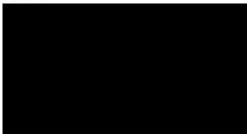
Professor Gabriel Scally



Your Ref:

Our Ref: BMcL-0115-13

Date: 18th June 2013

Dear Professor Scally,

Re: RAYCHEL FERGUSON (LUCY CRAWFORD AFTERMATH)

We have recently sent to you a copy of METL Management Executive dated 1/10/1993, and copy letter from DLS dated 8 May 2013 [ref: 319-062a] enclosing additional material from the Health and Social Care Board dealing with the services to be provided under the contract between the Western Board and the Sperrin Lakeland Trust. We would be grateful if you would consider this material and if it causes you to alter any of the opinions expressed in your report to the Inquiry, we would ask you to provide a short addendum dealing with this.

In addition, the Inquiry would appreciate your opinion on an additional governance issue which has emerged in oral hearings, which I set out below.

Mr William McKee, who was the Chief Executive of the Royal Group of Hospitals Trust from its inception in 1992 gave oral evidence to the Inquiry on Thursday 17 January 2013 in the part of the Inquiry dealing with governance issues arising out of the death of Adam Strain in the RBHSC in 1995. A link to the transcript of Mr McKee's evidence is provided below and I refer you in particular to the first 52 pages of his evidence. In essence Mr McKee told the Inquiry that from the inception of the Trust in 1992, until the issue of a Departmental Circular in January 2003, neither he, as Chief Executive, nor the Trust Board, had any responsibility for clinical care, clinical quality, clinical matters. See for example transcript at page 6 lines 1-4, page 12 lines 10-12, page 16 lines 1-5, page 17 lines 1-5, page 48 lines 12-22. When asked who had that responsibility in the Royal as at 1995/6 he said clinical safety was the responsibility, and entirely the responsibility, of individual clinicians. See for example page 16 lines 22-25.

Yesterday Mr Hugh Mills, who was Chief Executive of the Sperrin Lakeland Trust gave oral evidence in the part of the Inquiry dealing with the aftermath of Lucy Crawford's death. At page 44 the Chairman raised Mr McKee's evidence with Mr Mills, and at 45 of the transcript he was asked specifically by the Chairman whether the Trust had a responsibility for clinical care (at the time of Lucy's death in April 2000) and he said "Oh, certainly the Trust had a responsibility for clinical care". A link to the transcript is provided below.

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It is understood that the 2003 circular to which Mr McKee was referring is HSS(PPM)10/2002 [Ref-306-119], copy attached.

The additional question, on which the Inquiry seeks your opinion, arising from Mr McKee's and Mr Mills' evidence, is this. In your opinion who had responsibility for clinical care and clinical safety in the year 2000 (a) in the Royal Belfast Hospital for Sick Children ("RBHSC"), and (b) in the Erne Hospital? In particular what responsibility if any did the Royal Group of Hospitals Trust have for clinical care and clinical safety in RBHSC and how did such responsibility arise, and what responsibility if any did the Sperrin Lakeland Trust have for patient safety and patient care in the Erne Hospital and how did such responsibility arise?

Can I ask you please to let us have your opinion on this issue by next Wednesday 26 June 2013.

Thank you for your continuing assistance to the Inquiry,

Mr William McKee Transcript http://www.ihrdni.org/day_seventysix_17_01_13.pdf
Mr Hugh Mills Transcript http://www.ihrdni.org/day_onehundredten_17_06_13.pdf

Yours sincerely,

Brian McLoughlin
Assistant Solicitor to the Inquiry