Witness Statement Ref. No. 286/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: William McConnell

Title: Doctor

Present position and institution:
Retired since August 2009

Previous position and institution: *[As at the time of the child's death]*
Director of Public Health, Western Health and Social Services Board. Retired since August 2009.

Membership of Advisory Panels and Committees:

[Identify by date and title all of those between January 2000 – January 2012]
Member of Chief Medical Officer /Directors of Public Health group – 1985 until retirement
Ex Officio member of all DHSS(PS) Specialty Advisory Groups including Paeds/Anaesthetics etc.
Member of WHSSBoard and WHSSB Health Care Committee.
Member of Western Health and Social Services Board Area Medical Advisory Group.

[I have included only those relevant to the O'Hara Inquiry but was also a member of a number of other committees at UK/National, N.I. and local level related to Cancer services, Screening and Inter-sectoral work.]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
Previous statement for Inquiry– 047 – Approximately October/November2011
Reports – Verbal to CMO/DsPH meeting July 2001
- Verbal to Western Health and Social Services Board and its Health Care Committee – various over time.

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:
Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.
If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I.Questions Relating to your Qualifications, Experience and Career Background

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of April 2000:

(a) State your medical and professional qualifications, and the date on which they were obtained.
M.B B.Ch. B.A.O. [QUB] June 1970 ; Member of Faculty of Public Health Medicine [UK] 1985 ; Fellow of the Faculty of Public Health Medicine [UK] 1989.

(b) State the date of your appointment to the post of Director of Public Health (Western Health and Social Services Board), and provide a description of all of the professional posts held by you before and since that date, giving the dates of your employment in each case.
I was appointed to the DPH post [then Chief Administrative Medical Officer (CAMO)] in August 1985. Prior to that I was Assistant CAMO in the Southern Health and Social Services Board from 1981 to 1985 - Locum ACAMO [SHSSB] from 1980 to 1981 - Senior Registrar in Public Health in the Northern Ireland programme 1977 -1980; Senior/Clinical Medical Officer in Community Child Health from 1976-1977 - Senior House Officer in Anaesthetics/Intensive Care at the RVH from 1975 to 1976 - Practising in Canada in Obstetrics/General Practice – 1972 to 1975 - Senior House Officer and Junior House officer in Ards Hospital (Newtownards, Co. Down) from July 1970 to August 1972.

(c) Describe the duties which you were required to undertake in the post of Director of Public Health, and provide a copy of your job description(s) in respect of the period commencing April 2000. The following are the details of my Job Role as DPH. [I no longer have a copy of my Job Description .]
JOB DESCRIPTION attached to post:

The Director of Public Health will lead and manage the Public Health Medicine Department of Consultants and Specialist Registrars. The roles of the Director of Public Health are:

a) Delivering on the Public Health Medicine inputs to the commissioning/planning of Services; ensuring the delivery of the Statutory Functions delegated to him/her on behalf of the Board and delegated to the Board but which need essential Public Health Medicine inputs; and the essential Contribution to Health Promotion/Development both within Health and Personal Social Services and Intersectorally

b) To be a Member of the Board's Senior Management Team.

c) Ensuring that the Staff within his/her Department are supported, developed and enabled to deliver their roles while, at the same time, that they deliver on their defined responsibilities. This includes the need for them to be appraised regularly both formally and informally. This includes ensuring that their development needs, professional and personal, are identified and opportunities are secured to meet these and that their Continuing Medical Education/Continuing Professional Development profiles are up-to-date and met.

d) Ensuring that the Public Health Medicine Department objectives overall, and the individual work plans and objectives of Staff, are consistent with the Board's corporate and organisational objectives or that any mismatch is resolved. This will include ensuring that the professional inputs of staff to key regional or other initiatives are included in this equation. It also includes ensuring that the Public Health Medicine Department delivers across the ten Public Health competencies and meets professional expectations.

e) Advocacy and leadership on behalf of the health of our resident population. Reporting regularly to the Board, the public and other organisations who can affect health and social well-being on the key issues of health importance

f) Public Health adviser to the Board, accountable to the Chief Executive.

g) Ensuring that the three Domains of Health Protection, Health Promotion/Improvement and Service Development/Health & Social Care Quality are given due importance and balance in the Board's work and that there are good links between the 4 Boards, with the DHSSPS and with Trusts and Primary Care regarding these three Domains of Public Health work.

h) Working through Intersectoral Partnerships to improve health and reduce health inequalities.

i) Working with local communities to improve the understanding of health issues and to develop their capability and capacity to address their health challenges.

j) Working with Public Health and related networks to share expertise, knowledge and examples of good practice.

(d) In your capacity as Director of Public Health, please indicate whether you had any responsibility for the operation, management, supervision or control of the services provided by the Sperrin Lakeland Trust and Erne Hospital, and if so, state where that responsibility derived from and how you exercised that responsibility.

I had no direct responsibility for the operation, management, supervision or direct control of the services provided by Sperrin Lakeland Health and Social

Care Trust. The regulatory authority and management control for Trusts was with DHSSPS. The responsibility of the Western Health and Social Services Board, in relation to Sperrin/Lakeland Trust, was to commission Health and Social Care services from that Trust. Within the WHSSB, my line of accountability was through the Director of Health Care, Mr. Martin Bradley [also Chief Nurse to the WHSSB at that time], to the Chief Executive, Mr. Tom Frawley and thence to the Board and its Chairman.

(e) **In circumstances where a health and social services trust notified you or your office of an unexpected and unexplained death, what were your particular responsibilities, and where did those responsibilities derive from.**
In such circumstances, my role within the WHSSB would be to notify the Director of Health Care and through him, or directly if that was not possible, the Chief Executive and my Board of this. I would also advise what I knew of the circumstances, what action I was aware of being taken within the Trust and whether there was the potential for wider implications immediately apparent from the event in other settings either within or outside the WHSSB area. If I considered there were potential wider implications, I would notify my colleague DsPH in other Boards and the Chief Medical Officer/DHSSPS of the issue/s. At that time those responsibilities were derived from my own role/Job description, that of the WHSSB and from a common sense approach.

(2) Have you ever received any form of advice, training or education in order to inform you of the appropriate approach to fluid management in paediatric cases and if so please state,
(a) Who provided this advice, training or education to you? No – see below
(b) When was it provided? See below
(c) What form did it take? See below

(d) Generally, what information were you given or what issues were covered?
I have not received any specific advice, training or education regarding fluid management in Paediatric cases other than general advice in my medical student [1964 – 1970] and junior clinical [1970 – 1972] days.

(3) Have you ever received any form of advice, training or education in order to inform you of the issues relating to hyponatraemia in paediatric cases and if so please state,
(a) Who provided this advice, training or education to you? None prior to discussions of July 2001.
(b) When was it provided? See above
(c) What form did it take? See above
(d) Generally, what information were you given or what issues were covered?
See answer to Question 2 above.

(4) Prior to April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the
(a) Estimated total number of such cases, together with the dates and where they took place.
(b) Nature of your involvement.

(c) **Outcome for the children.** I have had no clinical experience of dealing with children with Hyponatraemia.

(5) Since April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children. See answer to Question 4 above

II. Steps Taken by you Following the Death of Lucy Crawford

(6) Starting from the time at which you were first informed about the death of Lucy, outline chronologically all of the steps that you took in the exercise of your responsibilities in order to address any matter associated with the treatment and death of Lucy. For the avoidance of doubt you should refer to all discussions, investigations or inquiries which you raised or undertook, as well as any steps taken by you to obtain any relevant documentation.

Having been telephoned on 14th April 2000 by Mr Hugh Mills, Chief Executive of Sperrin/Lakeland Trust [see reference to this in document 030.010.017 / LC-SLT(HM)], my responsibilities would mainly have included informing the Director of Health Care and Chief Executive of the contact from Mr. Mills regarding Lucy Crawford's death and any steps which were being undertaken by the S/L Trust Board, its Chief Executive and S/L Trust's Medical Director as conveyed to me by Mr Mills.

On 19th April 2000, it is recorded that Mr Bradley met with Mr. Mills to advise him further. I note from Mr. Mills' notes [reference above] that he further advised me that the "circumstances were still being examined" but I have no notes or recollection as to whether that was by a message or a telephone conversation.

On 21st April, Mr. Mills left a telephone message for me advising that he had asked Dr. Murray Quinn, Consultant Paediatrician at Altnagelvin Area Hospital, to review the Clinical notes relating to Lucy Crawford and provide advice to the S/L Trust. I do not recall any discussions with Mr. Mills in advance of him asking Dr. Quinn to conduct this review although he may have discussed this with Mr. Frawley or Mr. Bradley.

(7) It appears that on the 14 April 2000, following Lucy's death, Mr. Mills (Chief Executive of the Sperrin Lakeland Trust), made a report to you [Ref: 030-010-017]. Arising out of the report made to you, please address the following questions:

(a) What is your understanding of whether there was a requirement for the Sperrin Lakeland Trust to report Lucy's death to you? If there was a requirement, where did that requirement derive from?

While there may not have been any definitive requirement set out in relevant procedures or circulars for S/L Trust to report Lucy's death to the WHSSB, there would have been an expectation that any such occurrence would be reported to us as their major Commissioning body as well as the need for the

Trust to report this to DHSSPS who were their primary management authority.

(b) **What did Mr. Mills tell you about the circumstances of the death of Lucy?**
I can not recollect the detail of the conversation with Hugh Mills other than the information about Lucy having been admitted unwell, her collapse and treatment in the Erne Hospital and her transfer to Belfast and subsequent recording of death.

(c) **Having been informed of this death by Mr. Mills, what were your responsibilities as Director of Public Health, and where did those responsibilities derive from?**
My responsibilities, derived from my Job Role would have been to advise the WHSSB C.Ex. and D.H.C, the WHSSB and its Health Committee of Lucy's death and to work with Board managerial and professional colleagues to ensure that the S/L Trust had and were taking all appropriate steps to investigate the surrounding events. **[See also the response to Question 1 (e) above]**

(8) Following Lucy's death it would appear that you contacted the Sperrin Lakeland Trust to seek an update on developments that had occurred since Lucy's death. Dr. J. Kelly (Medical Director) wrote to you on the 15 May 2000 [Ref: 036a-046-098]. Arising out of this contact and correspondence please address the following matters:

(a) **Why were you interested in obtaining updated information from the Sperrin Lakeland Trust?**
As the major Commissioner of services from the S/L Trust, the WHSSB would have needed to be assured of the ongoing provision of services, including Paediatric services from that Trust. I was also aware of ongoing challenges for S/L Trust in securing adequate numbers of Paediatric staff and would have wanted to keep updated on any difficulties or progress with that. Also, the Chief Executive and the members of the WHSSB would have wished to keep apprised of the situation given the potential implications for the Commissioning of services and in order to be able to respond to any appropriate information requests from the Western Health and Social Services Council or the media.I would also have wanted to receive updated information on the progress of ongoing reviews of the events related to Lucy Crawford's death in order to keep professional and managerial colleagues within the WHSSB regularly updated on any related issues.

(b) **Having received updated information from Dr. Kelly, did you respond to his invitation to you to make any suggestions or additional comments that you might wish to make? If so, when did you respond, and what suggestions or additional comments did you make?**
I can not recall any detail of suggestions or comments I may or may not have made and, unfortunately, do not have any access to papers from that time.

(c) **At any time, did you provide the Sperrin Lakeland Trust with any advice about how they should be conducting their Review in relation to the death of Lucy? If**

so, what advice did you give and who was it provided to? If you did not provide any advice, please explain your omission to do so.
I have no recollection of the detail of any advice I may or may not have provided to Dr Kelly or other person within S/L Trust regarding their review although I am sure that there were regular conversations and discussions between staff of the Trust and the WHSSB, including me, about this. Trusts were independent entities responsible, managerially, to DHSS(PS) and responsible to the WHSSB primarily regarding Commissioning of services although I am sure that I would have discussed with Dr Kelly, following their initial review, the need for S/L Trust to consider having a wider review involving experts from outside the span of our area and settings/clinicians involved in any treatment roles. Mr Mills was an experienced C. Ex and Dr Kelly an experienced Medical Director, they were already in discussion with DHSSPS and I would have been aware that, should they wish to discuss any specific aspect of their review with me they would raise it with me. The absence of other specific advice was not an "omission".

(d) **Did you take any steps to ascertain why Dr. Kelly was of the view (as described in his letter) that Dr O'Donohoe felt personally responsible for this child's death? If so, what steps did you take, and what information were you given?**
Clinicians often feel personally responsible for a patient's death especially when it is unexpected and perhaps moreso in a younger person. I understood that there were concerns about documentation and clinical discussions about fluid management and the non-diagnosis of pneumonia/chest infection which might also have contributed to the child's condition. I was also aware that local clinicians and managers had considered whether Dr. O'Donohoe should continue to treat patients and had confirmed that he should. I have no recollection of any specific other issues followed up with Dr. Kelly.

(9) **Did the Western Health and Social Services Board receive a copy of Lucy's death certificate [Ref: 013-008-022]? If so, when was it received and was its contents brought to your attention?**
I do not recall a copy of Lucy's death certificate being sent either to me or to the WHSSB and shared with me and it would have been unusual for that to happen.

(10) **If the contents of the death certificate were brought to your attention, did you consider it, discuss it with anyone else or take any action in relation to it? Please provide a full account of any relevant consideration, discussion or action taken in relation to the death certificate.**
See answer to question 9 above.

(11) **If you considered the contents of the death certificate, did you recognize any incongruity in the fact that it was certified that Lucy had died from cerebral oedema due to or as a consequence of dehydration? If you did recognize an incongruity in this certificate, did you take any action in relation to it?**
See answer to Question 9 above.

(12) Did the Western Health and Social Services Board receive any part of the post mortem report in relation to Lucy, whether the provisional report, the final report, or the part that was added in November 2003 [Ref: 013-017-054]? If so, when was any part of the report received, and was its contents brought to your attention?

I do not recall a postmortem report having been received by the WHSSB and it would be unusual for that to happen in any clinical incident other than as part of a wider report provided into such an incident at a much later time. It is possible that it was but I certainly do not have any memory of this happening.

(13) If the contents of the post mortem report (or any part of the report) were brought to your attention, did you consider it, discuss it with anyone else or take any action in relation to it? Please provide a full account of any relevant consideration, discussion or action taken in relation to the post mortem report.

See response to Question 12 above.

(14) If you considered the contents of the final post mortem report (before it was added to in November 2003), did you have any concern that there was an absence of a definitive explanation for the cause of the cerebral oedema? If so, what were your concerns and did you take any action in relation to them?

See response to Question 12 above.

(15) It would appear that the Sperrin Lakeland Trust provided you with a copy of the 'Report Re: Review of Lucy Crawford Case' [Ref: 033-102-264]. Please address the following matters arising out of this report:

(a) What conclusions did you reach upon reading the Review report?

I, unfortunately, do not have access to any WHSSB records from that time. I believe that a search/trawl of WHSSB records both, electronic and paper, may have been carried out at the time of the initiation of the O'Hara Inquiry but I am not aware of what was found or whether/where that is still available. I have no personal records from that time as those would have been retained within the WHSSB. My best recollection regarding conclusions is as follows - 1. That the range of issues explored was appropriate. 2. That the range of staff involved/contributing to the review was appropriate. 3. That issues of concern had been identified regarding unclear/poor documentation, staff communication and a lack of desirable/necessary protocols and were to be addressed. 4. That the specific Cause of Death and Cerebral Oedema were still unclear and that further work/review would be desirable to resolve this.

(b) Did you make any formal or informal response to the Trust in relation to their Review report? If so, when did you make a response, who did you make the response to, in what form did you make a response and what did you say in your response?

See above response to (a). Any formal response would have been made by the WHSSB or the Health Care Committee. I am not sure whether I made any written personal response to the Review report given my lack of availability of records from that time, but I am sure that I would have

discussed the issues arising with Dr Kelly and/or Mr Fee. The opinion regarding appropriate fluids referred to comparing the type of fluid used with that which would have been used in RVH/RBHSC wards but, at that time, my understanding is that APLS guidelines would still have referred to the use of Solution 18 as had been previously mentioned by Dr Quinn.

(c) **Did you discuss any matter relating to Lucy's treatment and death with the Sperrin Lakeland Trust after receiving the Review report? If so, what did you discuss and who did you discuss it with?**
See above response to (a).

(d) **Did you identify any weaknesses in how the Review had been conducted? If so, what weaknesses did you identify and did you discuss them with the Trust?**
See above response to (a).

(e) **Did you identify any weaknesses in the overall conclusions or findings of the Review? If so, what weaknesses did you identify and did you discuss them with the Trust?**
See above response to (a).

(f) **The Review report contained the following conclusion:**
"Neither the postmortem result or the independent medical report on Lucy Crawford, provided by Dr. Quinn, can give an absolute explanation as to why Lucy's condition deteriorated so rapidly, why she had an event described as a seizure at around 2.55am on 13 April 2000, or why cerebral oedema was present on examination at postmortem." **[Ref: 033-102-265]**

Please address the following matters arising out of that conclusion:-

(i) **Did you have any concerns about the fact that neither the Review nor the post mortem had established an "absolute explanation" for the cause of Lucy's deterioration and cerebral oedema? If so, what concerns did you have, and clarify whether you took any steps to address those concerns?**
It was obviously very unsatisfactory for both the parents and the involved clinicians that no absolute explanation had been found either in the review or the postmortem but I was and am conscious that there are occasions, particularly where the clinical issues are physiological rather than anatomical, where an absolute explanation for a death is not found.

(ii) **In the absence of an absolute explanation for the cause of Lucy's deterioration and cerebral oedema, did you give any consideration to taking any of the following steps:**

- **Suggesting to the Sperrin Lakeland Trust other steps to take in order to bring clarity to the cause of the deterioration and the cerebral oedema**
  See response to 8(c) above.

- **Checking whether an Inquest was planned**
  That was an issue for the S/L Trust to address rather than the WHSSB or me.

- **Reporting the matter to the Coroner, discussing the case with him and suggesting that an Inquest should be arranged**
  That was an issue for the Medical Director and involved clinician/s to address.

- **Contacting the Royal Belfast Hospital for Sick Children to seek the views of the treating clinicians there, or suggesting that the Sperrin Lakeland Trust did so**
  That was primarily an issue for the S/L Trust and DHSSPS to consider although I did discuss with S/L Trust staff the advisability of having a wider outside expert review.

- **Arranging for the WHSSB to carry out its own investigation or review.**
  Given the actions already underway and the S/L Trust's managerial relationship to DHSS(PS) I would not have advised WHSSB to initiate a further review, although that would have been a matter for the WHSSB as a whole to consider and decide rather than me, as DPH. There can be problems with too many reviews of one event creating confusion and getting in each other's way.

Please describe the consideration which you gave to taking any of these steps and state precisely what steps, if any, that you took. If you did not take any one of the particular steps suggested above, please explain your omission to do so.

(16) On the 27 June 2001 [Ref: 036a-028-069] Dr. James Kelly (Medical Director, Sperrin Lakeland Trust) sent to you a copy of a report prepared by the 'Royal College of Paediatricians' in relation to concerns raised about the competency of Dr. J. O'Donohoe [Ref:036a-025-052], and the notes of a subsequent meeting between Dr. Kelly and the report's author, Dr. Stewart [Ref: 036a-027-067].

Arising out of that correspondence, please address the following matters:

(a) Did you give any consideration to the commentary contained in the report and in the meeting notes relating to the treatment and death of Lucy? If so, what consideration did you give to those issues and what conclusions did you reach?

I have no access to documents/records of any action I took at that time. I think that a trawl of WHSSB papers was conducted when the O'Hara Inquiry was set up and it is possible that some papers may have been recorded then. It was my practice to analyse such reports and develop a detailed analysis in order that any relevant points could be reported to and discussed with the C. Ex., D.H.C. and the Board and its Health Care Committee.

(b) The notes of the meeting between Dr. Kelly and Dr. Stewart highlighted that the "rate of change of electrolytes may have been responsible for the cerebral oedema" and a question was raised about the appropriate fluids to use for replacement. Did you consider this note and expression of opinion, and if so what conclusions did you reach in relation to it?

See above response.

(c) **Dr. Kelly asked for your comments, and you replied by suggesting that you would be happy to discuss the issues arising from the report with him [Ref: 036a-029-070]?**

Did you and Dr. Kelly meet to discuss the report to the extent that it concerned the treatment and death of Lucy? If so, when did you meet and what was discussed? If you hold a record of any such meeting, please provide a copy.

I believe that Dr Kelly and I did meet to discuss the report but I do not have access to any record of that meeting which would have been part of official Western Board records and retained by them on my retirement. I think that meeting took place after another meeting on a different issue, possibly at WHSSB offices which both Dr Kelly and I were attending but I cannot be absolutely sure of that. I would have been conscious, at that time, of Dr Kelly's and Sperrin/Lakeland's concerns to ensure Dr O'Donohoe's ongoing professional competence and that Dr Kelly had actions regarding that in hand.

(d) **Did you take any action in relation to the death of Lucy, on foot of receiving this report and the notes of the meeting? If so, please describe the steps that you took.**

It would have been usual practice for me to discuss it with the C. Ex. of the W. Board and to consider whether there were issues which needed to be brought to the attention of the WHSSB and/or the W. Board's Health Care Committee but I cannot, in the absence of access to the necessary records confirm any detail of this.

(17) **On the 5 July 2001 you corresponded with Dr. Fulton (Medical Director Altnagelvin H&SST) [Ref: 012-039-191], and the Directors of Public Health [Ref: 012-039-192], in relation to the implications of the death of Raychel Ferguson for fluid management in paediatric settings in Northern Ireland.**

Please address the following matters arising out of this correspondence and your knowledge of the circumstances of the death of Raychel Ferguson:

(a) **In your correspondence to Dr. Fulton you referred to a recent meeting of the Directors of Public Health [Ref: 012-039-192]. Who attended at that meeting, and advise whether any representative of the DHSSPS or the office of the Chief Medical Officer was in attendance?**

I was contacted by Dr Raymond Fulton, Medical Director of Altnagelvin Hospital Trust around 22nd/23rd June 2001. Dr Fulton indicated that he was concerned about the wider implications of events relating to the death of Raychel Ferguson. He indicated that there had been a review of the events involving a wide range of Staff involved. As a result of this, and a review of relevant information, Dr Nesbitt, in particular, was concerned that the use of an intravenous solution, Solution 18, may have resulted in the child developing hyponatraemia,

Dr Fulton advised me that Dr Nesbitt had contacted anaesthetic colleagues in other acute Trusts across Northern Ireland to acquaint them of his concerns and had

confirmed that there were other Trusts in Northern Ireland using Solution 18 in paediatric surgical patients.

Dr Fulton told me that he had informed Medical Director colleagues of the position and concerns at a scheduled Meeting of Medical Directors with the CMO/Medical Branch. This Meeting was one of a regular (usually monthly) series of Meetings. The CMO was not at this Meeting, which had been chaired by the Deputy CMO.
Dr Fulton indicated that he had then rung Dr Campbell, CMO, to indicate his concerns about the events relating to Raychel's death and the wider risk across Northern Ireland.

I agreed to raise this issue at the next meeting of the CMO/DsPH which was due very soon and the need for Paediatricians, Surgeons and Anaesthetists to develop agreed Guidelines on the use of I.V. fluids in paediatric surgical patients.

I wrote to Mr. Fee, Director of Acute Services in Sperrin Lakeland Trust, outlining the concerns and indicating that he should advise Paediatricians, Surgeons and Anaesthetists in that Trust and that, if further clinical detail or information was needed, they should contact Dr Nesbitt or Dr Fulton. I have been unable to locate a copy of my letter to Mr. Eugene Fee. I also indicated that I would contact relevant Staff in Sperrin Lakeland Trust to ensure that they were aware of the concerns, although Dr Fulton did indicate that Dr Nesbitt had already spoken with relevant colleagues there.

I raised the issue at the regular Chief Medical Officer/Directors of Public Health Meeting on 2nd July 2001. This was the usual method, at that time, of raising professional or clinical concerns which had arisen in any one Board, but which, potentially, had wider relevance. The issue was discussed and then it was agreed that regional guidance on the avoidance of hyponatraemia and the use of I.V. fluids in children should be produced and that relevant Anaesthetists, Surgeons and Paediatricians should be brought together by DHSSPS for this.

Following this, I wrote to Dr Fulton on 5th July 2001, to confirm that I had raised the issue for discussion and that the three other Directors of Public Health had agreed to alert relevant staff in their Boards to the concerns raised within the Western Board. See pages 026-006-007 and 026-015-029.

I am aware that the Chief Medical Officer/DHSS(PS) arranged for Guidelines regarding Hyponatraemia to be developed for use across Northern Ireland and these were issued in June 2002.

(b) What were you told about the circumstances of the death of Raychel Ferguson at that meeting of the Directors of Public Health, and who provided that information to you? In particular please clarify whether you were given any information about the relationship or suspected relationship between that death and the use of No 18 solution?

See answer to (a) above. My recollection is that I brought the issue of the circumstances of Raychel's death to the CMO/DsPH meeting and raised the

concern that there may be an issue with the use of No. 18 solution in children. I cannot recollect the rest of the discussion but that should be available in the minutes of that meeting. I have no access to that documentation now.

(c) **You indicated [Ref: 012-039-192] that you were aware that "that some paediatric settings within Northern Ireland have made appropriate changes [to fluids]..." Were you informed about the circumstances or the factors which led the Royal Belfast Hospital for Sick Children to change its guidelines in relation to the use of No 18 solution? If so, what were you told and who provided you with this information?**

I believe that this information was provided to me by Dr. Fulton, Medical Director of Altnagelvin Trust when he was informing me of Raychel Ferguson's death and we were discussing the need to have the issue raised widely within Northern Ireland.

(d) **Having been told about the death of Raychel Ferguson, did you give any consideration to whether there were any similarities between the cause of her death and the cause of Lucy's death? If so, what consideration did you give to that issue and what conclusions did you reach? If you discussed this issue with anyone else as part of your consideration of the issue, please identify who you discussed it with.**

See answers to (a) and (b) above.

(18) By June/July 2001, in light of your knowledge of the circumstances of both Raychel's and Lucy's death, did you give consideration to taking any of the following steps in relation to the death of Lucy, and if so, what steps did you take:

(a) **Ascertaining whether her death would be subject to an Inquest;**

(b) **Reporting her death to the Coroner;** Both (a) and (b) are matters for the Trust, Medical Director and/or the involved clinician to deal with.

(c) **Establishing your own external enquiry;** That would have been an issue for the WHSSB to consider, not for a DPH and, as the issue was already being dealt with by the Trust and DHSS(PS), a further additional inquiry would probably not have been considered useful at that time by the WHSSB.

(d) **Any other step?** I recall that the need for a better defined and more formal mechanism for raising, discussing and circulating information about events/incidents of wider implication was raised and discussed at that time but I cannot recollect in which setting or committee at DHSS(PS) this was mooted.

If you did not give consideration to any one of these steps, please explain your omission to do so.

(19) **As part of the litigation process which had been instigated by Lucy's family, Sperrin Lakeland Trust, through its legal representatives, obtained a medico-legal report from Dr. John Jenkins, in which he made the following observations:**

"[evidence of changes in Lucy's serum electrolytes] do raise the question as to the fluid management in the period from insertion of the IV line at 2300 to the collapse at around 3.00am." **[Ref: 013-011-038]**

"[w]hile no definite conclusions can be drawn regarding the cause of this child's deterioration and subsequent death there is certainly a suggestion that this was associated with a rapid fall in sodium associated with intravenous fluid administration and causing hyponatraemia and cerebral oedema." **[Ref: 013-011-039]**

(a) Were you provided with a copy of this report or apprised of its contents? If so, please state when you were provided with a copy or apprised of its contents?
I do not recall being provided with a copy of that report or having seen it. It is possible that, given that this document was related to the S/L Trust's medico-legal processes, it might not have been copied to the WHSS Board.

(b) If you were provided with a copy of the report or apprised of its contents, did you take any action, and if so, what action did you take?
See answer to Question 19a above.

(20) **On the 7 August 2002, Dr. Boon and Dr. Stewart sent Dr. Kelly their report in respect of the Royal College of Paediatrics and Child Health External Review concerning aspects of the practice of Dr. O'Donohoe. The report addressed the death of Lucy in the following terms:**

"With the benefit of hindsight there seems to be little doubt that this girl died from unrecognized hyponatraemia although at that time this was not so well recognised as at present" **[Ref: 036a-150-312].**

(a) Were you provided with a copy of this report or apprised of its contents? If so, please state when you were provided with a copy or apprised of its contents?
I do not recall being provided with a copy of that report or being apprised of its contents.

(b) If you were provided with a copy of the report or apprised of its contents, did you take any action, and if so, what action did you take?
See answer to question 20a above.

III.Other Matters

(21) **Have you or the Western Health and Social Services Board learned any lessons or changed any practice arising out of your experience of involvement in the processes of inquiry into the treatment and death of Lucy Crawford, or any other matter related to her death? If so, fully describe the lessons that have been learned or the changes in practice which have occurred.**

The Western Health and Social Services Board and the 3 other Boards were stood down in August/September 2009 and replaced with the PHA . The need for a rapid dissemination of events of wider import was discussed by DHSSPS and related circulars and processes were implemented by them.

(22) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The cause of Lucy's death;
No further points or comments

(b) The role performed by you, the Sperrin Lakeland Trust or the Western Health and Social Services Board when reviewing or investigating issues relating to: the cause of Lucy's death;
I feel it would be important to also include the role of DHSSPS in the overall consideration of the issues.

(c) The procedures which were followed when reviewing or investigating issues relating to the cause of Lucy's death;
No further comments.

(d) Lessons learned from Lucy's death and how that affected your practice;
No further comments

(e) Any other relevant matter.
I think it is very important for the Inquiry to be clear about the respective roles of DHSSPS, Trusts and the Health and Social Services Boards at the time of these events as there appears to be a clear danger of a misunderstanding that there was a direct managerial relationship between the Boards and Trusts which was not the case.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF
Signed:  **Dated:** 5th December 2012.

POST OF DIRECTOR OF PUBLIC HEALTH

JOB DESCRIPTION

The Director of Public Health will lead and mange the Public Health Medicine Department of Consultants and Specialist Registrars.

The roles of the DPH are:

a) Delivering on the PHM inputs to the Commissioning/Planning of services, ensuring the delivery of the Statutory Functions delegated to him/her on behalf of the Board and delegated to the Board but which need essential PHM inputs and the essential Contribution to Health Promotion/Development both within Health and Personal Social Services and Intersectorally.

b) To be a Member of the Board's Senior Management Team.

c) Ensuring that the Staff within his/her Department are supported, developed and enabled to deliver their roles while, at the same time, that they deliver on their defined responsibilities. This includes the need for them to be appraised regularly both formally and informally. This includes ensuring that their development needs, professional and personal, are identified and opportunities are secured to meet these and that their CME/CPD profiles are up-to-date and met.

d) Ensuring that the PHM Department objectives overall and the individual workplans and objectives of Staff are consistent with the Board's corporate and organisational objectives or that any mismatch is resolved. This will include ensuring that the professional inputs of Staff to key Regional or other initiatives are included in this equation. It also includes ensuring that the PHM Department delivers across the ten Public Health competencies and meets professional expectations.

e) Advocacy and leadership on behalf of the health of our resident population. Reporting regularly to the Board, the public and other organisations who can affect health and social well-being on the key issues of health importance.

f) Public Health adviser to the Board, accountable to the Chief Executive.

g) Ensuring that the three Domains of Health Protection, Health Promotion/Improvement and Service Development/Health & Social Care Quality are given due importance and balance in the Board's work and that there are good links between the 4 Boards, with the DHSSPS and with Trusts and Primary Care regarding these 3 Domains of Public Health work.

h) Working through Intersectoral Partnerships to improve health and reduce health inequalities.

i) Working with local communities to improve the understanding of health issues and to develop their capability and capacity to address their health challenges.

j) Working with Public Health and related networks to share expertise, knowledge and examples of good practice.