POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC103

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

BDV 44

Master Tape Seal Number(s):

T88749A

PERSON INTERVIEWED: DR DONNCHA HANRAHAN

ADDRESS: [redacted]

DOB:

PLACE OF INTERVIEW: GROSVENOR ROAD, PSNI

DATE OF INTERVIEW: 02/03/2005

TIME COMMENCED: 1330 HOURS

TIME TERMINATED: 1349 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN

2 D/CONSTABLE HALL, CARE UNIT, ENNISKILLEN

3

OTHER PERSON(S) PRESENT:

1 [redacted] SOLICITOR

2

3

MADE BY: D/SERGEANT CROSS

Tape Number and Tape Times:

D/Sgt Cross: It is 1330 and we are continuing the interview and I just want to confirm the same four people are in the room and remind you doctor that the caution still applies. I would ask you to confirm that we didn't ask any questions about these matters while the tapes were off.

Dr Hanrahan: I confirm that.

D/Sgt Cross: That's grand. We were discussing perhaps Doctor O'Hara's role, what you're saying is that Doctor O'Hara had all your information, he then gains further information from the post-mortem and your advice to Dara O'Donoghue as to what is recorded on the death certificate is very largely guided by what Doctor O'Hara.

Dr Hanrahan: I believe it is completely guided.

D/Sgt Cross: Completely guided?

Dr Hanrahan: I believe it is yes.

Dr Hanrahan: Ok. All the relevant points covered in Doctor O'Hara's summary are in the death certificate; nothing is in the death certificate that wasn't on Doctor O'Hara's summary.

D/Sgt Cross: And the information provided to Doctor O'Hara and to Pathology in relation to Lucy, that is what we have recorded on the autopsy referral form, is that correct?

Dr Hanrahan: The notes would have gone over with her as well.

D/Sgt Cross: And the notes?

Dr Hanrahan: Oh yes...

D/Sgt Cross: Right. You have mentioned doctor that you are still not convinced that the 127 was sufficient to cause coning are at least you weren't then and you're not convinced now?

Dr Hanrahan: No I'm not convinced no.

D/Sgt Cross: Well what do you think might have caused the coning?

Dr Hanrahan: In Lucy you mean?

D/Sgt Cross: Yes?

Dr Hanrahan: It was hyponatraemia but at a much lower level of sodium.

D/Sgt Cross: But it was the fact that it was possibly 116?

Dr Hanrahan: That's speculation; I believe that, that explains it much better than the information that I was party to or privy to at the beginning.

D/Sgt Cross: Were you aware Doctor of the volumes of fluid, is that part of the picture?

Dr Hanrahan: ...No... you can give as much as you want as long as the sodium remains, the actual value is I mean the more volume of dilute fluid you gave then I suppose the more sodium it will drop. It is actually the drop in sodium, which is, that was my opinion at that time, that the sodium was not striking, it was not the warning bell the lower sodium would have been.

D/Sgt Cross: So if the sodium level hadn't dropped so low the volume is irrelevant really, is that what you're saying?

Dr Hanrahan: It's not, what's going to impinge upon the clinical deterioration is the amount, because if you have, basically what you have is two compartments, blood and brain tissue and if the sodium content which is the main, if you have a cup with some sugar at the bottom of it and put fluid in, the water in, the sugar draws the fluid into it. It drops 1 inch of the sugar on it. So you get runs from dilute to concentrated, water will go from a dilute to a concentrate. So if the two fluids are roughly equally you won't get that shift which did happen and it was my opinion then and it is still my opinion that the 127 was not enough to cause that degree. A lower one would however be much more ...

D/Sgt Cross: Well then doctor you remember it was mentioned at the Inquest by some of your colleagues that a very, quite a large amount of fluid had been given to the child. Leaving the sort of the concentrations out of it, there is no record really of Lucy passing any urine or very little, there is a damp nappy mentioned at 11.00 pm, now there was a very large bowel movement.

Dr Hanrahan: She probably lost a lot of fluid into her gut I think what happened.

D/Sgt Cross: That's what I was going to ask, where does the fluid go if you're not passing it?

Dr Hanrahan: Basically what happens - you have gastroenteritis, which Lucy did have, which was subsequently proven on microbiology, the fluid runs into your gut.

D/Sgt Cross: From your blood basically?

Dr Hanrahan: From your blood, so diarrhoea and illness like cholera is the big issue for children in the third world. But it shouldn't happen here.

D/Sgt Cross: I've a list of questions doctor the vast majority, which I'm sure you have already answered, but if you bear with me while I run through them to make sure that I've covered everything. You have said doctor that it was your opinion that the Coroner should be informed and because of the uncertainty as to the exact cause of her death a post-mortem should be done.

Dr Hanrahan: Carried out yeah.

D/Sgt Cross: I have asked why did you not tell the coroner that a post-mortem was being done. What would you say to that?

Dr Hanrahan: Yeah it just didn't occur to me. In retrospect perhaps I could have, I suppose I'm not sure, I was under the impression that I had already informed the coroner and suppose I passed it on to Pathology really by that stage. With hindsight maybe I could have gone back to them, but I didn't.

D/Sgt Cross: In your experience is it common for pathology to do a post-mortem, produce a report and give that report to someone on the ward like yourself and for the hospital doctor, not pathology, to form the opinion that this should go to the coroner and the ward actually contact the coroner as opposed to pathology, does that happen?

Dr Hanrahan: I'm not sure; I don't know the answer to that...but I had been to the coroner myself and not go back to them. In retrospect I accept maybe I could have, but I think maybe Mr Leckey feels that in retrospect that Dr O'Hara might have sent it back as well. I don't know. I believe Dr O'Hara was too ill to be questioned at the Inquest as to why he didn't.

D/Sgt Cross: Yes.

Dr Hanrahan: I was quite an inexperienced Consultant at that stage, I may well have just felt that I had passed to a senior pathologist at the time.

D/Sgt Cross: Doctor do you recall discussing the findings of the post-mortem with any of your colleagues?

Dr Hanrahan: Not off hand, No.

D/Sgt Cross: Specifically do you recall discussing the post-mortem results with Doctor Jarlath O'Donohoe?

Dr Hanrahan: No, but when I rang him, he gave me the impression that he was waiting for the results, maybe he had arranged some way to get the report. He certainly had expressed a willingness to talk to the parents, but he wanted to wait until he had got his copy. I did not chase that up to check that he did get a copy. I didn't perhaps consider that was necessary for me to do that, but I was given the impression that he was waiting for his copy to come.

D/Sgt Cross: And doctor could I ask at what point, can you identify a point when you realised that it was incorrect fluid therapy that did the damage for Lucy?

Dr Hanrahan: Probably at the Inquest I think. There was another girl later on, which in Altnagelvin hospital that seemed, that Mr Millar to put to him. I think that the Crawford family had actually taken this up with the Erne and it would have been publicised to him and he saw that...My understanding at that stage with dilute, was the big risk, was if you had too much fluid, hyponatraemia and if you brought it back to normal too quickly as opposed to going from a normal where you would have a better buffering mechanism, you would be able to withstand more of the change, going from an abnormal back down to normal your brain is kind of shifted to an abnormal pattern, because a lot of people could be attempted to give dilute fluids to hyponatraemia and that is the wrong thing to do. But with normal sodium it would be almost a standard thing to do, when the volumes were too much I'm not sure I perhaps wasn't particularly familiar with fluid balance at that stage because I had been out of general paediatrics for about eight years at that stage...the big telling point is the actual sodium rather than the volumes.

D/Sgt Cross: Fair enough. The notes record and this is the Crawford's evidence, that you referred them back to the Erne to Jarlath O'Donohoe specifically for an explanation.

Dr Hanrahan: Well that would have been my standard practice at the time. Clearly Lucy had died in the Erne. That was what happened and it wasn't my standard practice, if I see a child with cerebral palsy, which I had seen many cases of in neurology I would refer them back to the obstetrician even if something had gone, I think the obstetrician should give the explanation.

D/Sgt Cross: And in doing so would you be happy that all the necessary information to give the Crawford's a proper explanation, would have been available to the Erne?

Dr Hanrahan: Yes, because most of the points on issue which would have been... under contention would have been what happened in the Erne.

D/Sgt Cross: You have already said that you didn't discuss with Jarlath O'Donohoe?

Dr Hanrahan: At the time, there was no contact between me or anybody from the Erne at the time.

D/Sgt Cross: And is that equally true of Sperrin Lakeland Trust, the management?

Dr Hanrahan: Absolutely yes.

D/Sgt Cross: There is a letter that Doctor O'Hara wrote to Mr Leckey, the Coroner, which says that at the time there appeared to be a difficulty in relation to Lucy's death, that may lead to litigation. Did that occur to you at the time?

Dr Hanrahan: I can't comment on that. He certainly didn't mention that in the post-mortem.

D/Sgt Cross: What I'm asking you is, if it appeared to Doctor O'Hara that there is difficulties here that may lead to litigation, did that appear to you to be the case?

Dr Hanrahan: ... I can't remember. I don't think so, no.

D/Sgt Cross: There was a review, Doctor, carried out in the Erne, well Sperrin Lakeland and some of the difficulties highlighted refer to communication problems maybe between yourselves and the Erne again I'm being repetitious here, but you have told me that you had no direct discussions with the Erne?

Dr Hanrahan: None.

D/Sgt Cross: Right. And Doctor Murray Quinn who is a consultant Paediatrician in Altnagelvin. He did a case note review. Have you seen that or were you made aware of it before the inquest we will say?

Dr Hanrahan: No. I was not aware until the television programme was made, it was made last year. I believe that Doctor Murray Quinn said that this needs an independent report as well, he said that at the bottom, but that wasn't put out in the programme. So I think it was portrayed as being rather bias, but I found that subsequent to the programme so I've never read the report, I don't know about it.

D/Sgt Cross: ...Could I ask, Doctor, have you been contacted at any stage really, by anyone from the Erne or Sperrin Lakeland in an attempt to influence your opinion on what happened?

Dr Hanrahan: I can honestly and truthfully say no. At no time.

D/Sgt Cross: Doctor is there anything you want to clarify or anything further that you want to say?

Dr Hanrahan: Could I just clarify where this investigation came from, was it as a result of the Inquest or as a result of this television programme, because there is already an investigation being made as a result of the television programme as far as I know. I don't know why there needs to be such a duplication, the O'Hara inquiry.

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D/Sgt Cross: That's a very different enquiry entirely. What happened was the Coroner, Mr Leckey, phoned or actually wrote and asked police to be present for the Inquest, therefore we attended, two of us sat through the Inquest. Now that was in February, some paperwork circulated then within the police service as to whether there ought to be a police investigation not because, you may not have been there at the tail end, but Mr Leckey had three options, he can refer to the Chief Medical Officer, to the General Medical Council and to the DPP. Now he decided to refer to the Chief Medical Officer and the General Medical Council, but he decided not to refer to the DPP and we had to consider that, had he reasons for doing that or not, did he think we were there and heard it all anyway so he didn't need to. But clearly if he had referred it to the DPP a police investigation would have started the following day, we would have had no option. But it was still at a senior level in the police at the time of the Insight Programme. Now the Insight programme made allegations that weren't part of the Inquest and there was a decision taken then there would be an investigation, Doctor, so that's where it comes from; but I would have to say it does look as if we're driven by Insight, to be honest. It was being considered largely on the basis of the Inquest.

Dr Hanrahan: Can I ask then were you aware of the tributes paid to me at the Inquest?

D/Sgt Cross: I was there and heard them. Yes I certainly am. Yes. Anything else Doctor you want to say?

PACE 21 served and interview terminated at 1349 hours.