EXTRA COPY

To
Mr. H. Mills,
Chief Executive,
Sperrin Lakeland Trust,
Enniskillen.

Subject [redacted] incompetence of Dr. O' Donohoe.

Dear Mr. Mills,

[redacted]

I will now say a few words about his incompetence and lack of clinical judgement in managing the patients.

1. Lucy Crawford
Lucy was admitted in the ward with a history of vomiting. The SHO could not put up the IV line so he called Dr. O' Donohoe who was on call that night. According to the SHO Dr. O' Donohoe examined the child and put up the

IV line. The SHO then got busy with the other three admissions. Dr. O' Donohoe told the nurses to give fluids at 100mls per hour. At three o' clock in the morning the child got a convulsion and went into respiratory arrest. She was later transferred to Belfast where she died. A P.M. revealed cerebral oedema. This child might have been given excess of fluids. All through the night fluids were running at 100 mls per hour. After the child died in Belfast he made additions in the chart. He wrote that he had ordered that the fluids should be given as a bolus of 100mls and then at 30mls per hour. In fact, neither the SHO nor any of the nurses were told to give the fluids at 30 mls per hour. Nursing records are always in detail and correct. There is no record of him ordering the fluids at 30mls per hour in the chart or in the nursing records. Later he spoke to the SHO and told him that

a) You can add whatever you want in the chart. The SHO replied that he did not need to add anything and that he had already written whatever had happened.

b) Have you got any medical defence or protection

c) I can put the blame on you and write down that it was all your fault but I won't do that.

You may like to confirm this with Dr. Malik who was the SHO on call that night. He was so distressed and tearful that he told me everything and asked me for guidance. Instead of being helpful and supportive Dr. O' Donohoe was trying to intimidate the SHO.

[redacted]

[redacted]

I strongly feel that it is my moral and ethical duty to inform and alarm the Trust about his inadequate medical knowledge. He has put the children's lives at risk on several occasions. I have not informed the GMC but if I feel it necessary I will. I appeal to the Trust Board to act quickly and swiftly before another child dies in the children ward.

Yours Sincerely

Dr. M Asghar
Erne Hospital
Enniskillen

copy to
1. Dr. C. Halahakoon, consultant paediatrician, Erne hospital
2. Mrs. E. Miller, clinical services manager, SLT
3. Dr. J. Kelly, director and consultant physician, Erne hospital
4. Dr. M.P.S. Varma, consultant physician, Erne hospital
5. Dr. T. Anderson, consultant obstetrician, Erne hospital
6. Mr. E. Fee, director, acute hospital services, SLT