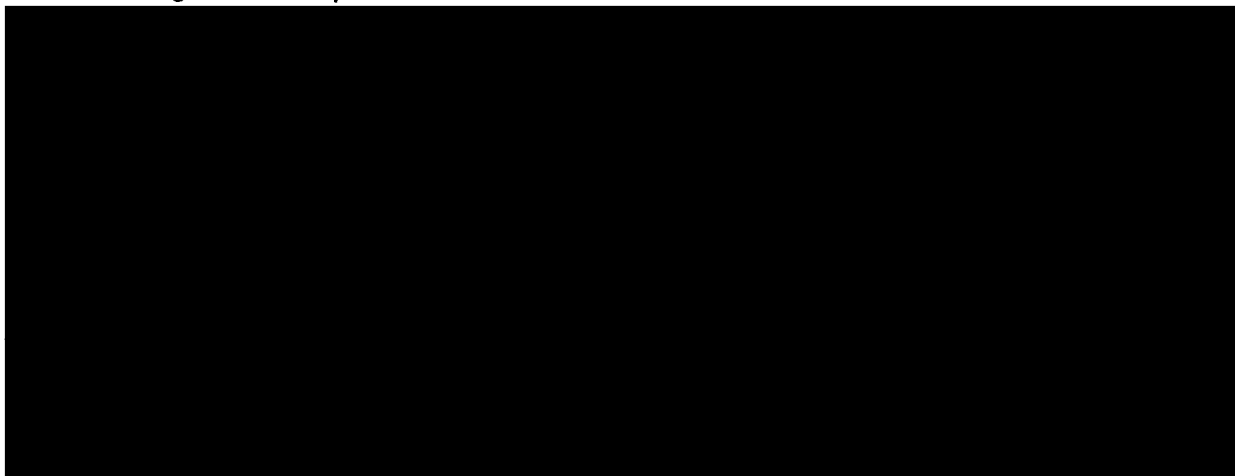
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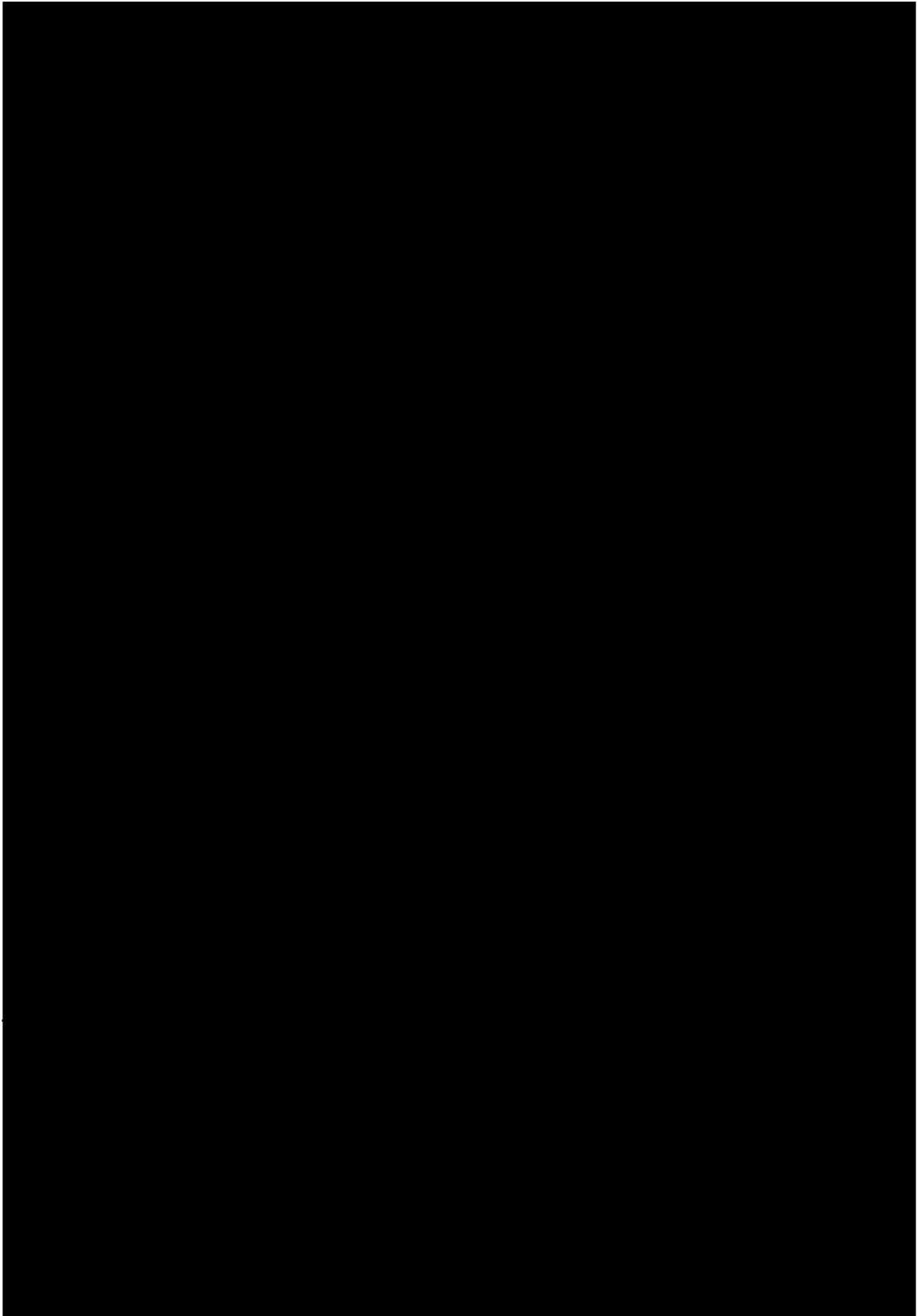
(iii) *Poor documentation*

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.



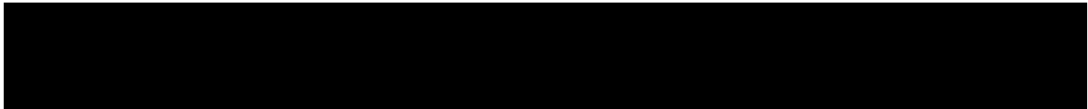
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Conclusion

Sperrin Lakeland Trust is a geographically isolated unit. The ability of paediatric services to provide the optimum care for 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

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