Monday, 17 June 2013

(9.00 am)

(Delay in proceedings)

(9.13 am)

THE CHAIRMAN: Good morning. Thank you all for getting here for an early start today. Let's get going, Mr Wolfe.

MR HUGH MILLS (called)

Questions from MR WOLFE

MR WOLFE: Good morning, sir. The next witness is Mr Hugh Mills, please.

Good morning, Mr Mills. The format, Mr Mills, with all of our witnesses is to ask you to refer to the witness statements that you have already provided to the inquiry and, having done so, to ask you whether you wish to adopt them as part of your evidence this morning. So far, you have provided us with three witness statements, WS293/1, 2 and 3, dated 16 November 2012, 11 March 2013 and 8 April 2013; is that correct?

A. Yes, that's correct. There's one issue that I would want to draw to your attention in relation to the witness statement -- the first witness statement, at question 36, that I want to clarify at this stage.

Q. That's a question, sir, that I asked you to:

"State the date on which you first became aware that an inquest was not planned in relation to Lucy's death

and explain the circumstances in which you were given this information and identify who advised you of this."

And the clarification you wish you bring to that answer?

A. I suppose the issue for me was, in trying to respond to the questions that the inquiry were asking me, I was endeavouring to provide as much information as I could and be as helpful as I could and what I have responded to here was, in fact, the Trust's position rather than my own personal position.

I would refer you if I could to my police interview statement and the reference there is 116-052-006. The bottom paragraph of that statement basically says -- in response to DS Cross, I was being asked about the fact that the inquest wasn't going to take place and I stated that:

"25 June the following year, we were asking when the inquest was happening."

When I say "we", that is the corporate "we":

"On 12 October, the following year, we were advised that there was going to be no inquest."

And I'm saying at that stage that I wasn't advised. I don't recall anybody ever telling me that there wasn't going to be an inquest.

In my preparation I have looked over my notes as to

where that has come from and, in my preparation for the police interview, it was suggested by my solicitor that I should find out from the Trust and I have obviously then inadvertently viewed the fact that I knew that rather than the fact that it was the Trust's corporate position that knew that.

THE CHAIRMAN: When did you know there wasn't going to be an inquest?

A. I don't recall.

THE CHAIRMAN: Right, thank you.

MR WOLFE: We will deal with that.

THE CHAIRMAN: But apart from that, you're adopting the three witness statements as part of your evidence and you have just referred to the police interviews and are you also adopting them as part of your evidence?

A. Yes, chairman.

THE CHAIRMAN: So I'll take the oral evidence that you give today on top of your witness statements to the inquiry and your police interviews?

A. Yes, chairman.

THE CHAIRMAN: Thank you.

MR WOLFE: As I say, we will come back and touch upon that inquest issue, but just to be clear before we move off what you have just said, you're saying that the Trust was informed, the corporate body was informed,

in October 2001?

A. In terms of my note of that, when I asked the question of the relevant department within the Trust in order that I had the information for the police interview, I asked those that were involved in the scrutiny committee, basically Bridget O'Rawe's department within corporate affairs, and it was from that department that I got the answer, the information that was provided there.

Q. Who within the Trust was aware, on or about 12 October 2001, that no inquest was planned?

A. All I can say is that I would have assumed it would have been the members from the Trust who participated in the audit, in the scrutiny committee, and that would be Ms O'Rawe and Dr Kelly.

Q. We'll come back to that. Let me just touch upon your qualifications and your career history. If we could have up on screen your witness statement at page 2, WS293/1, page 2. You helpfully set out for us your academic and professional qualifications. You tell us at 1(b) that you were appointed as chief executive at the Sperrin Lakeland Trust -- that's upon its formation -- on 1 April 1996; is that correct?

A. Yes, correct.

Q. Prior to that you were chief executive of the unit of

management known as the Erne Hospital; is that right?
A. No. The title would have been Unit General Manager of the Omagh and Fermanagh Hospital and Communities Management Unit.
Q. If we could have up on the screen, please, page 20 of this document. This is an appendix that you've added to your witness statement, which sets out your full career history and, as I say --
A. Yes, sorry, we operated for a year as the Sperrin Lakeland Management Unit; prior to 1995 it was the Omagh and Fermanagh Management Unit.
Q. So in terms of your general managerial role for Omagh and Fermanagh, it stretched back to 1990?
A. Correct.
Q. Just a little about your role as chief executive upon taking up that post in 1996. You have provided us with your job description. It's at page 22 of this document. It sets out the job purpose, which was:
"To be personally accountable to the chairman for the effective management of the entire business of the Trust, delivering services in accordance with quality specifications and within contract income.
"He will be expected to demonstrate clear leadership across the Trust and, in particular, to maximise the potential for multi-professional inter-programme and

inter-agency working. The chief executive will fulfil corporate responsibilities as a member of the Trust board and leader of the Trust's senior management team."
And at that time the senior management team comprised -- I'm talking now April 2000 -- amongst others Mr Fee; is that correct?
A. Mr Fee would have been a member, yes.
Q. And Dr Kelly was a member?
A. Yes.
Q. Who else among the protagonists who had some involvement in Lucy Crawford death, in the investigation of the death, was a member of the senior management team?
A. Bridget O'Rawe.
Q. So you were responsible for leading that team?
A. Yes.
Q. And in turn they were responsible for providing you with the information necessary for you to do your job?
A. Yes.
Q. In terms of the proximity of relationship, was it a close working team?
A. I suppose we operated a style that was, I suppose, familiar to me, and that was that it was -- my style was particularly democratic in terms of the leadership that was provided where we would have worked together and helped each other within the team, so it wouldn't have

necessarily -- there wouldn't have necessarily been an authoritarian style or approach in that sense. We worked as a team and we supported each other. By the nature of the geography of the management unit, we were spread across different sites, so it was, shall we say, challenging for the team to come together on a regular basis because of the fact that we were based in different locations. Trust headquarters was in Omagh --
THE CHAIRMAN: Is that where you were based?
A. Where I was based, in Strathdene House, on the Tyrone & Fermanagh Hospital site. Mr Fee's his headquarters were based in the Tyrone County Hospital in Omagh, which was about a mile away, but obviously had responsibility for the Erne Hospital as well. And Dr Kelly, because of his clinical duties as medical director, would have been based in the Erne Hospital site in Enniskillen.
Ms O'Rawe was based with me at the Trust headquarters.
MR WOLFE: In order to assist communications between yourselves, was there a provision for regular meetings?
A. Yes. We would have regular meetings through the formal meetings of the senior management team and there would also be regular meetings on a one-to-one basis, both in relation to updates and formal appraisal.
Q. And the various directorates within the Trust worked off clinical leadership within those directorates; is that

correct?
A. I'm not quite sure what you're asking there.
Q. There's a clinical director, for example, in the directorate within which Lucy Crawford was cared, and that was Dr Anderson; isn't that correct?
A. Yes. We're now talking about a clinical directorate within the Acute Services Directorate. The services of the Trust were the combined hospital and community services for the population of Omagh and Fermanagh, about 120,000 in terms of people. We had budget responsibility for around about 130 million per annum at the time, and the employees of the Trust were in and around 4,000 employees. The main service directorates within the Trust were the Acute Services Directorate, led by Mr Fee. We also had a directorate for mental health and elderly services and we also had a directorate for community services. So I suppose within that -- so we're looking then within the Directorate of Acute Hospital Services particularly in this case, and so within that then there was a structure which formed the membership of the hospital council and we had directorates -- I think it was three at the time: one for surgical and anaesthetics, one for medicine, and one for women and children's.
Q. And that's the one to which we're particularly

interested.
A. That's the one that we're particularly interested in.
Q. The job description in front of us, in a number of locations, particularly emphasises your leadership responsibilities. At 1.1, for example, you're to:
"Provide executive leadership and deliver high performance in all aspects of Trust activity."
In real terms, what do you say that meant?
A. That meant I was accountable for leading the Trust and responding to issues on behalf of the Trust and reporting to the Trust chairman and the Trust board.
Q. So in order to carry out that role effectively, you relied upon those reporting to you to provide you with relevant information in a timely fashion?
A. Yes. As I say, we operated on a basis whereby we supported each other and it was a team approach in terms of the -- I suppose both the strategic and operational issues in terms of the delivery of services for the local geography.
Q. In terms of that dichotomy that you highlight, operational and strategic, were you expected to keep an overview of both?
A. Well, for the aspects that we were expected to deliver services on, yes.
Q. So for example, when you have an adverse incident such

as the one we're most interested in, as appeared to have been the case, you were informed of it at a very early stage?
A. Correct, yes.
Q. And you maintained an involvement in it throughout the process?
A. Yes. This was a serious adverse incident because it had led to the death of a young child and it was important that I knew about it and was briefed about it and was assured that it was being examined appropriately.
Q. Just on leadership again, if I could move over the page, please, to paragraph 1.12. You were expected to:
"Monitor all activities of the Trust and take corrective/re-enforcing action wherever appropriate."
Again, does that have any particular resonance with the issues we're dealing with today on the operational side?
A. Well, yes, in essence, it's a catch-all. Most job descriptions include the catch-all clauses and that's certainly one of them. Obviously, how I could monitor all the activities of the Trust given the breadth of services that we were providing would be extremely challenging in terms of the detail, but in relation to the issues we're discussing today, yes, it would have been an issue that was drawn to my attention, and

I would certainly have seen it as one of the activities of the Trust that I would have been involved in knowing about and being able to respond to the issues that were emerging from it.
THE CHAIRMAN: So is that in the sense that there are issues which it's more directly relevant for you to be personally involved in, whereas medical incidents would be more difficult for you to get a grasp on, so you rely on your senior doctors to investigate and to report back to you?
A. Yes. They're the ones that have the clinical expertise. My background was primarily administrative and management in terms of my understanding and, in essence, I didn't have the technical background and I suppose that's what happens in most large organisations, that you require the technical expertise to examine the detail.
THE CHAIRMAN: Right. So the examination of the detail and the report back on the detail is for others to do, but you have to be assured that what has happened, what has been investigated, is satisfactory, which is why the review report does come back to you?
A. Yes, I feel that I have that responsibility, yes.
MR WOLFE: You have explained in your witness statement that Lucy Crawford's death occurred prior to the introduction

of what has been described as clinical and social care governance.
A. Correct.
Q. And at that time, as we've heard from Dr Kelly, amongst others, there was a developing awareness of the issues and indeed, if you like, the toolbox that was to go along with clinical and social care governance. In other words, there was a series of structures being put in place around the year 2000, late 2000, to advance the principles of governance; isn't that right?
A. Yes, that's correct. I think I provided a copy of a board minute at the time that showed, in September 1999, that we were involved in engaging the wider organisation through seminars and discussions about the development of clinical and social care governance, largely following the steps that had already taken place in England and Wales.
Q. And you have said that when it came to an adverse incident in the period before the introduction of clinical and social care governance, there were no formal arrangements in place?
A. Correct.
Q. And one of the approaches that might have applied, depending upon the particular circumstances of the case, would be to conduct or engage with what you've described

as the practice of obtaining an external peer review?
A. Yes.
Q. Is that how you would characterise the approach that was adopted in the Lucy Crawford case, the decision to utilise Dr Murray Quinn?
A. Yes. In relation to the information about my involvement in the appointment of Dr Murray Quinn --
Q. Don't worry about that for the moment; we'll certainly come to that. But in terms of what you've described -- maybe if we pick it up from your witness statement at WS293/1, page 4.

We're asking you, at 4, to:

"Describe the key features of the Trust's arrangements for clinical governance as they applied in 2000."

And you go on, in fact, to describe and you attach the Trust minutes from 1999, which indicates that discussions on the structures and arrangements for the introduction of clinical and social care governance were ongoing at that point. You fairly say that:

"Lucy's death occurred prior to the date of the introduction of these arrangements."

At (b) then you say:

"Whilst no formal arrangements were in place at the time of Lucy's death, there was a decision to follow the

practice of obtaining an external peer review of Lucy's care and treatment in the Erne Hospital."

And my question is: is that how you would describe the process that was adopted in the review of Lucy's case?
A. Yes, it was an internal review and the review team felt that they did not have access to the paediatric expertise within the organisation and therefore an external review was required.
Q. So just so that I understand it, you're describing Dr Murray Quinn's input as an external peer review?
A. Well, yes, it's an external review. You used the word "peer" and I've used the word" peer", but it's an external review to advise the internal -- I suppose we call it an internal review, but they required an external opinion or an external peer review of the ...
Q. Sir, it's your use of the word "peer review" that I'm picking up on; I haven't used the word. The use of the word "peer review" --
A. What I'm referring to in relation to the external peer review is the involvement of Dr Murray Quinn.
Q. Could I suggest to you the use of the word "peer review" in this context doesn't seem to tally with his description of the work he was engaged in for the Trust? He would say that he was asked to carry out a review of

the clinical notes in Lucy's case and to report orally and ultimately in a written form; he wasn't peer reviewing anybody.
A. Well, you're asking me to comment on Dr Quinn's --
Q. I'm asking you to explain for us your understanding of a process that you set in train.
A. Do you want to come on to my involvement in the appointment of Dr Quinn?
Q. No, I'm just, at a very early stage, asking you to explain your understanding of "peer review".
A. I was asked by the internal review panel to assist in obtaining an external opinion and I have referred to it there as "an external peer review".
Q. Who was peer-reviewed?
A. I suppose the case was peer-reviewed.
Q. The case was peer-reviewed? Very well.

You explain to us in your witness statement that at that time the Trust worked in accordance with a number of circulars. Could I have up on the screen, please, 319-045A-010? This was a procedure in place for:

"Notifying accidents, untoward events and unusual occurrences on Trust premises."

You referred to that, sir, as one of the documents that was in place at that time. It appears that this sets out a procedure for reporting, as the heading

suggests, untoward occurrences on Trust premises, and it involves staff who are aware of such events completing accident or injury forms. If we just move on to page 12 of the document:

"Staff are expected to complete an injury form, providing certain data in relation to the incident."
A. Yes. There's a series of forms or appendices associated with this procedure. I think we're talking about a procedure that was adopted in 1996 within the Trust. I'm not sure that this procedure was relevant to the issues of clinical adverse incidents and I suppose to some extent that process then became developed and you will have seen the form then that was subsequently used in the reporting of the incident.
Q. Yes. There was a critical incident report form used and completed by Mrs Millar with Sister Traynor.
A. So this procedure would have been prior to that and prior to any discussion about the introduction of clinical governance or the examination of clinical incidents.
Q. So although you refer to this guideline or this circular in your witness statement, it wasn't applicable to these particular circumstances?
A. I think I was asked what procedures were in place within the Trust and that document basically was one of the

procedures that existed at that time.

THE CHAIRMAN: Could we go back to page 10? If you look in the top half of the page, paragraph 1, sub-paragraph (vii):

"Any incident, including near misses, which may create concern for the health, safety or welfare of patients, residents ..."

Would this not apply? If the procedure applied to a near miss where something has gone wrong in a patient's treatment, but not fatally, would it not also inevitably apply where something has gone wrong and a patient has died?

A. I think what I'm saying, chair, is that this procedure was what existed in 1996, and it would have been superseded by the discussions that were taking place in developing -- I suppose in developing the type of process that would be required to address paragraph (vii) on page 1. And that was superseded by the introduction, albeit at a very early stage, of the clinical adverse incidents documentation.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: So, as the parents were given to understand in a letter sent to them by Mrs O'Rawe in about the autumn of 2000, when the Trust found itself having to explain to the parents that a review had been undertaken, it was

explained at that time that this process had been in place for two years, and what I wish to ask you is: was there no procedure or guidance drawn up around the introduction of the clinical or critical incident report form?

A. I don't recall any procedure or guidance. I mean, the form, obviously, will have been introduced. Whether there was guidance that went with it, I don't recall.

Q. We asked you in your witness statement about your knowledge of hyponatraemia and fluid management in the paediatric environment and you have told us that you had no advice, training or experience in that whole field, which I suspect is in keeping with what you have told us this morning, that in terms of these technical, medical issues, although you worked in, obviously, the health and hospital setting, that wasn't part of your knowledge base?

A. I knew nothing about fluid management or -- I'd never heard of the term "hyponatraemia".

THE CHAIRMAN: Can I take it for the record that you knew nothing about the death of Adam Strain in 1995 or Claire Roberts in 1996?

A. No, I knew nothing about that.

MR WOLFE: Let me bring you then to the events of 12, 13 and 14 April 2000, Mr Mills. It appears to be the case that

some time in or about 13 April, Dr O'Donohoe made report to the medical director, Dr Kelly, that there had been this serious adverse incident. That's your understanding; is that correct?

A. Yes. Can I bring up my note that I would have made at the time --

Q. Very well. It appears, as I say, to be the case that --

A. -- 030-010-017?

Q. Just on this document, your file supplied to the inquiry describes this as a diary entry; is that correct?

A. This is what I would describe as a diary note. There were certain issues of significance that occurred from time to time and I would have been -- it would have been my practice to compile a note of the information as I was advised of it or information on the actions that were taken. So this is a contemporaneous note of what was happening at the time.

Q. Did you keep a written diary or were you inputting into --

A. No, this would have been on a page and what I would have done would have been to write notes on a page that probably would have been carried in my diary and then subsequently then got them typed up within a few days or whatever of the issue of making the note at the time.

Q. Let's work down then, chronologically, these early steps

of your involvement, Mr Mills. The first entry seems to suggest that you received contact from Dr Kelly at 9 o'clock on the Friday morning.

A. Yes. There was some confusion about whether that was the right day or not. I do remember at the time I was advised that Lucy was still alive, which I gather would have been the case, and I was advised that there was an adverse incident regarding her treatment. The question was posed at that time whether:

"... the wrong drug or an incorrect dose or level of fluids may have been prescribed, although blood tests were not confirming this. The child had been transferred to the Royal Belfast Hospital for Sick Children, however at that stage was already being reported as brain-dead. Dr O'Donohoe had been asked to obtain a copy of the patient's notes and [at that stage] I agreed that I would advise Dr McConnell."

Dr McConnell was the Director of Public Health in the Western Health and Social Services Board.

Q. And all of this information is coming to you from Dr Kelly?

A. From Dr Kelly, yes.

Q. Could I take you to the second sentence where he advised that:

"There could be a situation where the wrong drug or

incorrect dose or level of fluids may have been prescribed, although blood tests were not confirming this."

Is that the level of detail that Dr Kelly spoke to you?

A. That's my summary. I don't recall any detail in terms of either volumes or types of drug. In fact, it wouldn't have meant anything to me anyway, probably, or whether it was the right fluid or the wrong fluid. I don't recall any of that.

Q. And the description of "blood tests not confirming this", is that a reference to the fluids or to the drugs or to both?

A. I have no idea. It was a note that I was taking at the time that basically said that the blood tests weren't confirming this.

Q. Because, as we know, the repeat electrolyte test did reflect a derangement, which experts have said was due to the fluids. And at least the information in relation to the bloods would have been known to the Trust at that time, that there had been a derangement, albeit the cause of that derangement was to be the subject of investigation; can you help us any further?

A. I can't and I can't speculate. It would be inappropriate of me to do so, chair.

Q. We'll come back to your contact with Dr McConnell. But over on to the Monday then:

"Janet Hall advised [you] of press interest."

Is she the communications person within the Trust?

A. Yes.

Q. And you had a discussion with Mr Fee in relation to how the Trust should respond.

A. Yes. I felt that if the death was not associated with an infectious disease, that we should be saying that in a public statement so that, through the press, the general public wouldn't be alarmed about the potential for infection. However, Mr Fee recommended at the time that, as the cause of death was still unknown, it would be unwise to make the statement, so we didn't refer to infection in the statement that was released.

Q. On Tuesday 18 April:

"Mr Fee provided an update of discussions with nursing and medical staff. They were generally upset given the suddenness of the death and another recent death of a chronically-ill child. He was meeting Dr Anderson to examine the case notes on Wednesday afternoon. He could not be definitive about circumstances from the information collated so far."

What the note doesn't say, but which we'll come to explore in a moment, is that by this stage, you had

agreed to establish a review under the auspices of Mr Fee and Dr Anderson; isn't that correct?

A. Yes. That's correct.

Q. And then, 19 April, you had a meeting with Mr Bradley, who was the Chief Nursing Officer in the Western Board --

A. Yes.

Q. -- and Dr McConnell was also advised that the circumstances were still being examined.

A. I had to be at the board headquarters that day for a meeting and I took the opportunity of meeting with Mr Bradley.

Q. Yes, and we'll come to that as well. On 20 April:

"Further discussion with Mr Fee, who by this stage had had an opportunity to review the notes, and he picked up upon in particular a comment attributed to Dr O'Donohoe within the notes, which indicated that he was uncertain about the instructions that he gave to staff."

Or at least that is how Mr Fee interpreted the note. Then you go on to record what Mr Fee appears to be telling you in relation to what the child had received. That's all building up to a request to you in respect of expert paediatric input to assist with the review; isn't that correct?

A. Yes.

Q. You agreed you would arrange that and, if we go over the page, please. It goes on and concludes with you indicating that:

"[You] spoke with Dr Quinn, who agreed he would look at the notes and provide his advice."

And again we'll come back to that interaction in some detail just presently.

I'll just take you through, for orientation purposes, the rest of the chronology at this stage. Friday 21 April, you asked Mr Fee to contact Dr Quinn to advise him of the main issues, something we've called his terms of reference or his brief. And you requested Mr Fee to ensure that Dr O'Donohoe was advised of the involvement of Dr Quinn. You record that:

"Mr Fee advised that the health visitor had been identified and would make contact with and speak with the family and [you] rang Dr McConnell at the Western Board to advise that Dr Quinn had been requested to provide the Trust with advice on the case."

Just moving through, you provided a briefing to Mr Frawley on issues; was he the general manager of the Western Health and Social Services Board?

A. That's correct.

Q. Is that your first contact with him?

A. Yes.
Q. In relation to Lucy?
A. In relation to this, yes. I could add that that was at a regular update meeting that Mr Frawley and myself would have had. It would have been one of the items that I would have taken the opportunity to inform him about.
Q. And then, on 4 May:
"[You] discussed the case with Dr Kelly and impressed upon him the need to convene a discussion with Dr Quinn, at which he [Mr Fee] and Dr Anderson should attend."
You were advised, on 5 May, by Mr Fee that:
"The parents had met with Dr O'Donohoe."
By 11 May:
"The review had processed to the stage where Mr Fee was awaiting one report from a member of staff."
And at this stage, he had spoken to Dr Quinn, who had, in Mr Fee's words:
"... provided verbal advice that the fluids may not have been excessive."
Is that fair?
A. Yes. I was receiving that information from Mr Fee at 11 May.
Q. So this indicates that you're keeping yourself

up-to-date with the various major developments in the ongoing review?
A. Yes, I was getting regular updates.
Q. Is there a further page?
A. Yes.
Q. Could we go over the page, please? Some of it obviously is redacted. It's not particularly relevant to our considerations. 23 May:
"Mr Fee advised that Dr Kelly and himself were meeting with Dr O'Donohoe the next day."
Do you know what that was to be about?
A. No, I have no recollection of what that specifically was about. It could well have been associated with the information that has been redacted. I think it would be important to emphasise at this stage that there were other aspects of this case that were associated with performance and discipline, which, by the nature of my particular responsibility, they had to be aware of, and as they emerged, because of the procedures that were in place at the time, I had to keep myself apart from those in case there was subsequently formal disciplinary action.
Q. Is that because, under the rubric of the procedures in place, you might be charged with hearing a disciplinary?
A. That's correct.

Q. 26 May, I think it is:
"Mr Fee advised [you] that the Trust was awaiting the written report from Dr Quinn and information on the tests carried out at post-mortem and [you] again reminded Dr Kelly that once reports were received, he should convene a meeting with Dr Quinn, Dr Anderson and Mr Fee to agree the way forward."
Could you help us with the annotations on the page then, please?
A. Yes. I have a note there that Dr Kelly was on leave. I'm not quite sure the dates for that at that time. "5 June" refers to the fact that Dr Asghar came to see me and provided me with a letter. His letter identified the fact that he had concerns about the treatment of a number of cases in the paediatric service, and he also identified issues associated with harassment and bullying. That says:
"Dr K [Dr Kelly] advised he was coordinating the date for the meeting. Dr A [that's Dr Anderson] was on leave and Mr Fee was going on leave."
That refers back to the meeting with Dr Quinn, Dr Anderson and Mr Fee that I had been asking to take place.
Q. 12 June then, "Dr Asghar's further letter", does that say?

A. Yes. I did reply to Dr Asghar on 8 June, identifying how we would deal with the issues that he had raised. We set up a decision in and around that date that we would review -- we would ask the -- we would set up a review. I think we were already beginning to think about asking the College to do the review. I am not quite sure when the College was asked to do the review of the cases he had identified. So that's around 8 June. And the letter also identified the fact that we were setting up an investigation panel under the Trust's harassment and bullying policy to examine the claims that Dr Asghar was making in relation to that.
Q. Yes.
A. So that's -- I'm not sure whether my reply is actually amongst the papers that have been presented, but I just wanted to put on record the fact that we did a formal reply to Dr Asghar on 8 June to the issues that he was raising, advising how we were taking forward those two points.
Q. Your chronology over the three pages, Mr Mills, doesn't touch upon any issue relating to the coroner; is that fair?
A. There's no mention of it within my papers. I was under the assumption that the coroner had been advised. I gather that was the case, the coroner was advised of

Lucy's death. Practice at that time would have been that the death would have been reported by the location where the death occurred, by the clinicians that were involved in pronouncing death.

Q. We'll come to that in due course. But just in terms of the note that you have made, it wouldn't appear that you were in discussion with any of your senior management team in relation to coronial issues and the need to report?

A. No. Because the death took place in Belfast and we wouldn't have been involved in reporting the case to the coroner.

Q. And the note doesn't indicate at all any information in relation to whether the coroner had been informed by Belfast or any issue to do with what conclusion had been reached.

A. No. I have no record of it and again I don't think I would have recorded -- I assume I was told -- because it was a matter for Belfast, it wasn't a matter for us -- that the coroner had been advised.

Q. Well, I want to test that with you later at a convenient time.

Can I look at the issue, moving forward, in terms of your contact with the Western Board, Mr Mills.

A. Sorry, have you finished the note?

Q. I have. Did you have something to add?

A. There was a further page.

Q. We can certainly go to that. It brings us probably further into the chronology than necessary, but if you want to --

A. So I am recording there on 12 June that Dr Asghar had provided a further letter and that Mr Fee advised that he was meeting with Dr Kelly on that day. Then, on 14 June, I also briefed Mr Frawley on the information that was coming forward and, again, that would have been at a regular meeting.

Can we go forward a page? The next page would be 030-008-015.

Q. Take us through this note, if you would, please.

A. Obviously there's information redacted in relation to the discussions that were taking place regarding Dr O'Donohoe's -- I think it was to do with the ...

Q. Harassment issue?

A. Harassment issue and the cover that was being provided in relation to the issues raised by another staff grade as well as Dr Asghar. I have there:

"Case of competency is building --

THE CHAIRMAN: Just for the record, this page is headed "15 June", so this is a discussion taking place around 15 June, is it?

A. This is my note of 15 June of the issues that were known to me on that date.

THE CHAIRMAN: Right.

A. "The case of competency is building."

The information I was receiving was that the issues in and around our concern about Dr O'Donohoe and his professional performance were beginning to dissipate, I suppose, in that sense. My concerns were being reassured. They were planning to meet Dr Quinn on 21 June, that's Mr Fee and Dr Kelly. I have a note here that:

"Lucy Crawford's fluid was a near miss, but not a direct cause."

And I have the word "Belfast" beside that. And:

"Others. [What's called] views from a distance."

MR WOLFE: I think you have explained, sir, in your witness statement the correlation between the first line of that and the second. What you have said in your witness statement is that:

"The reference to Belfast suggests that the opinion was from clinicians who cared for Lucy in the Royal Belfast Hospital for Sick Children, but [you] cannot be certain."

And then you go on to say:

"The reference to 'Others. Views from a distance'

reflects information Dr Kelly was providing on the issues being raised by junior medical staff."

Is that your understanding of the note?

A. That's my -- as I say, I have no direct recollection of the detail of that in terms of ... But in essence, I've written it down, I wrote that down at that time --

Q. Yes.

A. -- so I'm basically of the view that that was the information that I was receiving at that time, that we were obtaining information about Dr O'Donohoe from Belfast and from others about his competency.

Q. And the use of the term "near miss", does that suggest fluid error?

A. I don't recall whether it reflects either the type of fluid error or the volume of fluid error.

Q. But it refers to error?

A. It would refer to error.

Q. So the message that you're getting there is that the fluids that Lucy received were, in one shape or another, erroneous, or her fluids had been mismanaged, but they were not the direct cause?

A. That was to some extent an assurance that I was receiving at that time.

Q. But is my description of the assurance that you were getting accurate, that the fluids had been mismanaged,

there was an error, but they were not a direct cause of her death?

A. I can't recall specifically. That's what I have written down. We did know that they weren't recorded, the prescription wasn't properly recorded, and that might just be a reference to that. But whether it refers specifically to the actual volumes of fluid or the type of fluid, I could not give you any definitive response to that.

Q. But it was, of course, factually more than that, wasn't it, let alone the fact that the fluids had not been properly recorded in the way you would expect a prescription to be properly filled out, but you were aware from the earliest stage that Dr O'Donohoe was saying one thing in terms of what he intended for the child and the nurses were saying quite a different thing; isn't that right?

A. Yes.

Q. So in that sense, taking it from the perspective of the person prescribing, the child had not received the fluids that he had intended for her?

A. That's the view, yes. That was the view of the prescriber, yes.

Q. So in terms of a near miss and your understanding of what a near miss might be defined as at that time is my

description of it correct?

A. The view that I was getting was that the fluid aspect of her care may have been a near miss, but wasn't a direct cause of her death.

Q. And can you help us in terms --

THE CHAIRMAN: Sorry. Were you then being told what the cause of her death was?

A. No.

THE CHAIRMAN: Do you know if anybody knew what the cause of her death was? I'm just curious about how you were being advised that the fluids had not caused her death when it doesn't appear that anybody was very clear about what did cause her death at that point.

A. We didn't know what caused her death, no.

THE CHAIRMAN: So although nobody knew what had caused her death, you were being advised that the fluids did not cause her death?

A. I certainly have written it down here that the information that I was getting at the time was that the fluids would have not necessarily, as they were being prescribed, as they were being administered -- wouldn't have caused her death.

THE CHAIRMAN: Thank you.

A. We go on then, if I could, chair, to say that there were discussions about bringing in the regional adviser on

15 June. That is in relation to the Royal College of Paediatricians. "Dr H" refers to Dr O'Donohoe's colleague, Dr Halahakoon, who is described there as being the key, in other words she worked alongside Dr O'Donohoe and should be able to provide information.

The phrase "discussing with Bill McConnell" refers to Dr Kelly was discussing it with Bill McConnell tomorrow. Dr Kelly also agreed to ring the GMC helpline.

I think, chair, I suppose I'm anxious to show the proactiveness that was taking place at that time in relation to Dr Kelly in terms of taking forward the issues that were arising out of the death of Lucy Crawford and also the issues that Dr Asghar was raising.

THE CHAIRMAN: Well, the regional adviser is of the Royal College, right?

A. Yes.

THE CHAIRMAN: Dr Halahakoon is key because she works closest with Dr O'Donohoe and should be able to give a clear steer about the extent to which she had concerns about his competency?

A. Whether she had concerns or not about his competency.

THE CHAIRMAN: So there is then to be discussion with Bill McConnell of the Western Board?

A. I think what I'm referring to here is that Dr Kelly is discussing it with --

THE CHAIRMAN: What was the GMC helpline to be rung about?

A. The GMC would provide professional advice to anyone who would have concerns about a clinician in terms of either their personal or professional conduct and the general -- and they had a helpline to help those who were thinking of taking advice or providing information to the General Medical Council about a particular doctor.

THE CHAIRMAN: Thank you.

MR WOLFE: It was within the gift of employers to make referrals to the General Medical Council if they identified elements of misconduct or, on the other side, incompetence?

A. That's correct.

Q. And is it the case that, in respect to Dr O'Donohoe and the fluid error that I have defined for you a question or two back, no referral was made by your Trust at that time in respect of that error?

A. I think, chair, I would point out the fact that there were issues that were under consideration, serious consideration, and there were issues under discussion by the medical director with the General Medical Council as to whether a referral would be appropriate.

Q. Are you saying that a report was made at that time in the name of Dr Kelly in respect of an allegation of misconduct regarding Dr O'Donohoe?
A. No, I'm not, chair; I'm pointing out the fact that there is a record there in my note at the time that we were taking advice from the General Medical Council, Dr Kelly was taking advice through the General Medical Council in relation to their helpline.
Q. In relation to his competence?
A. Yes.
Q. Not in relation to his misconduct or alleged misconduct?
A. Well, in relation to how you take a case forward or develop or respond or satisfy yourself that the person has the competence to conduct their professional responsibilities.
Q. Yes, but on the other side, if there was a prescribing error that had arisen out of a failure on the part of a clinician to make a proper prescription, to write a proper prescription, that would be an issue of misconduct?
A. Well, that's an issue that -- those were issues that we were anxious to get the advice that we could at the time from the General Medical Council and from the College in terms of whether there were issues there of professional incompetence.

Q. I'm asking you about misconduct. You keep introducing incompetence or competence.
MR GREEN: May I interject, I hope to help? Dr Kelly wishes the inquiry to be very clear so that the inquiry isn't, as it were, misled by silence from this end of the room, that there was no phone call made by him to the General Medical Council. The position is that the meeting with Dr Quinn on 21 June dealt with issues of competence on the part of Dr O'Donohoe in addition to the other issues which we went through in some detail on Friday. If I could just remind the inquiry of the reference, it's 036A-067-102. It's the second page of Dr Kelly's note of that meeting, and I don't ask that it be called up; I'll just read it out because it's a brief entry:
"Dr Kelly asked is there an issue of competence, should consideration be given to temporary suspension? Dr Quinn stated that he saw no reason for suspension. The issues raised by the case are more about recording fluid prescriptions carefully and ensuring clarity of instruction."
So it's Dr Kelly's position in all of this that, whilst at the meeting on 15 June there was discussion of the GMC helpline being rung as a possibility, that wasn't taken forward because, at the meeting of 21 June, issues of incompetence were aired and Dr Kelly's

concerns about them allayed.
THE CHAIRMAN: Thank you.
MR WOLFE: It would appear, Mr Mills, that you're proceeding on the basis that the GMC were contacted?
A. I think there was confirmation that there was discussion, as recorded in my note, about contacting them. My note does not record that they were contacted.
MR GREEN: They were contacted in October 2001 by Dr Kelly, but there was no immediate follow-up contact following this meeting. That's the point.
THE CHAIRMAN: Is your general point that what this note shows is that, far from trying to cover up what happened to Lucy and any issues surrounding it, I should read this as being consistent with consideration being given to involving the GMC, consideration being given, through the regional adviser, to bringing in the Royal College, seeking the views of Dr Halahakoon and bringing in Dr Quinn for the Trust review?
A. That's correct, chair.
THE CHAIRMAN: Thank you.
MR WOLFE: And on the other side of the balance, Mr Mills, the other side of the scales, if an employer is aware of an act of misconduct, potentially an act of misconduct on the part of an employee, whether that's a nurse or a clinician, there would be -- let's describe it first

of all as an opportunity to report that matter to the regulatory bodies; isn't that correct?
A. The process, as I would have understood it at the time, would be that the matter should be investigated initially.
Q. Yes.
A. And if, as a result of that investigation, there were issues that should be reported to the professional bodies, then that would be the process.
Q. So if the investigation identified evidence of misconduct, then consideration should be given at that point to whether it would be appropriate to make a referral to one of the regulatory bodies?
A. Yes. There's also the disciplinary process that would be part and parcel of that as well, so in essence it might well be that until such time as the disciplinary process would be complete, then depending on the outcome of that, there might be a referral or a non-referral to the professional bodies.
Q. Let's look at that at the appropriate stage in the chronology then. I think we've finished with your diary entries. Obviously, there were further meetings as these matters moved over a period of years, but for introductory purposes, let's move then to some of the key actions on your part.

You notified the Western Board of this adverse incident as per Dr Kelly's advice; isn't that correct?
A. Yes.
Q. And you've told us that it was normal practice for adverse incidents involving medical issues to be reported to Dr McConnell.
A. Yes, Dr McConnell was the Director of Public Health. If he wasn't available, then obviously one of the other doctors would be advised.
Q. And could I just have up on the screen, please, a circular, which defines -- or at least defined at one point in time -- the nature of the reporting relationships between the Western Board and the hospitals within that area. It's at 319-045A-002. It's a circular, one of 86, and of course at the time of its publication the trusts were not in business as such.
We can see that the document is titled:
"Notification of untoward events/unusual occurrences to board headquarters."
And it goes on to say:
"This circular defines the procedure to be adopted when an incident occurs."
It covers the following categories. (1) relates to the mentally handicapped and mentally ill environment and obviously not relevant here. (2):

"Untoward events and unusual occurrences in board facilities or in respect of officers on board business."
And then that's the one that's relevant here, is it, Mr Mills?
A. When you ask "is relevant here", I'm not quite sure what you mean. The date of this is 1986 --
Q. Yes.
A. -- and this was relevant at the time that the board had, I suppose, direct management responsibility for the activities that were taking place in the units of management. What I was pointing out in my witness statement was that my career in 1986 was actually -- I had a familiarity with this system because I was in fact involved in the management of mental health and mentally handicapped services. But in terms of the direct management responsibilities, the Trust emerged from directly-managed units, it was initially -- we were initially set up -- the Erne Hospital would have been part of the Omagh and Fermanagh Management Unit from 1990 to 1995 and then, when the mental health services were amalgamated or merged with the Omagh and Fermanagh Management Unit, we became the Sperrin Lakeland Management Unit. So we were directly managed by the Western Health and Social Services Board until 1996.
Q. Yes.

A. So I suppose this circular would have been effective until 1996.
Q. The question that was asked of you in your witness statement, sir, was in relation to the question of where your responsibilities derived from in terms of reporting to the Western Board, and you referred to:
"Legislation, departmental board and Trust policies and circulars."
Which, at the time of furnishing us with your first witness statement, you didn't have in your possession. By the time of your second witness statement, when we, if you like, probed deeper into this whole area, you told us that the relevant legislation was the Coroner's Act and the Health and Personal Social Services (Northern Ireland) Order and you then referred to two circulars, one of which we looked at earlier -- the reporting internally, if you like, of adverse incidents or health and safety issues -- and this one then related to interaction with the Western Board.
A. Yes.
Q. So what we're anxious to do as an inquiry is to understand from the Trust perspective in the year 2000 just what was the nature of the governance relationship between the Trust and the Western Board and the officers who staffed the Western Board. So in terms of this

document that we have in front of us, which in total describes the procedures that were in place for reporting from a hospital setting to the Western Board an adverse incident, was that applicable in the year 2000?
A. What I've done in terms of furnishing the inquiry with this particular circular is identify the fact that those of us who would have been involved in the senior management in the directly-managed units of the Western Board would have been familiar with this process and this is the process that we would have used. When we became trusts, we continued with this process, we wouldn't have seen it being any reason why we would have changed this process. This is the one that we had used and we had always used. So what I suppose I've endeavoured to do in terms of informing the inquiry is this is what we were used to and this is what we continued with.
THE CHAIRMAN: And at no point did the Western Board say, "Why are you reporting to us, this is an old procedure which no longer applies"?
A. No.
THE CHAIRMAN: When Mr McKee gave evidence on behalf of the Royal, he said in very stark terms that in the years that he was talking about, 1995/1996, which is the

equivalent post-trust establishment era, he said that neither the Royal nor the Eastern Board was responsible for clinical care. By reporting what happened to Lucy to Dr McConnell and others, was Sperrin Lakeland acknowledging that, however defined the duty was, the Trust had a duty and the Western Board had a duty?

A. I can't comment, chair, on the situation in the Royal and the Eastern Board. We always felt that we had a responsibility to report incidents of a serious nature to the Western Board, and I think, as our main commissioners, the majority of the funding that we receive to run the services -- perhaps unlike the Royal, who would have received funding from the four different boards -- but the majority of the funding that we would have received was from the Western Board. They were our major commissioners and therefore we viewed that as a responsibility that we had to the Western Board.

THE CHAIRMAN: Thank you. But in part that's because the Trust felt that it had a responsibility for clinical care?

A. Oh, certainly the Trust had a responsibility for clinical care.

THE CHAIRMAN: That's immediately a huge difference between you and Mr McKee, because Mr McKee said -- and he agreed it seemed bizarre -- but he said the Royal Trust had no

responsibility for clinical care. I'm not asking you to comment on that, but it's clearly at odds with your view that the Sperrin Lakeland Trust did have responsibility for clinical care.

A. I can only speculate that Mr McKee was referring to the legal requirement that came in in, I think, 2003 --

THE CHAIRMAN: Yes.

A. -- for reporting of clinical incidents. It might have been 2004, but it was a legal requirement that came in.

THE CHAIRMAN: It came in in 2003, that's right.

A. Yes.

THE CHAIRMAN: Thank you.

MR WOLFE: So your starting position, Mr Mills, is that, come 2000, in essence you were carrying on, if you like, the pre-trust -- I hesitate to call them "habits", but it was certainly pre-1996 when the Trust was formed. But you would have seen yourself as having an obligation to report to the Western Board? Post-1996, was it still in your mind an obligation?

A. Absolutely.

Q. We'll move on in a moment just to look at some of the detail of that, but in terms of why it was an obligation, was it an obligation because of legal or contractual commitments or was it an obligation based on the fact that the Western Board was the main

commissioner of the Trust's services?

A. Well, I suppose primarily the Western Board was the main commissioner of the Trust's services. There was also very senior and experienced personnel within the Western Board whom we would have looked to for advice and direction.

Q. Yes.

A. And quite often, we would have got that advice and direction without necessarily asking it, and in essence, I suppose the Western Board would have been responsible, prior to the trusts being established, for directly managing services and directly responsible -- Dr McConnell would have been directly responsible for the management of medical staff across the Western Board. So it wasn't just about reporting specifically because they were the commissioners; they were a source to us of expertise and advice that we would have relied upon on a regular basis.

Q. In terms of your understanding of the responsibilities attaching to the Western Board once a report had been made, you have said to us that the Western Board would receive and consider the information about an adverse incident and advise the Trust on any details they required or actions they wished the Trust to take?

A. Correct, yes.

Q. That definition of your understanding of what they would have done or what you would have expected them to have done following an adverse incident, was that borne out of any particular experiences prior to the Lucy Crawford report?

A. If they felt there was any aspect of the report or any aspect of the information -- just in terms of the information that was provided to them at the outset or information that was provided to them as the case was investigated, if they felt there was anything that they wanted to know, they certainly would have asked, and that certainly would have been my experience.

Q. Dr Kelly, in his witness statement for the inquiry, understood that Dr McConnell, the Director of Public Health for the board, had a responsibility to be satisfied that the incident, as it was described, specifically referring to Lucy Crawford -- but I suppose broader than that, historically, any incident reported to the board had been properly reviewed. That was his understanding of Dr McConnell's role. And secondly, for disseminating any lessons learned across the Western Board and perhaps the wider HPSS in Northern Ireland if appropriate. Can I have your views on that, please, Mr Mills? First of all, had he a responsibility to be satisfied that an incident was

properly reviewed?
A. I would agree with what Dr Kelly has said. It certainly would have been my view that if we weren't doing the job properly, Dr McConnell would have told us.
Q. And again, if a particular incident gave rise to lessons of more general application, can you help us in terms of whether it was your understanding that the board and, in particular, Dr McConnell would have a disseminating role in that sense?
A. Yes, if that was known at that time, that would have been part and parcel of his responsibilities, advising other trusts within the board and indeed advising others across the HPSS system.
THE CHAIRMAN: Can you give us an example of that having actually been done in any area?
A. Off the top of my head, I'm afraid ...
THE CHAIRMAN: Because Dr Carson said, I think within the last fortnight, that he couldn't recall from this era any example of sharing between boards. Sorry, he said sharing between trusts, but I think it's the same principle, isn't it?
A. Yes, it would be the same principle.
THE CHAIRMAN: I understand, your point seems, to me, to make common sense that if there are lessons to be learned from any issue in Sperrin Lakeland Trust, the

Western Board would want to make sure the lessons are learned throughout the Western Board, but depending on how serious the issue is, they might also want to make sure that lessons are learned beyond the Western Board and, at least, in all parts of Northern Ireland. While that sounds instinctively right, can you give an example of it ever happening?
A. Sorry, chair, off the top of my head -- I do know there was a formal process for issues associated with equipment, where if a particular Trust had an issue that resulted in the failure of a piece of equipment, then there was a process in terms of where that could be reported through health estates and disseminated across all the trusts in Northern Ireland.
THE CHAIRMAN: When you say "health estates", did that go through the department or through the boards?
A. That would have been through the health estates of the Department of Health and Social Services.
THE CHAIRMAN: Thank you.
MR WOLFE: I want to ask you some questions, Mr Mills, about where the Department of Health and Social Services in Northern Ireland fitted into this -- let's call it reportage jigsaw. Because you have described the historical arrangements which were still in place, as you understood them, in 2000, and pursuant to those

historic arrangements, of course, a report was made to the Western Board.
You have said in your third witness statement to the inquiry that you understood that the Trust's line of accountability, pursuant to the 1991 legislation, was to the department. I think it was the inquiry that introduced the term "line of accountability", and you took it up in your answer. What was your understanding of what the Trust was accountable for in relation to the department?
A. Well, under the terms of my appointment there is what's called the appointment of what's called an accountable officer. That is primarily in relation to the financial issues that are associated with making sure that you ensure that the organisation has due approach in relation to the financial matters and ensure that you make sure that the money that you receive is properly accounted for and properly expended and ensure you don't overspend, issues primarily in relation to the financial matters.
Also, I suppose in relation to our workload at that time, we were largely dealing with the department when it came to issues of strategic importance. The big issue at that time was in relation to the Acute Services Directorate, whether or not there was going to be a new

hospital, or indeed what the format or what the future delivery of acute hospital services would be for the communities of Omagh and Fermanagh at that time, and there was significant involvement in our discussions with the department on the strategic aspect of that as decisions were taken forward and acute services -- I can't remember the exact timing of them. There were a number of reports set up by the department that would have examined acute hospital services across Northern Ireland, and we would have been involved in responding to those documents and feeding into them.
If we wanted funding of a capital nature, in other words funding that was associated with a capital scheme such as a building or equipment, that had to be approved through a business case mechanism by the department, so the department had to approve that. That funding came from that direction. Obviously, the money that we would have got for running services, what we would call the revenue stream, that came from our commissioners. And obviously our commissioners would have to be able to support the business case that was being presented to the department in terms of how the revenue would be -- say, for example, if there was a new building being provided, how the revenue to run the building or run the services that the building was being erected for ...

So that's the level of -- gives you a brief potted view, as it were, of the level of issues and discussions that we were engaged in as a Trust with the department. It was largely at that strategic level.

Q. So you have described the, if you like, communications being on that financial, significant financial and strategic level, and within your witness statement you have indicated the mechanisms by which those discussions could take place. There would be periodic meetings with the department's senior officials and there was a chief executive's group that would have had, as you describe, collective meetings with the permanent secretary and senior officials at that level.

Could I ask you about operational matters, such as significant adverse incidents that might, if you like, be the subject of poor publicity? Were those kinds of matters the subject of reportage to the department by reason of the fact that there was this managerial link-up between the department and the Trust?

A. I think, chair -- I mean at that time, I'm not quite sure of the sequence of things in terms of the assembly or whether there was a local minister or a devolved minister. But certainly, from that point -- I mean, at that particular point in time, we wouldn't have viewed the reporting of an untoward incident as something that

we would have reported to the department. In fact, I suppose to some extent I'm not sure who in the department I would have reported it to, and nobody in the department was telling me, "We don't get any reports from you, why aren't you reporting this?". I can't talk about it for other trusts, but nobody was actually coming and saying to me, "Why aren't you providing us with any reports?".

Q. Just to summarise, the accountability to the department, as you saw it, was on the financial and strategic. Insofar as, if you like, individual adverse incident were concerned, that wasn't a matter to be reported to the department and, in any event, there wasn't a mechanism to do so?

A. That's correct.

THE CHAIRMAN: Well, this is a rather uncertain world that we're looking back at, but what Dr Carson has said is that when the 2003 order took effect and a statutory responsibility for care was placed on the trusts, that did not actually replace a statutory duty of care which had previously lain with the trusts or the boards. He was suggesting before that it really lay with the doctors. Does that surprise you that, before 2003, Dr Carson suggested that in essence there was no statutory responsibility for care and that in effect

he was saying we're moving into an era where doctors had previously not been involved in management, where they worked independently, and we're breaking away from that era into the new where the trust boards, from 2003, had the responsibility, but in this interim period which would cover Adam, Claire, Lucy and Raychel, he's suggesting that it was only the doctors who were responsible for care? On your evidence to date, that seems like he's on a different track to your track.

A. I think in terms of certainly the legal duty and the procedures, what I'm saying is they didn't exist in the year 2000. The point that you're making is that the professional responsibility of clinicians to report -- and in fact that was done, that was done by Dr O'Donohoe by reporting the incident, and I suppose to some extent these were the early stages of the introduction of the clinical adverse incident reporting and we would have encouraged professionals within our organisation to make those reports. I don't think that this was the only report that we would have received, and it wouldn't necessarily have been received specifically just because there had been a death. There would have been other reports that would have been received. Largely, that was the responsibility, as we would have seen it at that time, to manage it through the processes that were

evolving and the doctors would have been responsible for reporting those issues and we would have been responsible for managing them, whether an investigation or not an investigation.

THE CHAIRMAN: Right.

A. And in essence, if they were serious enough, if they were significantly serious, then we would have reported them, as we saw, specifically to our commissioner, our main commissioner. We didn't see that there was a responsibility or an avenue to report them through to the department.

THE CHAIRMAN: Okay. There are two points. One is that whether or not he recorded it, Sister Traynor reported it through the adverse clinical incident report. That was a second route by which it came to your desk in effect; right?

A. No. That demonstrated that the training that was going into place about the development of reporting -- and, in essence, I suppose one of the issues that I was conscious of at that time -- because you'll have seen from my CV that I was involved in meetings and discussions that were taking place in England. There was this important development of this -- what was called "no-blame culture", ensuring that you did have an open system that encouraged staff to come forward, and

I think that demonstrates that, chair.
THE CHAIRMAN: And when Dr O'Donohoe comes to Dr Kelly or Sister Traynor comes to Mrs Millar, nobody says, "Actually, that's a matter between you and your professional body", it's accepted by the Trust as something it should investigate and it is also accepted by the Trust as something it should report to the Western Board?
A. Yes, chair.
MR WOLFE: There is, Mr Mills, an apparent tension between the evidence that you gave to the inquiry in relation to the requirement, if any, to report to the department and the information which Mr Frawley, the general manager of the Western Board at that time, has so far given to the inquiry through his witness statement. In his witness statement 308/1, page 14, he says:
"I would have expected the Trust to notify the department of an untoward death, such as that of Lucy Crawford, because the Trust's line of accountability was to the department."
So he says, in strict legal terms, taking account of the legislation, your line of accountability is to the department, not to the board. You have been reporting it to the board historically, good and proper that that arrangement continues, but in addition to that you

should be reporting it to the department; is he correct?
A. I can't comment on Mr Frawley's view. All I can do is comment on the fact that there was no process for that at the time and we wouldn't have, by routine, been involved in reporting critical incidents to the department.
Q. Does it surprise you that he would say that?
A. Again, I mean, I can't comment specifically. That's Mr Frawley's view.
THE CHAIRMAN: Let me ask you in a different way: the Chief Medical Officer for Northern Ireland has a specific remit, which is a bit more specific than the overall responsibility of the department. So if there are adverse incidents which raise clinical issues, do you see an argument that there should be some method by which the Chief Medical Officer is advised that things like this are happening?
A. I see an argument, chair, and, subsequent to the year 2000, there were arrangements brought into place to address that, yes.
THE CHAIRMAN: As a result of 2003 or even without the 2003 legislation?
A. As a result of the 2003 legislation.
THE CHAIRMAN: Thank you.
MR WOLFE: Your response -- and I realise it's not a direct

response because you wouldn't have had Mr Frawley's witness statement in front of you when you said it -- but what you seem to say is that nobody at the Western Board told us to report it to the department, or indeed nobody told you to report it to the department, specifically the Western Board. Did it really require the Western Board to make that kind of suggestion before it became incumbent upon you to report?
A. Again, I mean, I go back to the way that we operated in terms of liaising with board and indeed liaising within our organisation. There was a collective, as it were, I suppose insurance system that we worked with each other rather than necessarily pulled against each other, and, as a result of that, we would have supported each other. So I'm saying that as if to say -- as if to sort of say -- I'm not saying I'm blaming the board for not telling us; what I am saying is normally, if the board were concerned or wanted clarification as to whether or not we had reported it, they would normally be advising us and that would come through in the course of all the range of discussions that have taken place on this case.
Q. I'm going to ask you questions about whether the case was in fact reported to the department. You have told us, Mr Mills, in your third witness statement that you're uncertain as to when the department was made

aware of the death. You said that this may have followed the information received by Dr Kelly upon the report of the death of Raychel Ferguson in 2001 and may have been prior to 2002. Between those pillars -- June 2001, when Dr Kelly became aware of Raychel Ferguson's death, and some time prior to 2002 -- can you help us further in terms of who might have reported the death to the department and the circumstances in which that might have occurred?
A. That emerged, as it were, as a result of, as I understand it, a discussion between the medical director in Altnagelvin and Dr Kelly, our own medical director -- that's Dr Fulton from Altnagelvin. And as a result of that discussion, it emerged that there was basically concern now in relation to the type of fluid in relation to what was happening in the procedures in the Royal Belfast Hospital for Sick Children.
Q. Dr Kelly's alluded to that in his evidence before the inquiry. But my question is a slightly different one: was there a formal report of Lucy's death to the department?
A. No. What I was alluding to there in my witness statement was in relation to the evidence that Dr Kelly would have already provided at first-hand.
Q. Could I bring you to something that Dr McConnell has

said? If we have his witness statement up, please. It's witness statement 286/2, page 4. In his first witness statement to the inquiry, Mr Mills, we interpreted Dr McConnell as seeming to say that it was his understanding that the Trust had made a report to the department. We pick that up with him at (e) there:

"Did you take any steps to ascertain whether the Sperrin Lakeland Trust had reported Lucy Crawford's death to the department? If so, please account for the steps that you took."

He says:

"In the information provided by the Director of Acute Services of the Sperrin Lakeland Trust[that's Mr Fee] and [by yourself], the chief executive, I believe that Lucy's death had been notified to the department and did not therefore need to take any further steps to ascertain this. This is based on my recollection and I have no record, either paper or electronic, to confirm this."

So he doesn't help us much further in terms of the specifics of his understanding, save to say that he has this understanding which we can ask him about when he gives evidence later this week. Did you say anything to him, to the best of your recollection, that would have caused him to think that the department had been

notified?

A. No, I have no recollection of either telling him that it had been notified or saying that it was going to be notified. I have no recollection.

Q. Could I ask you to take a look at the following document, 030-009-016? This is, as the document suggests, a programme for a meeting Clive Gowdy who, on the date of the meeting, 14 June 2000, was the Permanent Secretary of the Department of Health; isn't that right?

A. That's correct, yes.

Q. This was a visit by him to your Trust headquarters?

A. That's correct, yes.

Q. The reason why I'm asking about this is that this document appears on file 30, which is one of the files supplied by you or your office when there was a call for documents on behalf of the inquiry. Is it reading too much into it, Mr Mills, to say that this was a meeting at which Lucy Crawford's death could have been discussed with Mr Gowdy?

A. Chair, I have no recollection of discussing Lucy's death with Mr Gowdy at the meeting on 14 June. When I asked for the original of that document, I discovered that on the reverse side of that document was my note that I have referred to, 030-008-015. So in essence, what I have done is, on 15 June, picked up a blank page that

was obviously the back of the agenda from the meeting the day before and I was making those notes on that.

Q. So that was the stationery at your fingertips to allow you to make the note?

A. That was the simple explanation for that.

Q. When you have a senior official down at your Trust from the department -- in this case, it doesn't get much more senior than the Permanent Secretary -- would you be expected by him to be bringing the department up-to-date with any significant developments occurring at the Trust, even if they are, if you like, on the operational side, such as a review into an adverse incident?

A. No, these meetings would largely have focused on the strategic issues and the development in terms of how the Trust was responding to those. And, as I said, a major issues for us, chair, at that time, was the future of our acute hospital services. In fact, I can see that the visit was arranged in the afternoon, perhaps to actually take the focus off the acute hospital services to one of our community services, which was a children's home, just to highlight the breadth of responsibilities that we had.

MR WOLFE: Very well. Would this be a convenient moment for a short break?

THE CHAIRMAN: Yes. We'll break until 11.15.

(11.03 am)

(A short break)

(11.25 am)

MR WOLFE: Mr Mills, now that we're dealing with the Western Board -- and just perhaps a little out of sequence -- could I just bring you to one issue that arises? You obviously, as appears from your records, notified the board on 14 April about the death. On 19 April, you had discussions with Mr Bradley.

A. Correct.

Q. And then, on 21 April, your note records that you informed Dr McConnell of the appointment of Dr Quinn -- let's describe it generally -- to provide assistance with the review. I want to ask you about that interaction.

You have said in your witness statement at page 10 that you recall at the time that Dr McConnell was satisfied with the Trust approaching Dr Quinn to provide his views on the case and no objections were raised; is that your recollection?

A. Yes. That's my recollection. The note actually says that I left a message for him on the ...

Q. Yes. If you want to bring that up, is that 030-010-018?

A. That's it, yes.

Q. We perhaps don't need to go to that. Your note says you

left a message. Your witness statement --
A. Sorry, I didn't say I spoke to him directly on that day, but subsequent to that I probably would have met him, certainly shortly after that or whatever, and in conversation he wouldn't have raised any problems with me that I recall about the appointment of Dr Quinn.
THE CHAIRMAN: Can I just ask you to give me a picture? You were based in Omagh, as was Dr McConnell; is that right?
A. No, Dr McConnell was based in Derry.
THE CHAIRMAN: Okay. Was Mr Frawley based in Omagh?
A. No.
THE CHAIRMAN: No?
A. The board headquarters was in Gransha Park in Derry.
THE CHAIRMAN: Thank you.
MR WOLFE: Indeed, Mr Mills, as well as conversations with Dr McConnell which you might have had, sporadically he received, from Dr Kelly, an update in or about the middle of May telling him about the progress with the review, but I want to put to you Dr McConnell's perspective.
If we could have up on the screen, please, 318-002-001. I can't help you in terms of orientating you with this document other than to say that it's a document that has been submitted on behalf of Dr McConnell. Just working through this, Dr McConnell

recalled a telephone call from yourself:
"... advising that he was thinking about approaching Dr Quinn with a view to asking him to review the case notes and provide the Trust with his opinion.
"Dr McConnell advised that Dr Quinn could certainly review the notes and, indeed, this may be helpful given that he had provided paediatric clinics to Tyrone County and Erne Hospitals prior to the appointment of consultant paediatricians in the Trust."
However, Dr McConnell says that he:
"... cautioned you that such a review would not be seen as independent as Dr Quinn would be seen as being too close to the situation; a wider external review through the Royal College of Paediatrics and Child Health would be required. A copy of Dr Quinn's review of the case was not shared with Dr McConnell."
Let me just unpack that with you. I can't assist you with who Dr McConnell was speaking to, but it is a note taken in November 2004. The first key issue that emerges from it is that he cautioned you in respect of how Dr Quinn's participation in this review could be perceived; do you recall that?
A. No, I don't recall that. Chair, can I just draw your attention to the first paragraph? Just to clarify the fact that the first paragraph says that:

"Dr McConnell recalled a telephone call from Hugh Mills advising that he was thinking about approaching Dr Quinn."
My record states -- and it's a note that I would have made at the time, as opposed to Dr McConnell's note -- and to point out that's made in November 2004 -- is a note that basically I left a message on Friday, 21 April to advise that we had asked Murray Quinn to provide the Trust with his advice. So in essence he was being advised after the event. So just to clarify that point is incorrect in Dr McConnell's note.
Q. Just to be clear on the significance of that, you're saying you left a message for Dr McConnell's attention after the decision had been made to --
A. And after -- after the decision had been made, after Dr Quinn had been approached, after he had agreed, and we were in the process of ensuring that he would receive the notes and the information.
Q. Whereas by contrast, the first paragraph here suggests that you engaged with Dr McConnell to consult his views prior to the appointment of Dr Quinn having been secured? Let me ask you that directly. Did you consult with him for his views prior to making, if you like, the appointment of Dr Quinn?
A. I have no recollection of that at all.

THE CHAIRMAN: Is your position that, on the basis of your note, you believe that you had engaged Dr Quinn and then were updating Dr McConnell that this had been achieved?
A. Yes, chair, on the basis of my note.
THE CHAIRMAN: Thank you.
MR WOLFE: Then moving directly to the second bullet point. First of all, in broad terms, an issue of independence of Dr Quinn was raised with you by Dr McConnell on his recollection; is that fair?
A. I don't recall him raising that with me. I certainly would have been aware of the potential of that aspect at the time. I haven't been asked as such to provide further information yet about the appointment of Dr Quinn, but I can answer that question as well, but certainly I would have been aware of that -- of the issue at that time in relation to Dr Quinn. There may well have been an issue perceived by others about his independence.
Q. Leaving aside for a moment, and we'll come to it, whether and how you resolved the issue of his -- that is Dr Quinn's -- independence, is it, doing your best, thinking back to that time, something that you were discussing with others?
A. No.
Q. But it was something that had occurred to you?

A. In weighing up the issues that I was considering at that time, I was aware of the fact that Dr Quinn had worked in the hospital before and would have known some of the nursing staff in the hospital before, and I thought that was actually an advantage, and indeed Dr McConnell refers to that as being advantageous as well, and I would have weighed that up in my decision versus the potential perception about Dr Quinn's independence.
Q. So it was something you were internally turning over in your mind as opposed to seeking views about?
A. Yes. I wasn't ignoring that fact.
Q. It does seem, if I may say so, to be a logical thing for a director of public health to raise with you, "Have you considered question marks about the independence of this gentleman who you're retaining?" It seems a sensible thing for a director of public health to be raising with you.
A. Well, I have no recollection.
Q. Could we just then move to the next part of his concern? So he seems, on the basis of this note, to be endorsing the view that Dr Quinn could be helpful in a limited exercise of reviewing the notes, but he seems to be suggesting here that there was a need for, if you like, a more rigorous or a wider approach, which necessarily couldn't involve somebody such as Dr Quinn, whose

independence, if you like, might be perceived as being not quite there. Was that the subject of discussion with you, the need for a wider review?
A. I suppose the difficulty, chair, I have is that this is a record that's been made in November 2004.
Q. I'm not asking you about it on the basis of the record; I'm asking you about it on the basis of: in or about 2000, were you having a discussion with Dr McConnell, formal or informal, at which he is saying to you, "There is a need for a wider review here"?
A. Personally, no, I wasn't having a discussion with Dr McConnell about a wider review, but as I've already identified, chair, we were having discussions in mid-June, as a result of the letter we got from Dr Asghar that we were commissioning a wider review, and I'm sure Dr McConnell would have known that or been a party to it. Whether he was suggesting it or we were suggesting it, I don't know.
THE CHAIRMAN: So this might be running two slightly different things together, the use or advisability of using somebody like Dr Quinn to look at Lucy's case notes on the one hand and who might be used for a wider review of all the issues Dr Asghar had raised on the other?
A. Yes, one followed quite close to the other, yes, chair.

MR WOLFE: In terms of your dealings with Dr McConnell, Mr Mills, can you think of anything that he suggested to you in terms of how the Trust might better investigate this death?
A. No, I have no recollection of anything that he might have suggested that would have helped improve the investigation.
Q. Was there any discussion with him of the need to check with the coroner what was happening with the case?
A. No, not that I'm aware of.
Q. Mr Frawley was the general manager, we've already introduced him. He and you met on 3 May and 14 June. That was part and parcel of your monthly chief executive meetings with him; is that right?
A. Yes. We would have met every -- well, month to six weeks. Those meetings would have been scheduled at the beginning of the year and diaried at that time and they were largely held, or if they had to be rearranged, were arranged with a few days.
They were quite extensive meetings and we would have been involved in discussing a range of issues. The agenda might have -- there might be some examples of that in terms of my papers, but there would have been considerable numbers of items on the agendas and the meetings would probably be an hour-and-a-half to two

hours.
Q. I don't think we need to go to those, but in general terms you would have used the opportunities of those meetings to update him with important developments within the Trust?
A. Yes, I think on 3 May I was raising it under any other business. And, on the subsequent meeting, then it was formally on the agenda.
Q. Again, was he suggesting to you, on behalf of the board, any steps that the Trust should be taking, either different or additional, to the steps that were already in train?
A. No, not that I can recall, and my record of those meetings would probably have recalled any suggestions. Although what I was basically doing was providing an update, so in essence I wasn't expecting any suggestions. This was information that was emerging and developing as the process was unfolding. So in essence, I was providing the information to the general manager, but if he would have identified an issue that we hadn't done or should have done, Mr Frawley would have normally suggested it.
Q. At the 14 June meeting, you have indicated that you believed you brought him up to speed with the, if you like, the Asghar development, the fact that you'd had

this -- let's call it a complaint -- in from Dr Asghar, which indeed touched upon the Lucy Crawford issues as well as other issues.
A. I did, yes.
Q. We'll come to the circumstances that pertained at the conclusion of the review process, but it's your recollection that the review report was provided to the Western Board?
A. It's my recollection, yes, that the review report was provided to the board.
Q. Let's go back a little then on the chronology, if you would, and we're going now to look at the circumstances in which the review was established. It was Dr Kelly's evidence last week that upon reporting the adverse incident to you, he indicated that there would be a need for a full review; is that fair?
A. Yes, I concur with that.
Q. It's your evidence to the inquiry that it was you who suggested that Mr Fee and Dr Anderson should coordinate the review.
A. I think, as a result of the discussions that were taking place between us, there was a view that it should be the directorate leaders, who were basically Mrs Millar and Dr Anderson, but they had identified a potential conflict of interest in relation to Mrs Millar because

she had a family connection with Mrs Crawford, and therefore she was ruled out and Mr Fee took her place.
Q. And terms of reference were drawn up. You say they were drawn up by Mr Fee and shared and agreed with Dr Kelly and yourself?
A. Yes, that's my recollection.
Q. Those terms of reference, we can have a brief look at them at 033-102-264. As you can see under the heading "Purpose of the review", this is them now incorporated within the review report itself, which we'll turn to in due course. But the main purpose of the review, you see it towards the bottom of the page, was:
"To trace the progression of Lucy's illness from her admission to the Erne and her treatments and interventions in order to try and establish whether and in summary whether there were any acts and omissions on the part of the Erne Hospital which could have caused the progression and outcome of Lucy's condition."
Then at (c):
"Whether there were any lessons to be learned for the future."
Did you participate in a discussion around those terms of reference?
A. My recollection of it is that they were shared with me. I looked over them and I felt that they were

satisfactory and would have met my approval at that time.
Q. And at that time, Mr Mills, was there discussion amongst yourselves, that is your senior management team, about what had gone wrong for this child?
A. No, I have no recollection of discussion at a formal meeting of the senior management team. It would have involved the Acute Services Directorate, so therefore the wider responsibility of the management team wouldn't have necessarily been involved in the discussions. So I have no recollection of it being an item that was discussed at the meetings of the senior management team.
Q. Well, informally then, were there discussions with you that caused you to believe that there was some act or omission that could have been responsible here?
A. The information that I received was from Dr Kelly, who is a member of the senior management team, as we've mentioned earlier, and he was advising that there was concern, as I said, on 14 April that it was the wrong drug or the incorrect dose level of fluids that may have been prescribed.
Q. So the review was going to look at that as a potential act or omission?
A. That was flagged up at the outset, so that's my note and my record of the fact that that was important for the

review to be looking at that aspect of it at the outset.
Q. As we moved through your diary entries earlier, it was Mr Fee who approached you in relation to the need for paediatric input, and you made the contact with Dr Quinn.
A. Mm-hm.
Q. And your note suggested that contact was made in or about 20 April.
A. Yes, that's correct.
Q. To the best of your recollection, how many discussions did you have with Dr Quinn before he assented to his involvement?
A. My recollection was that I rang him on 20 April, left a message for him to ring me back. I note that I was at a Trust board meeting in the Erne Hospital on 20 April and therefore, rather than being in my office in Omagh, I was in the Erne Hospital. When he rang me back on 20 April, I would have shared with him what the information I had at the time -- which was largely in and around there was a dispute between the nurses about the fluid that had been prescribed and fluid that had been administered to a child, and I would basically be grateful if he would help in looking at the case for us. I didn't go into any details because I didn't know the details in terms of how much fluid, what type of fluid,

and I didn't go into details of what he would be expected to do because I felt that was a matter for the internal review. I was being asked by the internal review to obtain a paediatrician, to provide him with support, and I felt it was up to the internal review to advise Dr Quinn what they wanted of him.

Q. So just to summarise at this point: this is the one and only conversation that you had with him in relation to this matter?

A. As far as I can recall, this is the one and only conversation I had with him at the time. I subsequently had a conversation with him in 2004.

Q. I'll deal with that in due course. So this is 20 April -- or thereabouts -- 2000, Mr Fee has asked for you to secure paediatric input, and in terms of describing what would be expected of Dr Quinn, you're saying quite clearly you were leaving that question of the degree of his involvement and how he would deliver an opinion to the review team itself?

A. That's correct. That's confirmed in the note that I made at the time. Basically I was passing on to Mr Fee the next day that Dr Quinn had agreed to examine the case and arranged for Mr Fee to forward the notes to him. So that was done on Friday 21 April, the next day.

Q. Well, let me just focus on that a little. Having

described the background of the child's case to Dr Quinn and having told him that a review was being established, had been established, how did he respond?

A. My record is that he had agreed to look at the notes and provide advice.

Q. Just for reference purposes, do you want to mention the reference for that document?

A. That's 030-010-018. That's what I recorded on Thursday, 20 April:

"I spoke with Dr Murray Quinn, Altnagelvin, who agreed he would look at the notes and provide his advice."

Q. Could I put to you Dr Quinn's perspective on this? He recalls being contacted by you, by telephone, asking if he was willing to review the hospital notes of the child and comment on certain aspects of the case. It's what he told the PSNI in a statement in 2004 or 2005. Would you have said that to him, that you would like him to review the notes of the child and comment on it?

A. I don't know that I would have been that specific. I basically would have informed him that there was a dispute that I was aware of between the nursing staff and the medical staff about the prescription and in relation to the fluids and I was asking him to look at the case.

Q. He tells the police -- and indeed he told this inquiry -- that in response to your contact with him, he was equivocal in his response in that he says that he merely agreed to look at the notes in order to put himself in a position to determine whether he was going to be able to assist and that it was in the context of a second telephone call with you that he agreed to assist. First of all, as a matter of process, could that have occurred in that way?

A. I don't recall a second telephone call with Dr Quinn. There was a call between Mr Fee and Dr Quinn on the Friday because I asked Mr Fee to contact Dr Quinn to advise him of the main issues that we need to examine and to forward the case notes to him. But I didn't have a second call -- I don't recall that I had a second conversation with Dr Quinn.

Q. Dr Quinn has outlined to the inquiry a series of limitations or constraints around his input and he tells the inquiry that those were outlined to you. Just to perhaps remind of you what he said, he says that in his conversation with you he outlined the fact that he wasn't prepared to interview the parents or the staff, nor for that matter was he prepared to become involved with any medico-legal work in respect of this case or indeed become involved in relation to any complaints

process that might emerge. Was that discussed with you in that way?

A. I don't recall that discussion with me.

THE CHAIRMAN: It might be hypothetical, but if he had said to you, "Yes, I will do this, but I won't meet the consultants, I won't meet the doctors, and I won't speak to the family", would that have made any difference to you or can't you say?

A. It is hard to speculate on that, chair. I suppose at the time if he had said in relation to the medico-legal and the complaints issue -- obviously, if he had raised that with me, I could speculate the fact that we weren't in a medico-legal -- there was no litigation or complaint at this stage, so I can speculate on that basis, but I couldn't speculate on the others.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: What he also told the police at the time was that, in terms of becoming involved, what he was prepared to do for the Trust was to review the records and discuss the issues which occurred to him as he read them. In other words, he's prepared to give an oral opinion in relation to what had gone on rather than become engaged in the formality of providing a report; was that discussed with you?

A. No, that wasn't discussed with me and I'd be quite

surprised about that. The purpose of asking him to do the review would have been to obviously get a written report from him.

Q. As we know, ultimately -- and we'll come on to some of the detail of this in a moment -- in June, when Dr Quinn met with Messrs Kelly and Fee, he was asked to provide a report; he would say persuaded to provide a report. Was that something that was made known to you at any time?

A. I don't recall it being made known to me at the time. Obviously, I became aware of it at a later stage. If there was any -- I suppose my view on it, on reflecting -- and I think I said this to the police in terms of my interview with them -- if there was any delay or any process or whatever in Dr Quinn's mind then I would have been surprised by the fact that following the meeting that was held on 21 June there was no hesitation in providing a report on 22 June.

Q. Yes, we'll come to the detail of that in a moment. Can I ask you some questions about the issue you touched upon earlier in terms of perceptions about his independence? Clearly, you were sensitive to that issue, according to your evidence.

A. Yes, chair. I think it's important to, I suppose, put the context of the paediatric service in the

Erne Hospital in mind. This was a small department. I think we had two permanent consultants in post at that time and the other posts were looked after by a series of locums. I was conscious that there was a dispute now within this department between one of the consultants and some of the nursing staff regarding the issue of prescribing and the recording of prescribing [sic] of the fluid. In essence, we hadn't received either a complaint or we weren't in litigation. This was an internal review and normally internal reviews would have looked to resources within the organisation, within the hospital. And in bigger hospitals -- and I'm not sure what the expert witnesses have said in respect of what would happen in small, local hospitals as opposed to bigger hospitals, but normally we would have looked to the expertise for an internal review within the organisation.

The only other consultant paediatrician within the organisation was a colleague of Dr O'Donohoe's, and that would have put her in a very invidious position in terms of examining the case on behalf of her colleague. To my mind, I, having thought about it -- and I suppose I was directly involved in doing it because Dr Kelly was on leave and it normally would have been dealt with by Dr Kelly. But I was aware of, through my previous

experience and working in Altnagelvin, of the expertise of the paediatricians in Altnagelvin and I knew that Dr Quinn had experience. I knew that I would have had the confidence in his abilities and I knew that other staff would have confidence in his abilities. So the fact that he had -- in the past, not currently -- been involved in doing outpatient clinics and ward rounds in the Erne Hospital, he would have been known to some of the nursing staff and therefore I felt it was important, in order for them to be open and to provide the information to the review, that they would have confidence in the people that were carrying out the review. And that's how I balanced my decision at that time on deciding to use Dr Quinn, even though, as it were, there was a perception or the potential for a perception, I think I would say, that he may -- because of his knowledge, but it was actually because of his knowledge, that was the strength, because of his knowledge in terms of working in the department at that time.

Q. He was known to you both personally and professionally; is that fair?

A. Yes, I knew him as a colleague in terms of working when I worked as the administrator in Altnagelvin Hospital from 1987 to 1990. I would have met him occasionally,

I suppose, in the context that I would have been involved in the local sailing club at Prehen. I think he mentions this in his witness statement. I would add that the local sailing club in Prehen was a dinghy club, we didn't have a social side to that club, and in those occasions that I would have been there, I would have been there as a sailing instructor, training and teaching on behalf of Derry City Council actually.

Q. Had you socialised with him?

A. No, I have no recollection of, when you say "socialised", being involved in any occasions whenever we would have had meals or involved in any social engagements together. I would have seen him involved in sailing events on sailing occasions.

Q. You have touched upon this in one of your earlier answers, but in terms of the choice of Dr Quinn to assist the review, you have said in your witness statement that it was, if you like, an advantage that he was known to nursing staff and some of the clinical team and vice versa because that brought, if you like, a confidence to the process?

A. Yes.

Q. Just help me to understand that. Why was it important that your staff had confidence in the reviewer as opposed to thinking about the issue from the perspective

of whether the reviewer -- I call Dr Quinn the reviewer for these purposes -- rather than thinking about it from the perspective of whether he can deliver a robust opinion?

A. I think confidence in his professional ability to deliver objective opinion would be the way that I would have viewed it because they would have known him. We were dealing with a situation whereby, I suspect, some staff were feeling they were being blamed, some nursing staff felt they were being blamed by a senior clinician, and I felt that if we were asking another clinician for their advice and involvement in this process, that one of the benefits would be that the nursing staff would have confidence in the person that was doing that review. In other words, you would expect them to be objective, and that's the basis on which I would have certainly always viewed Dr Quinn, that he would be objective and he would have complete integrity in terms of a review. But there's always the view that could be taken that we were asking staff to open up, you know, let's get to the bottom of this, let's get to know what happened here, and we needed to have that level of confidence, and I felt that by choosing someone with whom they would have confidence and certainly I had confidence and other people would certainly view

Dr Quinn as being very professional in his work and approach to things.

THE CHAIRMAN: Thank you.

MR WOLFE: You've said that you had no direct involvement in the review -- that's what you have said in one of your witness statements to us -- but you received updates?

A. Correct.

Q. And your diary entry suggests that. What you have just said about the need for staff to be able to open up in the context of this review and Dr Quinn, perhaps, being a vehicle to achieve that because, as you say, if the staff know him and are confident in his professional abilities and his objectivity, that might assist this process of opening up; is that what you mean?

A. Well, I felt that it would be useful if they had previous knowledge of the individual, that they would have confidence that the person would be independent and objective.

Q. Just on that, were you aware, from your process of engagement with Mr Fee, Dr Anderson and Dr Kelly, about the methodology that had been chosen by which to prosecute this review?

A. I have no recollection in terms of the detail as I was getting updates, periodic updates, as we went through,

as you can see in terms of my notes.

Q. Yes.

A. I've no recollection, for example, how the information that was being provided to me -- you know, what the methodology was in terms of how the information was being provided to me was being collected. I anticipated that statements would be requested and that would have been part and parcel of the normal process: statements would have been requested from the staff involved.

Q. And as part and parcel of a normal process, would you have anticipated that the staff would have been interviewed in relation to the statements provided?

A. If that was felt necessary by the review panel.

Q. But you would expect the review panel to analyse the statements to assess whether such interviewing was necessary? That would follow from that.

A. Yes, that would be correct, yes.

THE CHAIRMAN: Mr Mills, when you talk about "a normal process", what's the nearest comparator for this process?

A. At that time -- and again, I'm not sure when this would have been done around about that time, but we would have certainly been -- I would have certainly been receiving reports from the mental health directorate about adverse incidents that had taken place in relation to mental

health patients, so there would have been a multidisciplinary review process set up and investigation and statements taken from all of the witnesses that would have been involved in looking after a particular -- looking at a particular incident in that respect would be an example.

THE CHAIRMAN: Thank you.

MR WOLFE: Another part of a process might have involved the person appointed to assist the review interviewing the staff that you recognised as being involved with Lucy's care. And indeed, you've said that you would hope that the involvement of Dr Quinn might have promoted this sense of openness. Did you have an expectation that he might speak to your staff?

A. Certainly if the review team felt that that was necessary, then I felt that he would be very suitable for doing that, yes.

Q. We're at this point before you receive the review report -- and I'll ask you about your view once you received the review report -- but in terms of whether the review team saw fit to engage Dr Quinn in direct communication with the staff, you were leaving that to them?

A. Yes, absolutely. They were commissioned to do the review. There was absolutely no need for me to

interfere in that process.
Q. And are you telling us that in respect of the interviewing of staff, whether by the review team itself or by Dr Quinn, that was not something you had sought any clarification upon during the conduct of the review?
A. I don't recall any discussion or me asking about that at all.
Q. In terms then of the parents of the child, would it have been important for you, as chief executive of this organisation, to gain clarification about whether the parents were going to be engaged as part of the review process?
A. Again, I refer to my note of 20 April when I was discussing with Mr Fee how best we should communicate with the family to advise that the circumstances were still being examined. In other words, the circumstances of the death were still being examined. And we agreed it would be preferable if the family's health visitor could call with the parents rather than send a letter. Now, that was, I suppose, the view that we took at the time. Does the chief executive need to send to this family, who are obviously significantly distressed with the loss of their child, an official letter? And we felt it was better communicated through a member of our staff whom the family would have known.

Q. And that was your decision at the time?
A. That was our decision at the time. That's my record there.
Q. And in terms of the methodology which would apply to this review, specifically in terms of whether the family would be engaged to assist the review, is that not something so pivotal that you would expect to receive assurances or clarification upon?
A. Again, I would say that that certainly would happen nowadays. In the year 2000, it wouldn't have automatically happened. In my opinion, and from my experience, it wouldn't have automatically happened that the review team would have approached the family directly. It was a matter for the review team to engage them in the reviews.
THE CHAIRMAN: I thought nothing automatically happened in 2000 because there was no real template or procedure? So the procedure was entirely open to the reviewers to dictate; isn't that right?
A. Yes, if the reviewers --
THE CHAIRMAN: So to say to me that something didn't automatically happen is self-evidently correct, but it doesn't take me anywhere. Nothing automatically happened. There's no ABC guide to how to do a review.
A. I appreciate that.

THE CHAIRMAN: You do what was accepted last week and suggested by one of our experts as what was common sense and reasonable and you have spoken about the value of Dr Quinn was that he would have the confidence of the nurses. Now, who in the review had the confidence of the family? And with all due respect to health visitors, on the medical hierarchy, health visitors are fairly low down the scale. They do important work, but they are not comparable to directors; isn't that right?
A. No, they're not comparable to directors, chair.
THE CHAIRMAN: So the fact that the family wasn't automatically spoken to really doesn't take us anywhere, does it, Mr Mills?
A. No, chair, I'm advising you of our thinking at that time and that's the conclusions we would have reached at that time.
THE CHAIRMAN: Thank you.
MR WOLFE: What I'm wishing to understand, Mr Mills, is in terms of whether the family would be engaged to contribute to the review, are you saying you were given an understanding by the review team that they were not to be engaged?
A. No, I'm saying that that was a matter for the review team to decide. I'm basically recording what I've recorded at the time in terms of ensuring that, as

I felt and I knew at the time, the family knew that we were still examining the case.
Q. Yes. As we know, there is a suggestion in Mr Crawford's correspondence that they weren't so apprised. We'll come to that presently. Can I characterise your answers to my questions about the methodology at this stage of the process as being very much they're matters for the team that had been commissioned to conduct the review and were not being discussed with you?
A. I think it's important to state that the panel was established to conduct a review. It was important that that process wasn't interfered with.
Q. Yes.
A. And I would have let them get on with the review. And I know Dr Kelly was more closely associated with it on a regular basis in relation to how the review was progressing, so I wouldn't have get involved in the detail of the methodology of the review.
Q. Is it fair then to suggest that the review team were given carte blanche to simply get on with it as best as they saw fit?
A. I go back to what I said at the outset about the management style that took place within the organisation. People would have talked to one another, shared issues, shared ideas with one another. We would

have supported one another. So I'm not saying that they had carte blanche to get on with what they did. They would have come back and checked, there would have been discussions between Dr Kelly and Dr Fee. There would have been discussions, as I recorded, between Dr Kelly and myself and Mr Fee with myself, so we would have worked as a team. By and large, what I'm saying was that the responsibility for conducting the review was the responsibility of the panel that we had set up to do that.

Q. But at one stage or another -- let me pick another example -- you would have been aware of the fact that, for example, Dr Quinn was not in receipt of any of the reports or statements from the staff who had cared for this child? You would have been aware, to take another example, at one point or another that, as part of this review, nobody saw fit to engage with the parents to seek their view about what had happened to the child. Would you have become aware at one point or another that these things hadn't happened?

A. In relation to the former example that you've used, I'm not sure that I was aware that Dr Quinn wouldn't have had access to those reports. I can't comment on that. I'd need to look at my notes again specifically in relation to that. But I'm not sure that I would have

been -- wouldn't have been aware that he wouldn't have had access to those reports.

Q. Okay. Maybe we'll come back to that. What about the second one: would you have become aware that the parents weren't engaged?

A. I certainly would have been aware of that because I certainly saw that within the recommendations, that it was important within the follow-through from the report, one of the recommendations was that the family should be engaged.

Q. In terms of the feedback that you were receiving from the review, we know that Messrs Kelly and Fee met with Dr Quinn on 21 June. That was obviously an important meeting, the review was building towards a, if you like, stage whereby Dr Quinn would communicate his opinion to the Trust. Were you ever shown the record of that meeting? I'll put it up on the screen for you, Mr Mills, 036c-004-007. Obviously, just to put it in context, the report from Dr Quinn followed hot on the heels of this meeting, but this is a record compiled by Dr Kelly.

A. No, I have no recollection of having seen those notes.

Q. If one looks at this record, one can see that some issues remained with question marks after them. So for example, it says -- if one looks about halfway down the

page, there's a paragraph that begins:

"Dr Quinn notes that there was further fluids administered after the resuscitation, 250 ml of normal saline. Again, choice of fluid by anaesthetist was reasonable, but volume high. Could, after an hypoxic incident, this have produced the cerebral oedema."

I said earlier it'd end it with a question mark, but that one particularly doesn't, but it's a question clearly:

"Events remain unclear. [Then it goes on to say] could there have been earlier seizures resulting in hypoxia for 15 to 20 minutes prior to catastrophic seizure event? Did significant coning occur and when?"

You obviously, Mr Mills, took some degree of reassurance from Dr Quinn's conclusions as found in his report for the review; isn't that right?

A. That's correct, yes.

Q. But I wish to suggest to you that by reference to this document -- and we'll go on to look at the report in a moment -- that Dr Quinn -- even allowing for some of the reassurance that he clearly provided by his designation of the fluids that were given as being "appropriate" -- he nevertheless was asking questions about the fluids that were administered after this child's seizure; isn't that right?

A. Well, that appears to be from that note. I wasn't at that meeting.

Q. Yes. You would have expected your senior management team, comprising of Dr Kelly in this instance and Mr Fee, to provide you with an accurate report of that meeting by way of update?

A. I note the meeting was held on 21 June and the report that was provided by Dr Quinn was on 22 June.

Q. That's right.

A. So whether them providing me feedback from the meeting or the report was the outcome of the meeting, I suspect that superseded any need for any specific report to me from the issues that were discussed or arose within the meeting.

Q. So you have no specific recollection of being updated on the meeting per se?

A. I have no recollection of being. I knew that the meeting was taking place. I have -- and, again, I have to rely, as I say, on my written record from the time. I have a note here that's dated 15 June:

"M Quinn, the 21st. Eugene Fee and J Kelly."

So I was being told on 15 June that the meeting was taking place on the 21st.

Q. Yes, but no note to indicate that there was discussion after the meeting in respect of what had occurred at the

meeting?
A. No.
Q. Could we turn then to Dr Quinn's report? It's at 033-102-270.
MR COUNSELL: I wonder if I could ask for the witness to be asked, before we turn to the report, whether he was ever told either by Dr Kelly or Mr Fee that Dr Quinn had not been provided with any information before preparing his report, other than the case notes, and specifically was not provided with any of the notes or responses from any medical staff or doctors and, if he wasn't, if he had been, what his response would have been?
MR WOLFE: I was proposing to deal with that in the context of the review report itself because I think the issue will emerge, hopefully very cleanly, at that stage.
Just before moving to the full review report, could we examine, Mr Mills, Dr Quinn's report in isolation? Do I take it, Mr Mills, that --
THE CHAIRMAN: Sorry, we should establish, first of all: did you see Dr Quinn's report in isolation or did you see Dr Quinn's report as part of the overall review report? Can you remember?
A. It's a good question. I'm sure it would have been shared with me prior to the completion of the review because it was another month, wasn't it, before the

review was complete? So I'm sure, yes, I knew.
THE CHAIRMAN: Thank you.
MR WOLFE: Well, upon receiving it in advance of the publication of the review report, Mr Mills, was it the subject of discussion with you?
A. No, I don't recall a specific discussion on Dr Quinn's report. I suppose, in essence, there were a lot of technical issues within his report and I would have been expecting Dr Kelly and Dr Anderson and indeed Mr Fee to have more knowledge on those issues than I would have had.
Q. So having read the report in advance of the review being published, you saw the balance of advantage, really, in awaiting their report, which was going to bring everything together in one package, if you like?
A. I did, but I also took assurances from Dr Quinn's report and the general context of the information that he was summarising within his report.
Q. Yes. Well, there was, of course, time prior to the publication of the review report for you to make comment about Dr Quinn's report, if indeed you did receive it in, if you like, as an advance copy. Can I suggest to you, Mr Mills, that a fair reading of the report would have indicated to you that it raises questions as well as providing some answers? Let me be specific in that

respect.
You can see from the opening paragraph in front of you that he is saying that:
"[He has] reviewed the notes of this child as requested and is now making a short summary and some comments on the possible sequence of events in the case."
Do you see that?
A. Yes.
Q. Then if we move through the report, can I go over the page to 271? On the top paragraph, you may have already observed from the evidence which the inquiry has received to date, Mr Mills, that the sequence set out there in terms of when the child received normal saline by reference to the question of when there was evidence of her electrolytes being deranged has been misconstrued by Dr Quinn. In other words, the correct factual sequence has not been set out. Can I ask you this: you would not have been looking at this case to that degree of detail, would you?
A. No, I wouldn't have. I hadn't done any examination of comparison with the case notes and the sequence of events and, in fact, I suppose to some extent the detail and the technical aspects of that wouldn't have been part of my remit of knowledge in terms of having the

expertise to be able to examine that.
Q. You would have expected the review coordinators to have obtained certainty with regards to the facts of the case by taking whatever steps were necessary to engage with the staff?
A. Yes, they would have had much more expertise regarding the technical aspects than I would have had.
Q. On down the page then, there is a question:
"Why was the child noted to be floppy in the first place?"
Do you see that?
A. Yes.
Q. And he goes on to discuss the role which pneumonia might have played in the case and speculates, as he describes it, that:
"A bacterial infection may have been prompted or triggered by pneumonia."
But you can see that he is speculating. So in terms of one possible mechanism here, he cannot be sure; do you see that?
A. Yes. I see that he couldn't be definitive, yes.
Q. On down the page in relation to fluids, you can see that he is describing the volume of fluids over a period of seven hours, and he concludes by -- if we could just go over the page, please. You can see that he's working

through various permutations with regards to the degree of dehydration and he gives a figure in relation to 5 per cent and 10 per cent. You can work out from that report that he is saying that even at a level of dehydration of 10 per cent, this child had received too high a volume of fluids; isn't that correct?

A. No, I couldn't work that out in the sense that I wouldn't have known how to work that out or what process would have been involved in working that out.

Q. Well, the information that he's provided to you on paper is that the child received 100 ml per hour. That's what he said, he is working on that basis.

A. Yes.

Q. And he is saying that, even assuming for a 10 per cent dehydration, that only works out at as much as 80 ml per hour; do you see that?

A. Yes, I see that.

Q. So in a simple piece of maths, you can derive the view that she's received too much in terms of volume, even if she was 10 per cent dehydrated, although he goes on to say that he would be surprised if that was causative of the cerebral oedema.

MR SIMPSON: Can I just ask: is it being suggested that the fact that more was given than would be suggested on that page should have caused alarm bells to ring in his mind,

that is the mind of an administrator? Is that what's being suggested to him? Because if it is, I suggest that that is extremely unfair.

THE CHAIRMAN: In the context that if Dr Quinn wanted to say that, he had the opportunity to say it quite clearly and he didn't say it quite clearly?

MR SIMPSON: [inaudible: no microphone].

THE CHAIRMAN: I think that is fair, Mr Wolfe. The fact that the inquiry's been poring over this document for some very considerable time is rather different from the reading that Mr Mills might have been expected to give it in the spring of 2000 when he received it.

MR WOLFE: Well, let me establish from the witness what he was reading the report for.

What was the purpose in reading the report, Mr Mills?

A. Well, I mean, in essence it was one of the pieces of material that the review panel would have collated in terms of the report and whilst, as I have accepted, I probably would have read it before I read their final report, I would have assumed they would have been using the information within this report to inform their opinion and to have informed the recommendations that they would emerge with.

Q. One of the purposes of reading the report was to seek to

understand whether there had been any mismanagement of this child; isn't that right?

A. Yes, that's correct, that was the purpose of the internal review.

Q. And indeed you used this report in order to report to the parents that there had been no mismanagement.

A. Yes, that's correct.

Q. What I'm asking you is whether, upon reading this report, it was fair for you to conclude that it indicated to you that there had been no mismanagement of the child?

A. I think, with the benefit of hindsight, we would have recognised that that was a mistake at that time.

Q. So in terms of your reading of it, you should have been reading it in order to understand whether the doctor, Dr Quinn, was advising you in terms that there either was or was not mismanagement; isn't that right?

A. I was certainly focused on the conclusions that were reached by Dr Quinn, which was largely about that he would have been surprised that those volumes could have produced the gross cerebral oedema, causing coning. As a layperson, I was saying, "He's the expert, he should know".

Q. Yes. So if you like, was that the headline that you pulled out of the report?

A. It would have been significant, yes.

Q. And was that to the detriment of a more detailed understanding of what he was saying? Because he was saying here, in terms, that she did have more fluids than 10 per cent dehydration would have or should have allowed for.

A. We would have identified -- and as I would have seen in the internal review -- that there was confusion about the prescription and the way the prescription was recorded and that those records weren't adequate at that time.

Q. It was worse than confusion, wasn't it?

A. Certainly for the outcome, yes.

Q. You hadn't got to that point in terms of the outcome at that stage, but there has been a tendency in the documents -- and indeed from your evidence this morning -- to describe this as simply confusion and it was worse than that: the child had received more fluids as a result of this confusion than had been directed, according to the evidence available to you at that time, than had been directed by the consultant; isn't that right?

A. Chair, it's certainly not my view to minimise the issues that happened to Lucy Crawford and the consequence that her parents -- and the loss they have suffered, and

I don't think that I'm endeavouring to minimise any of the issues. I'm trying to report the factual information that I had at that time and the views that were being expressed to me.

THE CHAIRMAN: The concern that I have, Mr Mills, is that Dr Quinn's report significantly underplays what was wrong and the review significantly underplays what was wrong, and it gives false comfort. The questions, in, effect, which you're being asked are directed to why that wasn't effectively picked up by you when you read the document. Okay? So that's the context in which you're being asked the questions and you'll get every opportunity to say whether you think that is an unfair onus to put on you in the context of the wording of the report which you received from the review team and the wording of the report which you received from Dr Quinn.

A. I acknowledge that, chair. I appreciate that.

MR WOLFE: Moving down this page, then, another question:

"Did the child have a seizure or did she 'cone' at 3 am?"

Following the description, Dr Quinn finds himself saying:

"It may be that the mother informed the ward staff immediately she noted the problem, but again this is not clear to me from the notes provided."

So what he's describing is an uncertainty about the precise nature of the event which occurred at or about 3 am. It couldn't have been lost on you from a reading of the report that that was a piece of information that hadn't been either obtained or clarified.

A. Well, that's certainly information that Dr Quinn has recorded that he didn't have.

Q. Yes.

A. He didn't, to my knowledge, ask specifically for that or, if he did, that would have been through Mr Fee. There wasn't -- the information that the mother had provided to the ward staff obviously wasn't available in the notes. It might well have been available if he had specifically asked for it.

Q. The proper understanding of it is -- and we'll see in the report in just a moment -- that there was no input from the mother, no record of the mother's description of what had happened at or about 3 am. So here you have his report reflecting upon this absence of information. The point being, Mr Mills, if he's saying it in this report, he's raising the question of absence of information to the Trust and, of course, the Trust could follow that up, couldn't it?

A. Yes, that's correct. I have no recollection in terms of my view on this at the time. Looking at it now, it

could well have been that he was asking for the information that the mother provided to the ward staff. It doesn't necessarily say he was asking for a view from the mother directly.

Q. Your answer is in terms of procedures or methodologies. What he's pointing to is an absence of information which leaves him uncertain about a particular issue, whereas, can I suggest to you, you took certainty or reassurance from the report when in fact there was other work still to be done in order to bottom all of this out?

A. Yes, I've acknowledged that that was, in hindsight, inappropriate at that time.

Q. Could we go over the --

THE CHAIRMAN: I think we don't need to go through every example, Mr Wolfe. I've got the point.

MR WOLFE: Let me take this last example then, please. 273 over the page. About four lines down, he's repeating the sequencing mistake of earlier, but that's not the point I'm on now. He says:

"During resuscitation it became apparent that the child's sodium had dropped to 127 and the potassium to 2.5 and a decision to use normal saline was made. I am not certain how much normal saline was run in at that time, but if it was suspected that she was shocked, then perhaps up to 20 ml/kilogram could have been given."

Again, Mr Mills, another indication that in terms of the information available to Dr Quinn, there was a lack of clarity or an information gap. Did you appreciate that when you read this report?

A. As I said earlier, I think we received reassurance from the report in relation to the fluids. Certainly the report, the conclusion of the review team, was that the report was inconclusive. We didn't have a definite view to convey to the parents as to how Lucy Crawford had died.

Q. But you conveyed to the parents that there was no mismanagement in her case.

A. And as I said subsequently, that was incorrect and we subsequently have apologised to the family for conveying that.

Q. Yes. You apologised after the conclusion of the litigation; isn't that correct? But the point I'm on is this: on the basis of the report that you have, you could certainly take some reassurance from it, but he is identifying gaps in the information that's available to him, which should have alerted you and your review team to the fact that the whole story was yet to emerge.

A. He was certainly inconclusive and not definitive. By the time this report was received, we were already involved in discussions with the Royal College of

Paediatricians and Child Health and we had already taken a decision that Lucy's case would be part of that review. So whilst he was inconclusive at this stage, we were already engaged in taking forward another review of Lucy's case.

Q. Well, is that an answer to the question whether the Trust set out, after Dr Quinn's input, to try to answer these questions or to find information to fill these gaps?

A. Well, the purpose of the second review was in relation to Dr O'Donohoe's competence, but in essence we felt it was useful to have Lucy's case included in that review because Dr Quinn certainly wasn't providing definitive information about the precise cause of death. He was uncertain, we continued to be uncertain; we had no definitive reason for the cause of death.

Q. Could I just ask you about the decision on Dr Quinn's part to deliver a written report? You will recall that, during a television documentary, he was captured using the phrase "sweet-talked" to describe his part in the process. He defines the use of that word by reference to, if you like, the persuasiveness that was applied to him in order to move him from a position where he wasn't inclined to provide a written report to one where he was feeling obliged to do so.

A. Mm-hm.

Q. He contacted you after that.

A. No, I contacted him.

Q. That's right. You explain that interaction when you spoke to the police: you decided to contact him because you were concerned about what he had been captured as saying to the camera?

A. The impression that the programme put across was that he had been, as he used the phrase, sweet-talked, and I felt the slant the programme was putting on it was that he had been sweet-talked and been influenced by the content of his review, and I wanted to clarify with him whether that was the case. He assured me, no, that was not the case, the content of the review he stood over, but he wanted to point out it wasn't his intention to provide a written report.

You may recall that I also was doorstepped for that particular programme. I have significant empathy therefore with the pressure that Dr Quinn would have been under in relation to a situation where he wouldn't normally have been involved in, and I think his phrase was significantly unfortunate to say the least, but I took steps to clarify that there was no pressure put on him to influence the content of his review and he explained to me and I accepted that and I acknowledged

the pressure that he was under at the time of the interview in which he was doorstepped.

Q. I want to move on to look at the review report itself --

MR COUNSELL: I wonder if I could just return to one matter which relates to Dr Quinn's report? Mr Chairman, this witness told you a little while ago that when he spoke to Dr Quinn initially, this being on 20 April, and he referred to his notes to do this, Dr Quinn agreed he would look at the notes and provide his advice. And the words "the notes" appear on four occasions, I think, in his four-page report. He uses the expression "provided with the notes" and I wonder whether this witness could be asked whether he thought that the reference in Dr Quinn's report to "the notes" was something different from what he was asking Dr Quinn to do on 20 April?

THE CHAIRMAN: Yes.

MR WOLFE: Do you follow the question, Mr Mills?

A. Yes.

Q. The report furnished by Dr Quinn --

A. Was based on the notes?

Q. -- based on the notes --

A. Yes.

Q. -- that's what he's using as his reference tool, seems to be the implication. The question that emerges from my learned friend is whether the report provided by

Dr Quinn was anything different to what you might have expected him to be preparing in light of your earlier discussions with him.

A. My initial discussion with him was to engage him. As regards, as I said, what he actually did or what he was required to do, that was the responsibility of the review team, the review panel.

I would also say, chair, that it would have been probably customary at that time for these sorts of reviews to be primarily, and in the first instance, case note reviews, so it wouldn't have occurred to me for it to be unusual that all that was looked at were the case notes.

THE CHAIRMAN: Thank you.

MR WOLFE: It may, sir, when I think about it, be sensible to break now before going into the review report.

THE CHAIRMAN: Right, it's been a long morning. We'll break now and start at 1.45. Mr Mills, your evidence will finish this afternoon.

(12.52 pm)

(The Short Adjournment)

(1.45 pm)

Timetabling discussion

THE CHAIRMAN: Just before we resume, can I ask you to note one alteration to the timetable? The rest of this week

stands as it is and we'll hear Dr McConnell on Wednesday and Mr Frawley on Thursday. They might be slightly shorter days.

Professor Scally, who was due to give evidence next week on Wednesday, cannot now do that. What we've done is -- we were due to sit on Monday 1st and then I'd asked you to hold Tuesday the 2nd. We will now need Tuesday the 2nd, because what will happen is Professor Scally will give evidence on Monday 1st and Professor Lucas and Dr Gannon have agreed to facilitate us by giving give evidence on Tuesday the 2nd instead of Monday the 1st. So we'll still finish on Tuesday the 2nd, but we now have to use that day which I'd asked everybody to hold in reserve.

MR COUNSELL: Is the inquiry sitting on Wednesday the 26th?

THE CHAIRMAN: It is because Dr Carson, who went through a number of positions, and whose evidence we didn't get finished the week before last, he will give evidence on Wednesday the 26th.

MR COUNSELL: Thank you.

MR QUINN: So just the one witness on Wednesday the 26th?

THE CHAIRMAN: Yes, Dr Carson.

MR QUINN: Is it a day we might put other evidence into?

THE CHAIRMAN: No, it looks as if we're going to move from regularly sitting until after 5 o'clock to having

a couple of days in the next fortnight when we get finished early to mid-afternoon. I wouldn't mind seeing life outside for a little bit, but we'll still get finished on Tuesday the 2nd.

Mr Wolfe.

MR HUGH MILLS (continued)

Questions from MR WOLFE (continued)

MR WOLFE: Good afternoon, Mr Mills. We had reached the stage in the chronology where the review report was completed and, as I understand it, sent to you and Dr Kelly initially.

A. That's correct, yes.

Q. And you would have read the report, no doubt, and the appendices?

A. I did, yes.

Q. Could you tell me, would you have had any responsibility in your position as chief executive to satisfy yourself as to the thoroughness of the report, the quality of the report, the cohesion of its conclusions?

A. Yes, certainly if there had been any issues that were in the report that I was concerned about, I would have raised them.

Q. And the process, moving forward, from reading the report, did that lead to a situation where you would have sat down with the senior management team or the

authors of the report to talk about it?

A. I don't recall that we did do that.

Q. So in terms of your role then, you read the report, sought to understand it and then what? Was there any signal or communication from you personally to any of the significant players about what needed to be done next?

A. I recall noting the recommendations of the report and obviously saw those recommendations as being something that would be taken forward within the Acute Hospital Services Directorate and envisaged that they would be involved in implementing the recommendations of the report.

Q. You say you noted the recommendations of the report. Does that suggest that you mentally noted them as opposed to formally and outwardly noted them?

A. I didn't record them physically. I will have recognised and noted the recommendations in the report. I would have looked at them and observed them and I would say, yes, they're logical recommendations that were in that report and expected the Acute Hospital Services Directorate to take forward those recommendations. I didn't see anything within the recommendations that was my responsibility.

Q. Yes. In terms of, if you like, a quality control

function, you say that if you'd seen anything amiss with the report you would have brought that up. I take it, sir, from what you've told the tribunal that it was your view at the time that this certainly seemed to be a comprehensive report, that you didn't see any issue in it, any aspect of the report that caused you any difficulty?

A. That was certainly my view at the time, yes.

Q. Could I look at the report now, 033-102-265? Here, Mr Mills, you have a section of the report described as the process of review. Each of the steps undertaken by the review team are set out:

"The case notes were reviewed. All staff within the Trust who had an involvement in Lucy's care were asked to provide a written comment/response of their contribution to Lucy's case. Some separate discussions were held with Sister Traynor and Mrs Martin. Dr Quinn was asked to give his explain on three specific issues. A copy of the patient's notes were made available to him. The outcome of the post-mortem was considered."

And a meeting was held between Messrs Kelly, Quinn and Fee, leading to the report from Dr Quinn of 22 June, which is included in the appendix, and at that meeting they had an opportunity to discuss the result of the autopsy. So that's the methodology of the review.

Can I ask you some questions about that, please? In terms of the description of what was done, a conscientious reader of the report would have observed that, with the exception of the particular discussions that were held with Traynor and Martin, there were no other formal discussions held with staff; isn't that right?

A. Yes, I understand that. I'm not sure whether there were informal discussions, but it's not recorded here if there were.

Q. The appendices that you would have had access to contained a number of pieces of correspondence written to the nurses, asking them to provide statements, and you would have seen the statements?

A. Yes.

Q. On the medical side, the doctors were not, it appeared from the appendices, subject of a written request, but nevertheless they provided a statement. But there was nothing in the appendices to show that there was follow-up on those statements to probe for greater detail or greater explanation. Do you follow?

A. I do, yes.

Q. Did that strike you at the time of reading the report as something of an omission?

A. No, it didn't. As I said, I think at an earlier stage,

if there had been anything in the statements that had been made, I would have anticipated that that would have been taken up with the member of staff involved.

Q. Yes. So again, if you had read the report you would have seen that none of the clinicians chose to deal with any of the issues surrounding the fluid administration to this child; did that strike you at the time?

A. It didn't occur to me at the time, no.

Q. Did it occur to you at the time that none of the staff had been interviewed in relation to their statements?

A. No, that didn't occur to me at the time.

Q. Is that because it wasn't obvious to you or because you didn't think about it?

A. I can't recall specifically other than saying it didn't occur to me at the time.

Q. It would be in the essence of a reasonable approach to reviewing these matters to speak to the staff and interview them in relation to what they were saying.

A. As I said, I would have anticipated, if there had been something in the statement -- and might be in some of the statements, not necessarily all the statements -- if there had been something in the statements that the panel wanted clarification on, then they would have interviewed the staff.

Q. Well, you, reading it as the chief executive, could

I suggest you should have been on the lookout to see what the doctors were saying about the fluid management of the child?

A. Again, we're getting into the technicalities. I wouldn't necessarily have had the expertise to necessarily understand what the doctors were saying about the fluid management of the child.

Q. All I'm saying -- and I don't think I need to bring you through it -- is that the statements of each of the three doctors concerned, with the exception of Dr O'Donohoe -- and I will describe what he says in a moment -- failed to deal at all with the fluid regime received by this child; would that not have struck you as odd?

A. I don't think it would have, no.

Q. Why not?

A. Because I don't have the technical expertise to be able to understand it.

Q. With respect, it doesn't require technical expertise to recognise that doctors have failed to deal with an issue which is at the centre of your considerations, which is whether this child received appropriate fluid management.

A. Well, I acknowledge that, but there were those who were involved both in the review panel and in advising the

review panel who had more technical expertise than I had and they weren't raising the issue.

Q. Was it not part of your job to hold them to account?

A. Yes, I would acknowledge that, yes, if I had recognised it as an issue on which I should hold them to account on.

Q. You would also have observed from this description of the process that Dr Quinn was in receipt of the patient's notes, but the description of the methodology is silent in terms of anything else. A sensible and straightforward review, you might have hoped, would provide the reviewing doctor with all relevant material. Did it not jar with you, Mr Mills, that this doctor was not provided with all of the resources that were available to the Trust in carrying out his consideration of the case notes?

A. It didn't occur to me at the time, no.

Q. Should it have occurred to you?

A. I don't know that it would have occurred to me because I think I have said that, in my experience at that time, most of these reviews would have been done on the basis of the case notes.

Q. Presumably there was a determination to try to get to the bottom of all of this.

A. Absolutely.

Q. And here you have the doctor writing, Dr Quinn writing, a report on the basis of notes that were -- everybody seems to agree -- at best confusing and, on the other side, he isn't being briefed with what the clinicians and the nursing staff are saying. That didn't strike you as at all odd?
A. No. As I said, at that time, it would have been usual for just the case notes to be reviewed. If Dr Quinn had asked for additional information, I'm sure that would have been provided to him.
Q. You see, the Trust is the body asking Dr Quinn for the benefit of his expertise. So is it not beholden upon the Trust to ensure that he carries out his job effectively by providing him with the information? Or is it the other way round? Is it up to Dr Quinn, on your account, to ask for it?
A. I don't know, it could be either/or. If Dr Quinn felt he needed to ask a question about specific information, then I'm sure that Mr Fee and Dr Anderson would have obtained that for him.
Q. Moving away from the methodology, you can see within the findings section of this report that it says:
"Neither the post-mortem result nor the independent medical report on Lucy Crawford, provided by Dr Quinn, can give an absolute explanation as to why Lucy's

condition deteriorated rapidly."
Do you see that?
A. Yes.
Q. So you're reading a report, Mr Mills, that makes it clear that there was no absolute explanation for this outcome. And just looking at that, did that not strike you as a difficulty for the Trust, moving forward?
A. Certainly the fact that we had no definitive explanation to explain Lucy's death was a difficulty for the Trust, but as I've said earlier, by this stage of this report being received we were already involved in another review and we were already involved in discussions with the Royal College about setting up a review of a number of cases, Lucy's case being one of them.
Q. Well, there were opportunities available to the Trust to gather additional evidence before closing down this review; would you agree with that?
A. In essence, this was the outcome of this review. The recommendations contained in the review did not identify the fact that they needed to obtain additional evidence.
Q. Well, let me look at a couple of examples. 033-102-266. It's back to this point I raised earlier with you, which at the time was in the context of Dr Quinn's report. But under the heading "Level of description of event", you are being reminded that:

"With the exception of Nurse McCaffrey's report, little detailed descriptions of the event are recorded and no account appears to be in existence of the mother's description, who was present and discovered Lucy in this state."
That was an issue that could have been further investigated, and yet ironically, having decided for whatever reason not to seek the parents' views, the report is bemoaning the absence of those views. Did that not strike you as odd?
A. I don't recall that at the time. I do know that I had asked on a number of occasions about what was happening about the engagement with the parents and indeed one of the recommendations of the report was a follow-up meeting with the parents. That may well have led to further information coming to light.
THE CHAIRMAN: Mr Mills, you have said to me a couple of times today when you were questioned about the report that, for instance, the lack of any clear outcome, the lack of any clear steer of what happened to Lucy was a problem going forward, and you have said a couple of times, "Well, by the time the report came through from the review term, [you] were engaged with the Royal College and that led up to Dr Stewart's involvement". When were Mr and Mrs Crawford to be told about

Dr Stewart's role? Because when they were sent even the very limited version of the review report, they weren't told about Dr Stewart, sure they weren't.
A. No.
THE CHAIRMAN: If your concern about the lack of a definitive outcome to the review report is eased to a degree by the knowledge that Dr Stewart is going to be engaged on behalf of the Royal College, why not tell Mr and Mrs Crawford?
A. Certainly, I can acknowledge that.
THE CHAIRMAN: And perhaps even more to the point, Dr Stewart was effectively looking at the competence of Dr O'Donohoe, wasn't she?
A. That's correct, chair.
THE CHAIRMAN: And as part and parcel of that she was looking at what happened to Lucy and Dr O'Donohoe's role in that, but that was only one of a series of matters that she was investigating and reporting on.
A. That's correct, chair. I think I may have lent too much emphasis on the fact that because Lucy's case was being reviewed again, that I had an assurance that there was another mechanism coming forward that might help the Trust provide information to the parents in terms of the explanation of her death.
THE CHAIRMAN: Because that mechanism was never intended to

give the parents any more information, sure it wasn't.
A. Well, if there had been information that would have been definitive about Lucy's death, of course it would have been shared with the parents.
THE CHAIRMAN: Okay, well, we'll come on to that later.
MR WOLFE: So what you're saying is if the Royal College report had been definitive in terms of its description of the death, you think that would have been provided to the parents?
A. That certainly would have been if that had been the case.
Q. You seemed to say, Mr Mills, that notwithstanding the absence of conclusiveness in this report, you were to some extent reassured by the fact that, moving forward, there was going to be this Royal College process. But when we look at the evidence that was left untapped by the review, can you help us at all in terms of whether you raised with anyone the fact that there were certain evidential sources that weren't spoken to, weren't the subject of outreach?
A. No, I didn't raise those.
Q. Can I put a couple of examples to you? Leaving aside the family, who appear, for whatever reason, to have been ignored during this process, there is the clinicians at the Royal Belfast Hospital. There would

have been potentially some benefit in speaking to them to seek their views about what had happened to Lucy; is that fair comment?
A. Yes. Can I just clarify the point you're making in the sense that whilst you may have the view that the parents were being ignored -- and I acknowledge that in terms of the way that complaints are handled nowadays that parents are much more actively involved -- we did communicate with the parents. My understanding on my file was that the clinician who was involved in treating Lucy met with the parents, but wasn't able to provide them with answers, as indeed the Trust wasn't able to provide them with answers either. So I can't accept what you're saying that they were ignored.
Q. But "ignored" in the sense in which I mean it is where you have a report in front of you which bemoans the absence of an explanation for the events that occurred at or about 3 o'clock or bemoans the lack of a description of that event, highlights the fact that there's no account from the mother, and yet stops short of going after that evidence.
A. Yes. I acknowledge that, yes. I also, going back to your previous question, acknowledge that, yes, there was information from Belfast that wasn't obtained either.
Q. Can I ask also about Dr Asghar? Dr Asghar had written

to you on 5 June and you explained this morning how you were in correspondence with him. And indeed it's fair to say that Mr Fee and Dr Kelly met with him to look at his concerns. It doesn't, however, appear that he was spoken to, at least according to Mr Fee, with regard to what he could contribute to the review. His complaint went, if you like, in other direction, and that was the direction of the Royal College. Should his views have been sought and explored for the purposes of the review?
A. As far as I understand, Dr Asghar wasn't involved in the treatment of Lucy Crawford.
Q. Yes. But that would be a satisfactory answer, Mr Mills, if it wasn't for the fact that Sister Traynor, who wasn't involved in the treatment of the child, was spoken to, and in fact her specific opinion, according to Mr Fee, was sought in terms of how normal the fluid regime which Lucy Crawford received was. So you have the review choosing to go down the route of speaking to her and indeed, on her account, misrepresenting her views, but no decision taken to speak to Dr Asghar.
A. Well, certainly Sister Traynor was the manager for the ward as far as the managing of nursing staff and would have been able to talk about the nursing protocols that were in place within the ward. And also, Sister Traynor completed the initial report to Mrs Millar, who

completed the clinical incident review. So she was involved at the outset in reporting it.
Q. Well, if Dr Asghar had an opinion or an explanation to give in terms of whether the fluid regime applicable in this case was or was not appropriate, he likewise should have been asked to give that opinion just as Sister Traynor was asked to give an opinion. Is there a qualitative difference?
A. I can understand the difference.
Q. Was there a view abroad that Dr Asghar was a troublemaker who was attempting to find as much dirt on Dr O'Donohoe as possible?
A. Not that I was aware of.
Q. Are you aware that Dr Halahakoon, according to Dr Kelly, held that view?
A. I'm not aware of that, no.
Q. You have explained to us that you left it to the directorate to get on with the task of implementing the recommendations of this review.
A. Yes.
Q. And it was your expectation that they would do so?
A. Yes.
Q. You've told us that you spoke to the Trust chairman about the review; is that right?
A. Yes.

Q. And that was Mr Scott?
A. Mr Scott, yes.
Q. Was he provided with a copy of the review report?
A. I can't recall if he was.
Q. Is it fair to say, Mr Mills, that any of the tasks that involved disseminating this review report were not carried out formally in the sense of sending, under cover of a formal letter, a copy of the review report and asking the recipient to either meet or inviting them to forward their comments?
A. I think there is certainly a lack of evidence, in terms of the papers, that it was submitted formally. My impression was that part of the report was electronically available and part of it was hard copy. And probably what was happening was that the electronic version was forwarded by e-mail and the hard copies were going in the post and it may well have been part and parcel of the process that involved -- and we'll hear later about some people saying they didn't see some documents or hadn't seen some aspects of it. And I think part and parcel of what's happened here in terms of the process is associated with those administrative arrangements at the time.
Q. Just in terms of the administrative arrangements of the time, are you saying it was simply part of the way of

doing things of that time that when the Trust had commissioned and obtained a report as significant as this relating to the subject matter of an unexpected and still unexplained paediatric death, that this would not be the subject of a formal marking by the trust that this review had happened and these are our views on it as a trust?
A. Again, I would have expected that to have taken place within the directorate.
Q. What were you doing in your leadership role, Mr Mills, to ensure that these things were being done?
A. My involvement would have been through Dr Kelly and Mr Fee, through my regular meetings with them that we would have asked them in terms of -- I would have asked them in terms of -- we would have discussed how the recommendations were being taken forward.
Q. Two of the recommendations involved having to discuss the report. There was supposed to be a meeting held with staff in the directorate about the, if you like, lessons to be learned from the whole death and treatment of the child.
A. Yes.
Q. And there was supposed to be a meeting with the parents to discuss the outcome of the review.
A. Yes.

Q. Dealing with the first of those, it's the inquiry's understanding that that meeting didn't happen.
A. I subsequently understand that. I think I took the view that in my witness statement I thought that it did happen, but I don't have any specific documentation to support that view.
Q. Because there's absolutely no record of such a meeting happening?
A. Mm-hm.
Q. Now --
A. It could be that I'm confusing it with the other meetings and other discussions with the staff within the area.
Q. It would appear to be your expectation -- and perhaps the expectation of Dr Kelly as well -- that the onus was on the directorate to carry out such a meeting through Dr Anderson or Mr Fee or a combination of both.
A. That's correct.
Q. The point which arises is whether you, with your chief executive hat on, should have been taking steps to reassure yourself that that recommendation had been implemented.
A. I acknowledge that, yes.
Q. And you failed to do so?
A. I agree, yes, it wasn't ...

THE CHAIRMAN: Sorry, I just want to get this clear, Mr Mills. Were you led to believe that this meeting had taken place by your senior directors, Mr Fee and Dr Anderson?
A. No, chair, I can't recall specifically. I just have the impression in my mind that it might have been a view that was conveyed to me by Mr Fee or whatever in terms of the discussions that were happening with the staff. I can't recall specifically, but I was of the mind that there was meetings with staff following the review.
THE CHAIRMAN: Thank you.
MR WOLFE: It was Dr Anderson's evidence to the inquiry that, having submitted the report, after it left his desk, he received no feedback, no contact at all, no direction in terms of contacting parents or implementing the other recommendations. Have you any explanation at all as to how this omission to further the first of those recommendations, the meeting with the staff, how that omission could have occurred?
A. No, I have no explanation to offer in that respect.
Q. Would it be wrong for the public to infer from that omission that the Trust was not serious about learning lessons from the death?
A. As I say, it was -- as I viewed it, the recommendations all applied to the directorate and I anticipated that

the directorate would be taking that forward.
Q. But you didn't seek evidence to demonstrate to you that it had happened?
A. I have no evidence to provide and I have no recollection of seeking evidence.
Q. The family ought to have been contacted in respect of this review quite quickly after it reported; isn't that right?
A. Well, indeed before the review reported I had an expectation that the family would have had a meeting with Dr Anderson and Dr O'Donohoe.
THE CHAIRMAN: As part of the review process?
A. No. Just from the point of view of ensuring that the family were being communicated with and, I suppose, in essence, because the first meeting with Dr O'Donohoe hadn't been satisfactory, I had a view that there was to be a further meeting with Dr O'Donohoe and Dr Anderson.
MR WOLFE: And yet it was --
A. I have in my note here, chair, of the discussion I had with Dr Kelly on 4 May, "? Date with family".
Q. So it was your expectation that a meeting should happen?
A. Yes.
Q. The problem appears to have been in delivering on that and ensuring that you had established a commitment on the part of your staff to deliver on it.

A. I acknowledge that, yes, it wasn't executed.
Q. The review was completed on 31 July and, as I say, came with this recommendation to meet with the family. They raised a complaint with the Trust on 22 September; isn't that right?
A. That's correct.
Q. And by that time, there had been no contact with the family to say, "We have produced this review and these are the conclusions"; isn't that right?
A. Yes, that's correct.
Q. The Trust then became engaged with the family in a series of correspondence, which indicated a reluctance on the part of the Trust to release to them a copy of the report before a meeting took place; is that a fair description of what was happening?
A. Yes. Just in terms of the sequence, it might be helpful to go back to a meeting I had with Dr Kelly on 25 July. I have in my note of that meeting, "Meeting with family to be arranged", and then it emerged as a recommendation in the review. So I suppose in essence I was asking for it to be arranged, it was a recommendation of the review, and I was very surprised subsequently to receive Mr Crawford's letter and find that that hadn't taken place.
Q. Yes.

A. I had some assurance of the fact that the family were involved in discussions with Mr Stanley Millar. I felt that Mr Millar, knowing of him and being familiar with how he, as it were, advised and advocated on behalf of patients and families, I felt reassured that he would be, as it were, providing them with good quality advice in terms of supporting the family. So I had that assurance as well. But I was very disappointed to hear that, by 22 September, that meeting hadn't taken place. I thoroughly expected it to have taken place.
Q. And who in your view within your organisation ought to have taken steps to arrange the meeting?
A. Well, I think that we had to decide who would be involved. I think it was Mr Fee, Dr Anderson and Dr O'Donohoe.
Q. Why did you not take the step, as the leader of this organisation, to set up the meeting?
A. I suppose in essence because, as I say, I still viewed it as a function of the Acute Services Directorate to take forward the implementation of the recommendations within the review.
Q. But the review was commissioned on behalf of the Trust, of which you were clearly the senior manager. And yet, you seemed to have presided over a situation where you were urging a particular step to be taken, but not

seeking reassurance from your staff that that step had in fact been taken.
A. The fact that the review itself was saying what I was saying gave me perhaps a false assurance that they were actually taking that forward.
Q. And did you speak to anybody about this failure of communication?
A. I can't recall specifically speaking. I knew that it had -- I knew that it had been a failure on our part, yes.
Q. Presumably you were of the view that somebody had failed to carry out your instructions.
A. Well, they had failed to carry out their own recommendations.
THE CHAIRMAN: However you characterise, it is a failure to carry out instructions or a failure to carry out their own recommendations; what happened to anybody as a result of that failure?
A. Are you suggesting that ...
THE CHAIRMAN: At the very least, to put it politely, somebody should be carpeted over the fact that a Trust review that has ended with recommendations that the parents of a dead child should be met and that hasn't happened, that should lead to somebody being carpeted by you, shouldn't it?

A. Possibly, chair.
MR WOLFE: Why was the Trust not willing to release the review report to the family until a meeting could be arranged?
A. I can't recall the specifics of that. I suppose I anticipate that because the recommendation of the review came forward that there should be a meeting to share the contents of the report with the family, then in essence what they were ... What was probably trying to happen was we were trying to implement the recommendation of the review rather than respond to the specific request.
Q. Well, a less kind analysis would suggest that the Trust was trying to keep control of the process by not letting the family have the report to consider outside of a meeting to be arranged with the Trust.
A. Well, I don't recall the detail of that.
THE CHAIRMAN: If you look at the recommendation in full -- could we bring up, please, 033-102-268? The recommendation at (d) to meet the family is:
"We may at least be able to demonstrate our openness and show to them the measures that have been taken to analyse the care of Lucy's admission."
What better way to demonstrate your openness and show the measures that you've taken than by giving them

the report? Rather than bring them into a meeting at which they'll hear some medical language, however simply it can possibly be explained, but they would be in no better position than you would be to understand the medical language, isn't that right --
A. Yes.
THE CHAIRMAN: -- in all probability?
A. Yes.
THE CHAIRMAN: And there are 22 appendices to the report --
A. Yes.
THE CHAIRMAN: -- so the idea that any family would be able to absorb the main points or the essential points at a meeting without having seen the written report in advance is really fanciful; isn't that right?
A. Well, that certainly could be a view that could be taken. The view that we took at that time, which was in essence -- as I speculate -- was in an effort to proceed to implement the recommendation from the review.
THE CHAIRMAN: Well, that leads on to, when they eventually said, "We want to see the review", they're sent a review that is incomplete because they're not sent the appendices and they're not sent the recommendations.
MR WOLFE: In fairness, the recommendations are alluded to, but they're not set out in the same way we see them up on the screen and, indeed, as the chairman notes, they

weren't sent the appendices.
A. Yes.
Q. How could your staff have understood that it was appropriate to send the report in that fashion to the parents?
A. I'm not sure and, unfortunately, I wasn't there at the time the report was sent to the parents so I can't comment on how that decision was reached.
THE CHAIRMAN: This isn't an accident. I'm telling you now, Mr Mills. I do not believe that it was an accident. I believe a deliberate decision was taken not to send certain information to the parents, and that would be consistent with the final page of this report having been altered in the version that was sent to the parents; okay?
Nobody from the old Sperrin Lakeland Trust can explain to me how that happened: you say you weren't there when that decision was taken, Mr Fee couldn't help, Dr Anderson couldn't help, Dr Kelly couldn't help. So I'm left in a position that unless something else emerges, I believe a deliberate decision was taken not to give that information to the Crawfords. If you have anything else to say on that point, I will listen to it.
A. I certainly, chair, cannot recall any deliberate decision being taken not to share that information with

the Crawfords.
THE CHAIRMAN: My concern about this is that it points in exactly the opposite direction to the Trust showing openness and the measures which have been taken to analyse what happened to Lucy. This is the reverse of openness.
A. I can acknowledge how it's perceived, but as I say, I can't add any information as to why that decision was taken.
MR WOLFE: The process of correspondence between the Crawfords and the Trust commenced, as we noted, with a letter from Mr Crawford on 22 September 2000, in which he instigated the complaint process.
A. Yes.
Q. Was his complaint ever addressed in accordance with the procedures of the Trust?
A. I know we entered into an exchange in terms of a number of letters, seeking to meet with the family, and it would be a matter of personal regret that we never reached -- and I'm not blaming the family in any way -- we never reached a position whereby we achieved that in terms of having a meeting. I think there was, in hindsight, perhaps too much emphasis placed on trying to achieve that meeting rather than necessarily answering directly the issues of the complaint.

Q. I just want to understand your view of whether the complaint was appropriately addressed. If I could have up on the screen, please, 015-032-144? This is Mr Crawford writing to you about two months after receiving the revised copy of the review report. He's here reminding you of his complaint:

"'My complaint relates to the inadequate and poor quality care provided to my daughter Lucy following her admission on 12 April.' The foregoing assertion has not been answered in specific terms. I would be grateful for your response by 31 March 2001."

This case may, Mr Mills, be in a sense different because you've already undertaken a review, but in the absence of a review, how would you have, as an organisation, proposed to deal with a complaint about medical mismanagement of a patient? Would there be an investigation?

A. Yes, there would be an investigation of the complaint. My recollection was that the Trust would have identified -- associated with each complaint an investigative officer -- in this case it was Mr Fee -- and therefore Ms O'Rawe, who was the director of corporate affairs, who will have handled the complaints process, will have liaised with Mr Fee in terms of providing an initial response and further subsequent

responses to the Crawford family.

Q. Applying the normal complaints procedures, was this complaint investigated in accordance with those procedures?

A. I suppose because of the review that had already taken place, then Mr Fee had that information and would have used that information and that's how that information would have been used to encourage the family to come along and discuss that review.

Q. Dr Quinn, when he gave evidence last week, explained that he didn't want to be part of a complaints process. In fact, I think he told us that if a complaint was invoked, if the process for complaints was invoked, that would generally involve the Trust having to seek expert input from outside of the Western Board area and perhaps two doctors would be involved. Whereas you were -- as we see, if we could turn over the page to your response to this letter at 015-034-146 -- writing back to Mr Crawford to address the point of his complaint. What you're saying to him is in the third paragraph:

"The outcome of our review has not suggested that the care provided to Lucy was inadequate or of poor quality."

Were you, Mr Mills, providing him in this correspondence essentially with the answer to his

complaint?

A. I think the first paragraph, first of all, chair -- the first paragraph identifies the fact that at this stage, in my absence, Michael MacCrossan, on my behalf, had sought to clarify for Mr Crawford the reason we initiated the review. In terms of our response, we're also acknowledging the fact that there are many unanswered questions about the causes of Lucy's death. We're also saying, in relation to the third paragraph -- and I go down to the end of the fourth line:

"We do, however, accept and acknowledge that our review has flagged up issues, which the Trust will wish to address for the future. These include communication and written records and are referred to in Mr Fee's report."

I do acknowledge that in terms of the first sentence:

"The outcome of our review has not suggested that the care provided to Lucy was inadequate or of poor quality."

I do acknowledge that that is incorrect, but I didn't take the view that that was incorrect at the time.

Q. You're saying that that was with the benefit of hindsight and you had now reached the view that that was

incorrect?

A. That's with the benefit of the further evidence that was provided subsequent to that from the Royal College, from the litigation processes and from the inquest.

Q. Yes, but it's Dr Quinn's evidence to this inquiry that, even as you wrote that sentence at the time, that would not have been a fair reflection of the opinions that he was expressing to your senior managers, nor, for that matter, as contained in his report.

A. I suppose in essence, unfortunately, that was the view that I had taken and the Trust had taken at that time.

Can I also clarify in relation to the point that Dr Quinn is making about two medical officers? I think this came up in the evidence this morning. I think that that's in what I would refer to as the appeal process part, the second stage of the complaints procedure. The Crawfords in terms of, say, for example, not being satisfied with the response from the Trust, have a right of appeal. I'm not sure whether that's -- they get a reminder of that in relation to that letter if the second part of the letter is available. It might have been available in one of the other letters, but they should have been advised that there was an appeal process.

Q. Could we just go over the page to 147, please --

A. Have we any of the other letters in terms of the Crawford family available?
Q. -- to see if we can bottom this out --
A. I'm just trying to explain that Dr Quinn's perception -- in terms of where do the two doctors come in -- I suppose what I'm saying is that's the second stage of the complaints process and I would have understood that, in reviewing the Trust's response to a complaint -- the appeal by the way would be to the Western Board at this time -- and in reviewing the Trust's response to the complaint, that the board can establish a review, a formal review, and, at that stage, bring in medical experts to advise it.
MR GREEN: Can we try 146a?
MR WOLFE: Thank you, Mr Green.
A. Sorry, chairman, that's a different date at the top.
Q. It may well be, but do you recognise it, sir, as page 2 being a continuation of page 1?
THE CHAIRMAN: The last paragraph on the right-hand page seems to tie in:
"I trust this further letter helps to address more specifically your concerns about the adequacy and quality of care ..."
Mr Mills, we'll double-check, but it does appear to be a continuation, even if the dates aren't identical.

A. Yes. We're still pursuing the meeting. I suppose in essence that still hasn't concluded our response to the complaint because a final letter would have included the right of appeal.
THE CHAIRMAN: But I think ultimately, what happened -- and subject to correction -- is that the Crawfords withdrew from the complaint process and went down the litigation route instead.
A. That's right, yes.
MR WOLFE: Are you saying then, Mr Mills, that you would have anticipated that, following your procedures to the letter, there should be correspondence, if you like, bringing an end to the complaint process and advising the Crawfords of their appeal right?
THE CHAIRMAN: Unless the Crawfords withdrew from the complaints process.
A. I think what happened was that the litigation process started the following month. It started in April 2001, so the complaint process hadn't completed.
MR WOLFE: Very well.
A. There should be a reference, I think, in an earlier letter about them receiving a copy of our information leaflet on the complaints process.
Q. Certainly a letter of claim was issued by solicitors on behalf of the Crawfords in the weeks or so after this

letter, which is in front of us on the screen.
A. That's right. Normally, in acknowledging a complaint, it was our practice at the time to issue a leaflet advising the complainant the details of the complaints process.
Q. Could I ask you about a number of concerns expressed by Dr MacFaul in his report on behalf of the inquiry in relation to the steps that appear not to have been taken following this review? Dr MacFaul expresses the view that the coroner should have been informed of the Trust's review in 2000 and the conclusions reached by it; did you give any consideration to that?
A. I have no recollection.
Q. Should the coroner, in your view, have been informed that you were undertaking a review and the conclusions reached by it?
A. I certainly wouldn't have been -- it wouldn't have been a practice at that time. My understanding was that the coroner had been informed about the death and I was anticipating and it was all -- the expectation was that an inquest would be subsequently heard.
Q. Faced with such an inconclusive report, at least in terms of the mechanism pertaining to Lucy Crawford's death, did you give any consideration to whether Dr Quinn should have been revisited and asked to clarify

his views in light of all of the other evidence which had been gathered and which had not been put before him?
A. No, I have no recollection of considering that.
Q. Do you think that is a step that ought to have been considered?
A. I think if Dr Quinn had identified that he needed more information, yes, that would have been, but again I can only speculate on that point.
Q. Of course, his report did identify the need for information or at least pinpointed information that was outstanding.
A. Yes, but maybe it needed to be done more forcefully in terms of asking for that information.
Q. I want to ask you about the Western Health and Social Services Board at this juncture. It's your recollection --
MR SIMPSON: Mr Chairman, before my learned friend moves on to that, might I just go back to the point that you raised about the deliberate nature of what was sent to the family and just ask if one document could be brought onto the screen? 033-029-059, if that's the correct reference. There is a series of e-mails internal to the Bridget O'Rawe file, which may set in train some thought process on the part of the chairman. So it looks as if some type of summary was being asked for through

Mr Millar.
THE CHAIRMAN: 27 November.
MR SIMPSON: Without wishing in any way to assist the witness, perhaps, sir, you might look at that and see if anything can be gleaned from it.
THE CHAIRMAN: Thank you.
MR WOLFE: This indicates that Mr Fee was being contacted by Ms Millar, who in turn had received some communication from Stanley Millar, who was at that time acting as an advocate for the family. Do you understand the relationships in that way?
A. Yes, I do. There's no family connection as I understand it; Christine Millar was an employee of the Trust, who worked in Ms O'Rawe's department.
Q. And Mr Millar seems to be suggesting that the family would appreciate sight of some type of summary of the report before coming to a meeting, I think is the full context, as we might observe from --
A. Yes.
Q. -- other correspondence.
A. Again, I'm not aware of the background to this. As I said earlier, I don't recall seeing this memo, but it does identify that, yes.
Q. But it --
A. It might lead up to the explanation for why, in my

absence in January, a summary of the report was sent.
Q. Yes, it may go some way there, but plainly if the family are not aware of the fact that, for example, Dr Quinn has provided a report, then asking for a summary of the review might in their mind at that time be entirely satisfactory but not, of course, satisfactory if they knew that there were other important documentations which would have been otherwise accessible.
A. Yes, and again, chair, I wasn't aware that the report that had been sent them didn't contain the appendices. That wouldn't have been my view at the time. I have compared the two reports and I would suggest, chair, that there are -- apart from the documentation of the recommendations, the recommendations are the only aspect of that report that has been summarised. The rest of the report was primarily verbatim. The only aspect of that report was, in fact -- the recommendations that were summarised.
THE CHAIRMAN: I'll double-check that, Mr Mills, thank you.
MR WOLFE: Again, the process of how the review was conducted is another change that is summarised in the report that goes to the family by contrast with the report that was available for internal consumption, but the chairman can check that.
Could I ask you about the report and any interaction

with the Western Board as a result of its production? Do you have any memory of engaging with the Western Board in respect of the conclusions reached by the review report?
A. No, I have no recollection of any specific engagement.
Q. Do you believe that the findings of the review report were sent, albeit, as Mr Frawley points out in his witness statement, there doesn't seem to have been any formal correspondence and he certainly isn't aware of any record of the report being received in the Western Board?
A. I acknowledge that I haven't any formal record of that either and I suspect, as I said earlier, that this was probably sent by e-mail with the hard copies going in the post separately, and that's perhaps what has happened here.
Q. There doesn't appear to have been any response, whether formal or informal, to the report from the Western Board.
A. Again, I have no evidence of anything written. I think there's an indication that there were discussions between Dr Kelly and Dr McConnell. I'm not sure specifically about that.
Q. Would you have expected the board to have made a formal response to a document like this being sent to them?

A. No, not specifically. Again, I would have anticipated that if they would have seen anything within the document which required further clarification or further investigation, they would have drawn that to our attention. So, no, I have no record of that.
Q. But to be clear, you would have anticipated a response from them if they saw problems with the reports or difficulties with the conclusions reached and such problems as that?
A. I can only surmise and again speculate to some extent that they probably had the same view I had. They saw the report and saw the recommendations of the report and took those to be the responsibility of the Trust, that's the responsibility of the directorate to implement those recommendations. There wouldn't have been anything in the recommendations that would have been addressed to them.
Q. Let me bring you to the Royal College reports. You've told us in your witness statement that you received the Royal College reports --
A. Yes.
Q. -- and that you discussed the first of the reports -- that's the report authored by Dr Stewart, by herself -- and you discussed that with Dr Kelly on 27 June 2001.
A. I think I have that record.

Q. Yes, that's 030-040-052.
A. Sorry, I'm looking at my original notes here. Can it come up?
Q. I don't need to call it up.
A. It's dated 27 June 2001.
Q. Yes. Indeed, I think there was an earlier meeting at which Dr Kelly was notifying you of his intention to meet with Dr Stewart.
A. Yes, on 25 May my note says:
"The document from Moira Stewart [I think he was in receipt of it on 25 May]. Factual account, no major concern, but devoid of opinion. Jim Kelly to see her and discuss."
That's my record of that meeting.
Q. So he was interpreting her first report as indicating no major concerns?
A. Yes.
Q. And he communicated that to you at the May discussion?
A. Yes.
Q. But as you summarise, he was going to have a meeting with Dr Stewart, which either occurred on 31 May or 1 June, according to, I think, Dr Stewart's records, to discuss in greater detail perhaps the content of her report.
A. That's correct.

THE CHAIRMAN: Sorry, how do you interpret the note:
"No major concern, but devoid of opinion"?
What does "devoid of opinion" get at? Is that the lack of a conclusion?
A. I think that's, again, the lack of a definitive conclusion about the cause of the death. And again, chair, it could be that it's a lack of opinion about -- because it was a performance review in relation to Dr O'Donohoe.
THE CHAIRMAN: It's going to be wider than exactly why Lucy died, isn't it?
A. Yes. So I'm sorry, I can't be specific.
THE CHAIRMAN: But "devoid of opinion" could be an opinion about what to do with Dr O'Donohoe?
A. Yes, it could be. But I suppose to some extent there's nothing in my record of that meeting that says that Dr Stewart was identifying: here's what caused Lucy Crawford's death.
THE CHAIRMAN: Thank you.
MR WOLFE: And your record for 27 June doesn't help us, Mr Mills, in terms of the detail of what you discussed with Dr Kelly, save that chronologically we know that by this stage the Trust has the report and also has the benefit of the meeting between Kelly and Stewart; isn't that right?

A. That's correct, yes.
Q. Did that meeting with Dr Kelly, to the best of your recollection, involve him updating you on what Dr Stewart had said at the meeting?
A. Again, as I have recorded here, he was probably handing me a copy of the report at that meeting from Moira Stewart, and I have here "some case issues" and obviously "HM to read" means I needed to go away and read it.
Q. Yes. Well, what happened thereafter then? If you were not in a position to engage in a discussion about the views being expressed by the Royal College because you hadn't read the report at that point, was there further opportunity to discuss with Dr Kelly the views that Dr Stewart was expressing?
A. I'm not sure. I can't recall specifically.
Q. Can I ask you this: at the meeting between -- sorry, I thought you were going to come back in there.
A. Sorry, I was looking at the other issues that were discussed at the meeting that have been redacted to see if there was anything that might have been referring to that.
Q. Can I ask you this: at the meeting that occurred with Dr Kelly on 27 June 2001, were you given any impression at all about what Dr Stewart had concluded with regard

to Lucy Crawford's care?
A. I was given a copy of her report and, yes, I would have subsequently read the report. But as I said, there was nothing conclusive in her report.
Q. Well, her report, if we can turn it up briefly, suggested several possible explanations for Lucy's deterioration. 036a-025-056. And the next page, if you would, please. Would you agree, Mr Mills, that in terms of attempting to clarify Lucy's deterioration that this report is adding further detail to what you had already received from Dr Quinn? She was now identifying several possible explanations whereas, by contrast with Dr Quinn who perhaps, I think, could be fairly described as not giving much in the way of detail in respect of the development of the cerebral oedema, at least in the context of his report, did you read this report of Dr Stewart as helping you towards a greater understanding of what might have occurred?
A. Again, chair, certainly the report added to the information that we had. It covered technical issues, which I wouldn't necessarily have been familiar with in terms of the detail. I think it was the next page that I suppose I tended to focus on. That's 058.
Q. Just before we leave this, you would have seen that she was addressing several possible explanations, some of

which, to take for example (ii), was raising a question mark about the fluid therapy that this child had received. So she's saying that:

"Biochemical changes are often well tolerated and easily corrected with appropriate fluid replacement, although these results do show a change over a relatively short period of time."

Was this report raising for you concerns which weren't in your mind previously?

A. Not specifically, no.

Q. Let's go over the page then to 058. Here she sets out one view of the appropriate approach to fluids upon the assumption that there was a fluid deficit by reference to dehydration of 7.5 per cent. She's saying the volume given doesn't appear excessive. However, she's indicating there is debate about the most appropriate fluid to use and goes on to say that:

"The APLS guidelines indicate that the deficit should be replaced with normal saline."

Is there anything in that that caused you to have concerns about the fluids which Lucy had received?

A. I didn't understand at the time necessarily the issues associated with the debate, the issue of replacement or maintenance. Again, I mean, I didn't have the expertise to fully understand that. I suppose I know more about

it now, having read some of your documentation as a result of what you have received. And unfortunately, my interpretation was to focus on that sentence above:

"The volume given therefore does not appear excessive. There is debate about the most appropriate fluid to use."

And Dr Kelly was already telling me that there had some concerns emerging relating to the use of fluid No. 18.

Q. Well, Dr Kelly was your avenue for an explanation of these technical issues.

A. Yes.

Q. Did he attempt to explain to you anything about what Dr Stewart said at the meeting which they had had in respect of the report?

A. As I said, my record discusses it and I haven't any notes about the detail other than there's no -- the information isn't in the report or isn't in Dr Stewart's report that provides us with a definitive explanation as to what caused Lucy's death.

Q. She's going to be giving evidence to the inquiry and she would say that she, in the course of her discussion with Dr Kelly, so far as she can recall, made it plain to him that the change in electrolytes in Lucy's case resulted from the administration of Solution No. 18 and she

suggests that Dr Kelly alluded to that in his note of his meeting with Dr Stewart. Can I ask you this: did Dr Kelly, so far as you can recall, tell you anything about Dr Stewart's concerns about the fluids?

A. Dr Kelly certainly was concerned about the fact that Solution No. 18 appeared to have been removed from the Royal Belfast Hospital for Sick Children. He would have identified that and that there was debate, but it was -- I suppose to some extent ... I'm sure, sir, you're aware of what's called the Bolam principle.

Q. Of course.

A. And I suppose, what in essence was -- there seemed to be debate going on between doctors as to whether Solution No. 18 was appropriate or inappropriate.

Q. We'll ask Dr Stewart what she meant by that insertion into her report when we speak to her tomorrow. But what she seems to be saying -- and the point I'm putting to you -- is this: that by the time she engaged in a meeting with Dr Kelly, she was unequivocal in terms of her description of the process leading to Lucy's demise. My question to you is a straightforward one: whether that information was shared with you.

A. I didn't get that information and I don't know whether that was Dr Kelly's interpretation of what she was telling him.

Q. Let me put up on the screen, please, the note of the meeting. It's 036a-027-067. Did Dr Kelly show you this note of his engagement with Dr Stewart?

A. No, I didn't see that.

Q. Your recollection, it seems, is of not being told what Dr Stewart says she explained to Dr Kelly. Can I ask you this, Mr Mills: arising out of Dr Stewart's report and Dr Kelly's discussion of that report with you, what conclusions did you reach in terms of whether you had obtained any greater clarity in respect of Lucy as a result of the Royal College process?

A. I certainly hadn't reached any conclusions that there was any definitive reason being expressed by Dr Stewart for Lucy's death. And I tended to focus on those sentences that I've identified:

"The volume given does not therefore appear excessive and there is debate about the appropriate fluid to use."

I suppose again I would have maybe focused on that too significantly as a point of reassurance that really what had happened to Lucy would have appeared to have not necessarily been associated with the fluids, and was there some other factor that was unexplained. I think I've stated in my witness statement that there are many situations in the Health Service where there aren't

explanations reached as to cause of death.
Q. You, as a Trust, went back to the Royal College to carry out a more detailed review in relation to the conduct and competence of Dr O'Donohoe; isn't that right?
A. Yes.
THE CHAIRMAN: Sorry, why exactly did that come about? The purpose of the first College report was to give you an expert view on the extent to which it was safe for Dr O'Donohoe to continue to treat children.
A. Yes.
THE CHAIRMAN: What was missing from the first report which brought you back for a second time?
A. Again, Dr Kelly would probably be able to better answer that. I can't recall, chair, specifically.
THE CHAIRMAN: It's unusual enough to go for one report to the Royal College, isn't it, never mind to go back for a second one?
A. I know there was the ongoing issues, I suppose, associated with the harassment aspect and the disciplinary aspect, and indeed there were health issues in relation to Dr O'Donohoe. So obviously, these other cases had been flagged up, probably by Dr Asghar. In fact, I think that's what initiated it. Dr Asghar had flagged up these other cases, that's right -- my memory, it's bouncing back. Dr Asghar had flagged up these

other cases and we would have included Lucy's case again.
THE CHAIRMAN: Okay. Mr Wolfe?
A. And to say then, chair, that the second review went beyond the case note review. There was interviews with a range of staff as well as the case notes.
MR WOLFE: Can we just take a look at the conclusion reached by the Royal College in respect of Lucy, arising out of their second report? 036a-150-312. Under (iii), it says:
"The prescription for the fluid therapy for Lucy Crawford was very poorly documented and it was not at all clear what fluid regime was being requested for this girl. With the benefit of hindsight, there seems to be little doubt that this girl died from unrecognised hyponatraemia, although at that time this was not so well recognised as at present."
You would have observed that conclusion, Mr Mills?
A. Yes. I think that -- I'm trying to find my timeline. This was 2002?
Q. 2002, August 2002.
A. Yes. And certainly by that time, we were already aware of what had unfortunately happened to Raychel Ferguson in Altnagelvin, and Dr Kelly and Dr Fulton would have certainly been involved in the discussions that were

subsequent to that, which led to the withdrawal of Solution No. 18.
Q. And by this time, had you drawn a parallel between the death of Lucy Crawford and the death of Raychel Ferguson?
A. I hadn't personally, no. I knew there were differences: one child had had surgery, in Raychel's case, and in Lucy's case there wasn't surgery involved.
Q. The common denominator was the use of --
A. But there were question marks about the use of Solution No. 18.
Q. Yes, in a situation where each of the children, the experts were appearing to say, were in need of a suitable replacement fluid as opposed to the use of Solution No. 18, which primarily was of use in a maintenance fluid situation.
But before moving on to that, did you recognise, in the conclusion reached by Dr Boon and Dr Stewart for the Royal College, that it was the issue of fluids that had led to the hyponatraemia that had led to the child's demise?
A. Yes, that's specifically identified there, yes.
Q. You indicated earlier in answer to the chairman's intervention that --
THE CHAIRMAN: You said if there had been information from

Dr Stewart which was definitive about Lucy's death, the Crawfords would have been informed. Is that definitive about Lucy's death?
"There seems to be little doubt that this girl died from unrecognised hyponatraemia."
A. I think, chair, in what had happened at this stage was there was a litigation process that had commenced and I think I have stated in my witness statement that I was under the impression that this information would have been passed to the litigation team.
THE CHAIRMAN: Well, this document wouldn't be a privileged document for litigation. This isn't a document obtained for the purposes of litigation; this is a document obtained for the purposes of investigating an issue raised by another doctor within the Erne about the competency of Dr O'Donohoe, isn't it, as opposed to Dr Jenkins' medico-legal report, for instance, which was obtained by the Trust for the purposes of litigation?
A. Yes, I can understand that, chair, but I'm not sure I would have acknowledged the difference of that at that time.
MR WOLFE: By the time of receipt of this report from the Royal College, Mr Mills, you were already familiar, were you not, with the conclusions which Dr Jenkins had reached in his report?

A. I'm not sure when I would have received Dr Jenkins' report or known of the conclusions of Dr Jenkins' report because it was part of the litigation process.
Q. You have told us you did receive the report of Dr Jenkins.
A. Yes, but I'm not sure of the timing of that.
Q. It was a report that was prepared in or about -- the date is 7 March 2002 and he reflected in his report the fact that, for the purposes of the fluid regime that Lucy should have undergone, the appropriate approach would have been to use a solution with a higher sodium content than she actually received.
A. Mm-hm.
Q. So in essence, even before the report came in from the Royal College, the Trust was aware, through this report from Dr Jenkins, that the fluid management of Lucy was problematic, is that fair --
A. Yes.
Q. -- whether or not you were personally aware of that?
A. Yes, I'm not sure I was personally aware, but the Trust would have been aware, yes.
Q. In terms of what steps you took arising out of the receipt of this Royal College report, again you'll have to help us with this. There doesn't appear to be any documentation to indicate that this was formally shared

with the Western Health and Social Services Board, for example.
A. I don't see a record of that. My understanding was that -- I think it was Dr Kelly and myself, Mr Fee and Dr Anderson -- would have been familiar with the contents of the report. As was pointed out, this was beginning -- well, we were already sort of well advanced, it wasn't just beginning, in terms of our review of Dr O'Donohoe and potential issues surrounding the relationship that existed between Dr O'Donohoe, other staff and Dr Asghar. Where we went really in relation to the follow-up to this review was trying to establish mediation arrangements between Dr O'Donohoe and Dr Asghar. So we were largely addressing the harassment and bullying aspects.
Q. I understand what you're saying, that the report was disseminated and actioned, to use Dr Kelly's word, in-house, but are you telling us that you have no recollection of the report being disseminated outside of your organisation?
A. I have no recollection of that, no.
Q. Because you have described your understanding of the, if you like, governance relationship that existed between yourselves and the Western Board. And it would appear that they were shown the review report, they were shown

the first Royal College report, and then we have this third report, which unequivocally implicates hyponatraemia as being the cause of the problem.
A. Yes.
Q. And does it strike you as odd that that was not, to the best of your recollection, shared with the Western Board, given the nature of the governance relationship that continued to exist at that time?
A. Yes, I can acknowledge that. I think by the time this report came, that conclusion was already well-known by the Western Board as a result of the discussions that had been taking place in relation to Altnagelvin's experience, so I'm not so sure that was necessarily new information.
THE CHAIRMAN: Sorry, Mr Mills, that can't be right. If the Western Board knew about Solution No. 18 from Raychel's death, it doesn't follow for one moment that they know that there is now an expert paediatrician who's attributing Lucy's death to hyponatraemia. In fact, this makes things even worse because now, in terms, you're saying, "Look, there is not just one death from hyponatraemia in the Western Board area, here's a second", and the Western Board wouldn't have known that without seeing Dr Stewart's report; is that not right?

A. We are talking here about mid-2002.
THE CHAIRMAN: Yes.
A. As I understand it, Dr McConnell had already written to the other boards and to Altnagelvin Hospital by that stage; is that not correct?
THE CHAIRMAN: Alerting them to what?
A. Alerting them to the potential problems associated with Solution No. 18.
THE CHAIRMAN: Yes. But not alerting them to the fact that we now know that it wasn't just Raychel who died after receiving Solution No. 18; it now appears, from what Dr Stewart says, that Lucy also died. The awareness that there was a Solution No. 18 problem was clearly there by mid-2002. The awareness that Raychel's death was attributable to Solution No. 18 was known by mid-2002. But where was the awareness that Lucy's death was attributable to Solution No. 18 and hyponatraemia?
A. Well, I suppose in essence there was no -- nothing definitive at that stage.
THE CHAIRMAN: That's right.
A. As has been pointed out, there was the report from Dr Jenkins, which was prior to this as well --
THE CHAIRMAN: That's a litigation report obtained by Sperrin Lakeland. Would Sperrin Lakeland have shared that with the Western Board?

A. Dr Jenkins' report?
THE CHAIRMAN: Yes.
A. No.
THE CHAIRMAN: But now you have a different report from a different source and you have shared Dr Stewart's first report.
A. I think what I said was I felt this report wasn't telling us anything new that we didn't know before and perhaps this is --
THE CHAIRMAN: But it would have been telling the Western Board something that they didn't know before.
A. I can acknowledge that, yes.
THE CHAIRMAN: It would also have been telling the Crawfords something they didn't know before and it would also have been telling the department something they didn't know from before.
A. I can acknowledge that, chair, but I would point out, as I said previously, that we were involved in litigation at that time.
THE CHAIRMAN: I am sorry, Mr Mills, but whatever about the litigation, you now have a report which is not a privileged legal report, but what you had said to me earlier was that if you'd had anything definitive for the Crawfords, you would have shared it with them. But now I have to interpret that answer as meaning: we'll

share it with the Crawfords unless they're suing us, in which case we won't share it with them.
A. It would have certainly been my intention at that time to have referred to our legal advisers prior to sharing it with them.
THE CHAIRMAN: Thank you.
A. I wouldn't have taken the decision.
MR WOLFE: Can I move on briefly, Mr Mills, and ask you about some issues arising out of the coronial process? Could I bring up on the screen, please, what Mr Leckey has said in relation to what he perceived as the obligations of the clinicians at the Erne Hospital? It's 115-034-003. About halfway down the page he says:

"Also, in my view [this is in addition to the obligations of the clinicians in the Royal] a duty to report was imposed on doctors at the Erne Hospital who would have been aware that, when Lucy left the Erne Hospital for transfer to the Royal Belfast Hospital for Sick Children, she was in a moribund state. Once the Erne Hospital became aware that Lucy had died, I would have thought it was highly probable that her clinical management there would have been the subject of discussion within the hospital. I find it difficult to understand why the consultant in charge did not consider it appropriate to make contact with my office."

Can I juxtapose that, Mr Mills, with something you said to the police service, 116-051-006? The first intervention by you on this page contains your explanation in 2005 for why you did not see it as the responsibility of your clinicians to make the report. You say:

"The actual death took place in Belfast and the coroner for Belfast area is obviously the Belfast coroner, John Leckey. In essence, because the death didn't occur in our area, obviously it wouldn't have been part of our jurisdiction, so my view is that it was quite rightly reported by the Belfast staff to the Belfast coroner. They contacted the coroner's office and reported the death to the Belfast coroner, so that seemed to me to be appropriate."

You do seem to be suggesting in that answer, Mr Mills, that there was, if you like, a geographical aspect to all of this: you had no obligation or your clinicians had no obligation to report because the death didn't happen at your hospital or in your area.
A. That, I understand, was the convention at that time.
Q. Was that your understanding of the legal position?
A. I don't know that I have an understanding of the legal position, but that was my understanding of what actually happened. That's what was happening.

Q. Had you ever received training in the application of the Coroner's Act?
A. I don't recall specifically. I might have attended a session that was provided by the Central Services Agency Legal Directorate at one stage, but I don't recall it specifically.
Q. Section 7 of the legislation talks in terms of:

"Every medical practitioner who has [if you like] reason to believe that a patient died of or a person died of ..."

And then there's a series of factors. So it's not limited to where the patient died, Mr Mills; do you understand that?
A. Yes, I understand that, chair. I can only repeat what the convention was at that time.
THE CHAIRMAN: I think we'll take this up with Mr Leckey because I'm curious. On the face of the statute, every medical practitioner who's aware of this has a duty to report, which in theory should mean that -- every medical practitioner, which could include a nurse. In theory, you could have eight or ten reports of the same death to the coroner. I'll be asking Mr Leckey, whatever about the statute, whether it was the practice, in fact, for Daisy Hill or the Royal to report a death or whether it was the convention that only one did and

how often he received reports from two different doctors in the same hospital.

MR WOLFE: Can I just develop this a little further in this way, Mr Mills? Dr MacFaul is concerned that a simple act of communication between the two hospitals would have established beyond doubt precisely what the coroner was proposing to do with this death. So had that been done, that would have avoided everyone apparently labouring under the misapprehension that there was to be an inquest. I think that's probably fair comment.

A. Yes, I agree yes.

Q. But I think your answer to that is there was no such communication between yourself and your opposite number in the Royal or clinicians and their opposite numbers in the Royal?

A. Certainly I wasn't involved in any communication.

Q. Could I take you to a point that you intervened with this morning when we were taking you through the formal exercise of proving your statements? You say that -- was it question 36, the answer to question 36, where you said the information that --

THE CHAIRMAN: Yes, it's witness statement 293/1, page 19.

MR WOLFE: Question 36:

"The information that there was no inquest planned was made known to the Trust on 12 October 2001. I do

not recall who advised me of this."

What would the normal process be, Mr Mills? Would it be a case of a question being raised at the scrutiny committee and then the legal team going away and addressing this issue with the coroner's office and then reporting back to the Trust?

A. As I understood it, yes, that's what was happening.

Q. And you're obviously quite certain that the information was known to the Trust on 12 October 2001. You said in your dealings with the police service, if I could have it up on the screen, please, 116-052-006 -- now, this is in perhaps consonance with the point you have just made this morning. At the bottom of the page you say:

"Now I wasn't advised, I don't recall anybody ever telling me that there wasn't going to be an inquest. It was the scrutiny committee who was advised and, in essence, that would include Dr Kelly and Ms O'Rawe."

Can you help me with this: Dr Kelly has given evidence to the inquiry and he maintains that he certainly wasn't aware that no inquest was planned at or about 12 October 2001. Moreover, he was continuing to raise with the scrutiny committee into 2002 the question, "What is happening here with regard to an inquest?". When you say that Dr Kelly and Ms O'Rawe were advised in the context that we find here in this

police account, what did you mean?

A. Well, as I said, this is as a result of being asked, in preparation for the interview with the police, by my solicitor to find out when we knew what the situation was in relation to the inquest. I took steps proactively before my police interview to ask the directorate of corporate affairs what was the information that we knew, as a corporate organisation, about the inquest. I didn't go to the -- I didn't see the source material, I didn't see the minutes of the scrutiny committee, I got a message back that basically said, "We were asking on 25 June what the situation was regarding the inquest and we were told, apparently at a meeting that took place on 12 October, that there was to be no inquest".

Q. And --

A. So all I have, as I said, is a verbal response to the questions that I would have asked and I would have taken a note of that. So that was the information and that's how that information is provided. I have no source material to refer to which identifies the minutes or who was at the minutes. It's an assumption in relation to who was at the meeting. It's an assumption, because Dr Kelly and Ms O'Rawe are the Trust representatives on the scrutiny committee, that they were at the meeting.

Q. But you're not saying, just to be clear, that they would have known necessarily, in or about 12 October 2001, that there wasn't to be an inquest?

A. Again, as I said, they're members, on behalf of the Trust, on the scrutiny committee so if they attended that meeting and that's what's recorded in the minutes of that meeting, that's the information that I had.

Q. Have you given any consideration, Mr Mills, to the fact that, notwithstanding the Trust was aware from late 2001 that no inquest was planned, nobody at the Trust went back to the coroner to say, "Arising out of reports that we have gathered" -- and let's leave aside Dr Stewart's first report about which you have expressed a view, but certainly by the time you have obtained the Jenkins report and then the second Royal College report, you were clearly aware that fluids and fluid mismanagement in Lucy's case was an issue, did you give any consideration to going back to the coroner or directing one of your clinicians to go back to the coroner to apprise him of what your team had discovered?

A. No, I don't recall giving that consideration.

Q. Do we infer from that that the Trust didn't understand that it could do that or, alternatively, perhaps that the Trust had no inclination to raise this difficult issue with the coroner's office because of what it might

bring to its door?
A. Certainly there was no aspect in relation to the latter aspect you've identified. And again, I'm speculating, I just have no recollection of any discussion or any consideration of referring the case to the coroner.
Q. Can I ask the question slightly differently? I'm conscious that you're not able to help us about precisely when you discovered that there wasn't to be an inquest, albeit that the information was in the system from late October 2001, but when you discovered that there wasn't an inquest planned, did that not jar with you given the nature of the information your organisation had discovered in relation to the deterioration and death of Lucy Crawford?
A. I know that we were probably involved in litigation at the time and I suppose I assumed that that would be a matter that would be discussed within that setting.
Q. But you're not telling us that it was discussed in --
A. I don't know, I wasn't involved in those discussions. I don't know.
Q. Can I bring you to one final point, please? It concerns the wording of the apology that was issued to the Crawford family at the conclusion of the inquest following the settlement of the legal proceedings which had been commenced by the Crawford family. You'll find

it at 067h-004-006.
It's clear from the papers available to the inquiry that the drafting of this apology ran through several exercises of drafting, but the words that were finally arrived upon are that:
"[You are] writing on behalf of the Trust to indicate our regret and apologies for the failings in our service at the time of Lucy's death in April 2000. These failings, not fully identified in our original review, became evident later in the process following another reported death in Northern Ireland. At that time we sought, through your legal representatives, to reach settlement on the legal proceedings."
The first point, Mr Mills: is the phrasing of "these failings not fully identified in our original review" intended to communicate the fact that some failings had been identified in your earlier review?
A. I mean can't recall any inference on that -- in that aspect of it being considered or discussed at the time.
Q. Hopefully I'm not putting the emphasis on it, but there does seem to be an intentional use of the words "not fully identified".
A. I mean, I suppose to me that could ... That could have meant at the time that was being drafted that the review didn't identify them.

Q. Well, the second part of the sentence indicates that the failings became evident later in the process following another reported death in Northern Ireland and that's a reference to the death of Raychel Ferguson; is that right?
A. Yes, I would anticipate that would be the reference there.
Q. Is that written in that way because you, as a Trust, recognised that in terms of the fluid management of Lucy Crawford, there was a correlation -- albeit not necessarily a direct correlation, but a correlation nevertheless -- between the death of Raychel Ferguson and the death of Lucy Crawford?
A. There were similarities, yes.
Q. Because it won't be lost on you, Mr Mills, that the primary reason for examining Lucy Crawford's death and, in particular, the investigation into the aftermath of the death is the potential for lessons to have been learned, which would have avoided the unnecessary death of Raychel Ferguson.
A. Yes, I can appreciate that.
MR WOLFE: I'm obliged. I have no further questions.
THE CHAIRMAN: Thank you very much. Any questions from the floor before I come to Mr Simpson?
Mr Simpson, have you anything? Mr Mills, thank you

for coming today and thank you for helping us. You don't have to say anything more, but if you want to say anything before you leave the witness box, you're welcome to do so.
A. Thank you, chair. I'd just like to add my condolences to the families for their loss. I appreciate that the circumstances that they have been through have been significant to them and ...
(The witness withdrew)
THE CHAIRMAN: Thank you very much. That brings us to an end today. Is it Dr Stewart first tomorrow --
MR WOLFE: I believe it is.
THE CHAIRMAN: -- and Mr Bradley?
MR WOLFE: It makes sense to deal with it in that order.
MR DAVIES: Mr Bradley, I think, in the morning and Dr Stewart in the afternoon, although Dr Stewart can be made available earlier.
THE CHAIRMAN: I think it makes sense to do Dr Stewart in the morning and then we get into the run of three witnesses from the board: Mr Bradley, Dr McConnell and then Mr Frawley; is that okay?
MR DAVIES: Yes, it is.
THE CHAIRMAN: So back at 10 o'clock tomorrow morning. Thank you.
(3.45 pm)

(The hearing adjourned until 10.00 am the following day)

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