INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

RAYCHEL FERGUSON

(LUCY CRAWFORD AFTERMATH)

:

WRITTEN SUBMISSIONS ON BEHALF OF DR JARLATH O'DONOHOE

Preamble

1. From 28 May 2013 onwards, the Inquiry into Hyponatraemia Related Deaths heard evidence dealing with the aftermath of the tragic death in 2000 of Lucy Crawford before the Chairman, O'Hara J.

2. The Inquiry had already heard evidence earlier in the year regarding the clinical issues that arose from the treatment of Raychel Ferguson and this stage of the Inquiry was intended to hear evidence

   "so that you might determine to what extent there was a failure to learn appropriate lessons from Lucy's death, and whether any such failure had important consequences for how Raychel was subsequently treated."[1]

3. The Inquiry is obviously aware that the Terms of Reference of the Inquiry were amended in 2008 to exclude any investigation into the facts surrounding and following the death of Lucy Crawford, but that in the 2009 Consultation Paper the Chairman determined that:

   ".... the terms still permit and indeed require an investigation into the ***events which followed Lucy's death*** *such as the failure to identify the correct cause of death and the alleged Sperrin Lakeland cover up because they contributed, arguably, to the death of Raychel in Altnagelvin. This reflects the contention that had the circumstances of Lucy's death been identified correctly, and had lessons been learned from the way in which fluids were administered to her, defective fluid management would not have occurred so soon afterwards (only 14 months later) in Altnagelvin, a hospital within the same Western Health and Social Services Board area.*[2]*" [Emphasis added]*

4. Throughout this stage of the Inquiry much time was spent examining events that, viewed in a vacuum, would appear to have been outside the Terms of Reference as amended as the Inquiry heard evidence concerning the treatment of Lucy Crawford by various members of the clinical and nursing teams, including Dr O'Donohoe. No

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[1] Opening: I. Introduction: Paragraph 1
[2] Footnote to the Revised Terms of Reference 2008

objection was made by any counsel, including me, to the calling of that evidence as it was clearly heard to contextualise other evidence that followed that actually dealt with the aftermath of Lucy's death and how it may have impacted upon the treatment of Raychel Ferguson and indeed others.

5. The primary submission made on behalf of Dr O'Donohoe is that the evidence relating to the treatment of Lucy at the Erne Hospital, in the ambulance to Belfast and after her arrival at the Royal Belfast Hospital for Sick Children, should only be used to contextualise the evidence that related to events relating to what took place following Lucy's death. On behalf of Dr O'Donohoe we respectfully endorse the approach adopted by Counsel to the Inquiry, namely that:

"the Inquiry must pursue the remaining limited issues with a degree of sensitivity[3]*"*

6. The role of Dr O'Donohoe in events that followed the tragic death of Lucy, as opposed to his role in events that involved her treatment at the Erne and subsequent transfer to the RBHSC, are of a very limited compass. Therefore, any perceived paucity of commentary or submission regarding issues, clinical or otherwise, relating to the time before Lucy's death should not be seen in any way as complacency on the part of Dr O'Donohoe or his representatives. Rather, the absence of such commentary or submissions is intentional and an attempt to remain faithful to the Terms of Reference as amended.

7. Dr O'Donohoe gave evidence before the Inquiry on 6 June 2013. He confirmed the content of the written witness statements[4] that he had provided during the investigation stage of the Inquiry. He was examined at length and in detail about his involvement with Lucy Crawford, his clinical knowledge at the relevant times and generally. Prior to giving his evidence I spoke in camera with O'Hara J and provided him with information regarding Dr O'Donohoe's health, both mental and physical. In short, Dr O'Donohoe's memory has been impaired not only by the passage of time but also by his health. For example, Dr O'Donohoe has no recollection of any meeting with Mr Fee and Dr Anderson despite there being documentary support for such a meeting taking place with Dr O'Donohoe being present[5]. It is submitted that Dr O'Donohoe gave his evidence honestly and straight forwardly and endeavoured where at all possible to give an accurate account of events. However, inevitably he was not always able to provide comprehensive responses to questioning and this may well have been in part due to those health issues combined with the passage of time. It is submitted that there should be no suggestion that Dr O'Donohoe at any stage did less than his best to assist the Inquiry.

Role in Events Involving Lucy's Treatment

8. In summary, Dr O'Donohoe's role during events surrounding Lucy's treatment as opposed to the aftermath of her death is as follows:

9. When Lucy was admitted to the Erne Hospital on 12 April 2000, she was under the care of Dr O'Donohoe although she was initially seen by his Senior House Officer, Dr Malik.

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[3] Opening: II Inquiry's Revised Terms of Reference; Paragraph 13
[4] WS 278 dated 16/1/13 and 4/3/13
[5] 033/102-285

10. Dr O'Donohoe was called back to the Erne whilst on call having returned home at the end of his shift. He was called in as Dr Malik was unable to insert a cannula into Lucy.

11. Dr O'Donohoe was able to observe Lucy whilst local anaesthetic was taking effect prior to the insertion of the cannula. He was able to observe her taking fluids orally.

12. Dr O'Donohoe inserted the cannula in the presence of clinical and nursing staff and orally prescribed fluids, namely a bolus and 30ml per hour thereafter. Dr Malik was present at that stage.

13. Dr. O'Donohoe ordered a repeat urea and electrolyte measurement to be carried out.

14. Dr O'Donohoe then returned home where he remained until he was called back to the Erne when Lucy went into seizure at 0255 on 13 April 2000. Thereafter, he remained with Lucy during her transfer to the RBHSC where he handed over her care to staff at that hospital.

Acknowledgement of Failings

15. Dr O'Donohoe acknowledged in his evidence that there were failings in the treatment of Lucy Crawford. A healthy baby attended at the Erne Hospital for treatment for a comparatively straight forward condition but was effectively moribund within a matter of hours. There was mismanagement of Lucy whilst at the Erne Hospital and Dr O'Donohoe was the consultant in charge.

16. The fluids prescribed orally by Dr O'Donohoe were not the fluids that were in fact administered.

17. Dr O'Donohoe accepts that there was inadequacy in the communication of the intended prescription of fluids to nursing and clinical staff.

18. Dr O'Donohoe accepts that there was inadequacy in the record keeping involving Lucy's case including, inter alia, what had been prescribed and what her state of dehydration was during her time at the Erne Hospital.

19. Dr O'Donohoe accepts that the fluid management of Lucy ultimately led to her death.

Role in Aftermath

20. There was no formal procedure at the Erne in place at the relevant time for the reporting of clinical incidents or untoward events[6].

21. Dr O'Donohoe did however make a prompt communication to Dr Kelly on 14 April 2000 requesting a clinical incident inquiry. Therefore, Dr O'Donohoe was proactive in bringing Lucy's case to the attention of those in more senior positions than him.

22. Dr O'Donohoe participated in the investigation into Lucy's treatment. He co operated throughout and did what he could to assist the investigation.

23. Dr O'Donohoe was aware that the Coroner's Office had been contacted in relation to Lucy's death as Dr Hanrahan had made said contact, and Dr O'Donohoe was aware of same.

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[6] As per report report of Messrs Fee and Anderson.

Acknowledgement of Failings in the Aftermath of Lucy Crawford's Death

24. Dr O'Donohoe accepted in his evidence that there were failings by him, by act or omission. He apologised for those failings and any impact that they may have had upon any person.

25. Dr O'Donohoe accepted there was poor communication with the family of Lucy after her death. In particular:

    a. A failure to attend at the first meeting with the family with Lucy's medical notes despite that meeting being at one weeks notice and therefore adequate time being available for the obtaining of the said notes.

    b. A failure to ensure that a productive second meeting with the family took place.

2. Dr O'Donohoe accepts that there was no reference to fluids in the report that Dr O'Donohoe prepared after Lucy's death. He acknowledges that fluids were an issue and should have been referred to and discussed in his report.

3. Dr O'Donohoe accepts that he did not directly contact the Coroner and ask for a reconsideration of the decision not to have an inquest. However, Dr O'Donohoe stated that he had spent some considerable time outside Northern Ireland and was unaware of the possibility or mechanism of such a referral. He was of course aware that the Coroner's Office had been contacted by Dr Hanrahan and that no Coroner's post mortem had taken place or was due to take place.

Conclusion

4. Dr O'Donohoe was involved in the aftermath of Lucy Crawford's death, but to a comparatively limited degree. He acknowledges failings and expresses genuine regret in regard to those failings.

5. Finally, on behalf of Dr O'Donohoe it is once more respectfully submitted that this stage of the Inquiry is dealing with the aftermath of Lucy Crawford's death and not her treatment at the Erne Hospital. Therefore, the Inquiry should refrain from dealing with the treatment of Lucy beyond that which is strictly necessary to put into context the aftermath evidence.

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