STATEMENT OF DR JARLATH O'DONOHOE

I, JARLATH MICHAEL O'DONOHOE, of [redacted] MBBCH, MRCP, MSC, FRCPCH, qualified in Dublin in 1978 and was appointed as a Consultant in Paediatrics at the Erne Hospital, Enniskillen, in July 1997. I had previously worked in a similar post in Queen Mary's Hospital, Roehampton, London and had been a Senior Registrar in Paediatrics at the Westminster Children's Hospital before being appointed as a Consultant in 1992 I attach a copy of my curriculum vitae as an exhibit to this statement marked "JMOD 1". I was the Consultant on call on the night of 12th April 2000, the night Lucy Crawford was admitted to the Erne Hospital, Paediatric Ward. "On call", means that I would do my normal day's work from 9am to 5pm or usually later. I would then be available to be called by the junior medical staff for advice – and if appropriate to attend - throughout the night until commencement of my normal duties the following day. I was on call every second night as there were only two Consultant Paediatricians on the rota.

I received a call from Dr Malik at approximately 9.30pm. He was the Senior House Officer in Paediatrics on duty at the Hospital that night as the admitting doctor. Dr Malik telephoned me as he was having difficulty getting an IV cannula into a child who had been admitted with a history of vomiting and drowsiness. I was not asked my opinion on a diagnosis and understood that I had been contacted because of Dr Malik's problems with insertion of a cannula which can be a difficult task in a young child.

I attended and saw the child who appeared sleepy but could be roused. Dr Malik and Nurse Swift were present in the room when I saw her. Dr Malik had already carried out a full examination and noted it in her medical notes and from my observations I agreed with his assessment that she was dehydrated (though only mildly). She took some fluids orally. I applied the anaesthetic cream to the child's hand and was successful in inserting the cannula. As I was doing so I instructed Dr Malik and Nurse Swift (who as a nurse would be responsible for setting up the drip and punching in the numbers for the dosage and rate) as to fluid management. Dr Malik appeared to be making a note as I talked, (part of his function as a Junior Doctor). It would also have been for him to write out the prescription in the relevant part of the notes. Neither Dr Malik nor Nurse Swift queried my instructions, nor asked me to sign the prescription chart.

When I checked on Lucy some minutes later she was standing on the couch in front of her mother and looked well. I returned home between 11pm and 11.30pm believing that my instructions for management of Lucy were clear and that everything was under control.

I received a second call from Dr Malik at approximately 3am the next morning. Dr Malik gave a brief but vague account of the child having suffered a "strange episode", which he could not describe in clear terms. My presumption was a febrile convulsion. I went immediately to the Hospital. I repeated the blood electrolytes tests on my arrival given the recent history of diarrhoea which had been told to me by Dr Malik.

When I arrived at the Hospital I was surprised to find that a saline drip was running freely. I was surprised because I had not instructed that this should be set up and I reduced the flow to 30ml. The blood electrolyte tests showed that Lucy's sodium level had dropped to 127. I reviewed the patient and was concerned to note that her pupils were fixed and dilated. I knew at this stage that something had happened but could not comprehend how this could have occurred given the sodium level obtained. Dr Malik had been bagging Lucy and I took over but it was clear that there was no respiratory effort.

I tried to intubate the child but the bagging was satisfactory and I thought it best to wait for the Anaesthetist to arrive to perform intubation. My only concern at this stage was Lucy's condition rather than an investigation into its cause. Lucy was intubated by Dr Auterson and taken to the Intensive Care Unit. As she required a child's ventilator and none was available at the Erne Hospital she needed to be transferred to the Royal Belfast Hospital for Sick Children. I spoke to Dr McKeague as per the Letter of Transfer attached to this statement. I went with a nurse from ICU in the ambulance with Lucy to the Royal Victoria Hospital for Sick Children. Towards the end of the journey she required a dopamine infusion because her blood pressure was falling.

I did not write any of the initial notes following Lucy's admission and did not write the fluids prescription or make any entries on the fluid balance chart. I had appropriately delegated the management of her fluids to a competent junior doctor and nurse who were going to be with Lucy whereas I would not be present. I had attended to insert a cannula but it was not necessary for me to stay to directly supervise her care. Dr Malik was responsible for Lucy's care and Nurse Swift had the responsibility for setting up the drip and it was the role of the Nursing staff to monitor and complete the fluid balance charts. After her transfer Dr Crean from the RVH rang and queried the fluids given. As I had no role in the actual administration of fluids or completion of the fluid balance charts it is impossible for me to comment on what actually transpired during the hours when I was absent from the hospital.

As the circumstances of Lucy's sudden deterioration could not be explained I reported the death to Dr Kelly Medical Director on 14th April 2000. I also met with the parents but had no explanation as to why Lucy had died as I did not have her records at the time of the meeting because I had given the notes to Dr Kelly when I reported the death of Lucy Crawford to him.

This Statement is a true and accurate reflection of my dealings with Lucy Crawford to the best of my knowledge and belief.

Signed .....

Dated 26/4/2005