Witness Statement Ref. No. 287/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Eugene Fee

Title:

Present position and institution:
Retired May 2005

Previous position and institution: Director of Acute Hospital Services and Director of Nursing, Sperrin Lakeland Health and Social Care Trust
[As at the time of the child's death]

Membership of Advisory Panels and Committees: None
[Identify by date and title all of those between January 2000 – August 2012]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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, Career and Training

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

State your nursing and professional qualifications, and the date on which they were obtained.
Registered Mental Nurse – Feb 1974, Registered General Nurse – July 1976

(a) State the date of your appointment to the post of Director of Acute Hospital Services, 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.

Director of Acute Hospital Services and Director of Nursing – January 1997 until May 2005 (retired) – copy of Job Descriptions attached
Acting Director of Acute Hospital Services, Sperrin Lakeland HSC Trust, April 1996 – Jan 1997
Director of Acute Hospital Services, Sperrin Lakeland Management Unit, Aug 1995 – March 1996
Assistant Unit General Manager, WHSSB Area Mental Health Unit, August 1990 – July 1995
Acting Assistant Director of Nursing, Belfast City Hospital, August 1989 – April 1990
Nursing Officer, Belfast City Hospital, January 1986 – August 1990
Charge Nurse, Purdysburn Hospital, December 1977 – December 1885
Staff Nurse, Purdysburn Hospital, June 1976 - December 1977
Post Reg. Student Nurse, Belfast City Hospital, September 1974 – June 1976
Staff Nurse, Purdysburn Hospital, February 1974 – September 1974
Student Nurse, Purdysbury Hospital, July 1990 – February 1974

(b) Describe your duties and responsibilities in the role of Director of Acute Hospital Services and provide a copy of your job description.
Copies of Job Descriptions attached

(c) Please explain what responsibility, if any, you had for clinical governance at the Erne Hospital and/or within the Sperrin Lakeland Trust, and if applicable, outline how you exercised this responsibility?
As the operational Director for Acute Hospital Services and Executive Director of Nursing, I shared the responsibility for the overall management of the Trust through the Senior Management Team and the Trust Board. I had developed a Clinical Directorate structure for

the management of the hospital services and had a professional forum for nursing and a nurse management structure through which I provided direction and leadership across the full range of nursing services within the Trust. I also chaired a number of committees including the Infection Control and Ethical Committees that played a role in setting and monitoring clinical standard.

(d) In any case where a patient had died at the Erne Hospital, and where that death was unexpected and unexplained, what were your particular responsibilities, and where did those responsibilities derive from?

There was no set arrangement for the management and follow-up of such incidents at that time in N. Ireland. Interim guidance was released by the DHSSPSNI in June 2004.

In such circumstances the event would be reported through the management system to include reporting it to the Director of Acute Hospital Services. The manager for the area would have completed and submitted a Clinical Incident Report. As a matter of routine I would have discussed the death with the Medical Director and the Chief Executive or his Deputy in the event of him being absent for any reason. I would also advise the Commissioner of Services for the area within which the patient was resident. Normally following discussion between the parties above and the Clinical Director a decision would be taken in relation to the need for a review of the case and who would be involved. Such reviews normally included a review of the case files and seeking accounts of the circumstances relating to the care of the patient from those involved in the delivery of that care. In some cases an external opinion or input would be sought. I was involved on a number of occasions of seeking such an external input and briefing them on what input we required. I would also been responsible for updating relevant senior officers in the Trust and at Commissioner level.

(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?

I have no recollection of receiving any formal education or training in the area of the appropriate management of fluids in paediatric cases. I did have a children's surgical placement during my general nurse training.

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

(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,

I had no advice, training or education to inform me of the issues relating to hyponatraemia in paediatric cases.

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

(4) Prior to April 2000, describe in detail your experience of dealing with cases of hyponatraemia, including the

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

Prior to April 2000 I have no recollection of experience of dealing with cases of hyponatraemia.

(b) Nature of your involvement.

(c) Outcome for the children.

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

I have had no experience of dealing with children with hyponatraemia since April 2000.

(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.

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

(6) Fully describe the key features of the Trust's arrangements for Clinical Governance and state, Clinical Governance arrangements were established within the Trust after the adoption of Best Practice Best Care in N Ireland, 2002. From recollection I think the Trust was starting to give consideration to the structures and processes they would put in place for the management of Clinical and Social Care Governance around 2000. Prior to the establishment of these structures and arrangements they managed various elements such as Infection Control and Clinical Incidents through committees. These were later managed under the Clinical and Social Care Governance arrangements established.

(a) **Did those arrangements apply in Lucy's case?**
Yes

(b) **If so, how were the arrangements for Clinical Governance applied in Lucy's case?**
A Clinical Incident Report was completed and submitted by Mrs. Millar, Clinical Services Manager for the Women & Children's Services and a review of the case was commenced.

(c) **Were any arrangements in place by which incidents (such as the death of Lucy) would be examined by or within the Trust's management processes? If so, please explain those arrangements and how they operated in relation to the death of Lucy.**

Please refer to response at 1D

(7) **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.**
I do not have access to a my diary for the period, but from records available actions included the following steps;
14/4/2000 - Advised by Dr. Kelly, Medical Director of the death and he requested that a review be established.
Met with Dr Anderson, Clinical Director and agreed joint co-ordination of review
Rang Dr. Hamilton, WHSSB to advise him of the death
Discussed actions with Mr. Mills Chief Executive
17/18/4/2000 Dr Anderson and I met with staff to advise them of the planned review and offer support.
Telephoned Ms. Marian Murphy, Health Visitor Manager to establish which Health Visitor was involved with the Crawford family.

18/4/2000 Contacted Mrs. Martin, Infection Control Nurse to seek information on acute viral gastroenteritis and Rota virus.
19/4/2000 Met with Dr Anderson to review clinical notes and agree action plan.
20/4/2000 Telephoned Mr. Mills to advise of case note review and that we had decided that we needed a Pediatrician input. We agreed that I would contact the family's Health Visitor to request that she would visit the family and offer them support.
Mr. Mills later advised that Dr. Quinn, Altnagalvin Hospital had agreed to have an input.
21/4/2000 Phoned Mrs. Doherty, Health Visitor and requested that she visit the family to offer support and to advise them of the planned review and to propose to arrange a meeting with relevant clinician to share information with them.
Letters drafted to nursing staff involved in care to request a written report on their input.
Telephoned Dr. Quinn to set out the background and confirm request for input into review.
Letter drafted to Dr Quinn setting out request for input and areas that we would welcome his opinion. Letter and relevant case notes prepared for postage.
27/4/2000 Met with Str. Traynor and S/N Swift in Ward
Telephone conversation at 10pm with S/N McManus
Updated Mr. Mills re conversation with Dr Quinn and contact with Health Visitor Doherty.
28/4/2000 Meeting with Dr. Anderson and Mrs. Millar, Clinical Services Manager - discussed review
2/5/2000 Telephone feedback from Dr. Quinn.
5/5/2000 advised Mr. Mills that family had met with Dr. O'Donohoe

10/5/2000 Met with M. Bradley WHSSB, Commissioner and Chief Nurse brief him re case
12/5/2000 Mr. Bradley visited Erne Hp. To met me and visit staff on ward.
Met Dr. Anderson and Mrs. Millar, discussed review
16/5/2000 Met Mr. Mills, discussed review
26/5/2000 Updated Mr. Mills
6/6/2000 Met Dr. Kelly and discussed review
9/6/2000 Met with Dr O'Donohoe
10/6/2000 letter sent to S/N McManus
20/6/2000 Met with Dr Kelly, planned for meeting with Dr Quinn on 21/6/2000
21/6/2000 Dr Kelly and I met with Dr. Quinn at Altnagelvin to discuss his verbal feedback on review of case notes.
26/6/2000 Received written report from Dr Quinn
5/7/2000 Memo to Dr Anderson enclosing draft report
6/7/2000 letter of thanks sent to Dr Quinn
20/7/2000 Letter received from Dr Anderson providing feedback on draft report
24/7/2000 Met with Dr. Kelly, discussed review
31/7/2000 Met with Dr Anderson, final report agreed.

(8) **It appears that following Lucy's death you made a report to Dr. Hamilton of the Western Health and Social Services Board [Ref: 033-102-286]. Please address the following matters:**

(a) **Who is Dr. Hamilton and what was his/her role at the time?**
Dr Hamilton was a Medical Consultant employed by the WHSSB and was part of the commissioning team for acute hospital services.

(b) **Why did you report Lucy's death to him/her?**
It would have been common practice to advise the commissioner of untoward events or matters that affected the delivery of services

(c) **What did you tell Dr. Hamilton about the circumstances of Lucy's death?**
I don't recall the detail of our conversation, but the note states that I informed him of Lucy's death and of the press interest.

(d) **What other matters did you bring to Dr. Hamilton's attention?**
I don't recall the details but I am sure that I would have advised him of the Trust's intention to review the case.

(9) **State precisely why the Sperrin Lakeland Trust decided that it was necessary to carry out a Review in respect of Lucy Crawford?**
I don't recall the details, but it would have related to the sudden deterioration in Lucy's condition and the unexpected death.

(10) **Describe your role and responsibilities in the conduct of the Review?**
I was asked to jointly conduct the review.

(11) **Describe the role of Dr. T. Anderson in the conduct of the Review? Identify any differences between his role and your role?**
Dr Anderson agreed to jointly conduct the review.

(12) **Did you or any colleague seek advice or guidance in relation to how to conduct the Review, such as through the British Association of Medical Managers, or any other source?**
I don't recall seeking specific guidance as outlined above and I am not aware if any of my colleagues sought such advice.

(13) **Did you carry out the Review by following any guidance, instruction or protocol, whether written or unwritten? If so, please describe the guidance, instruction or protocol you were following, and if it was contained in a written document, please provide a copy.**
There was not specific protocol or instruction in use at that time.

(14) **Ms. E. Millar completed a Critical Incident Report form in which she recorded that she spoke to you and Dr. Anderson after a Nursing Sister had contacted her to report concerns about the fluids prescribed/administered to Lucy. [Ref: 036a-045-096]**

Please address the following questions arising out of the Critical Incident Report:

(a) **When you spoke to Ms. Millar did you seek to establish more precisely the nature of the concerns that had been expressed to her by the Ward Sister? If so, what did you establish?**
I don't recall the conversation but note from the Clinical Incident Report that Mrs. Millar recorded that she had received the information from the Ward Sister and that concern had been expressed about the fluids prescribed/administered. Sister Traynor was the Ward Sister for the Children's Ward at that time. I am sure that I would have explored the nature of the concern in more detail at the time and this issue was the subject of exploration during the review of the case.

(b) **Were you able to establish through Ms. Millar or otherwise who it was that had expressed concerns about the fluids that had been prescribed/administered to Lucy?**
I don't recall the discussion with Mrs. Millar but from the Clinical Incident Report the concern appears to have been raised by Sister Traynor.

(c) **What steps did you or any colleague take as part of the Review to investigate the concerns that had been expressed to Ms. Millar?**
I met with Sister Traynor and S/N Swift on 27 April 2000 and the note I had typed of the discussion focused on the level of documentation of the intended fluid replacement and the accuracy of recording of the IV fluids given.

(d) **What were the specific concerns that had been expressed?**
The absence of a prescription for the fluids.

(e) **Were those concerns documented in the Review report or elsewhere? If so, please refer to the relevant document where those expressions of concern can be found. If they weren't documented, please explain the omission to do so.**
I do not have a document to hand that outlines these concerns as outlined at 14(d) but a typed note of the meeting with Sister Traynor is contained at 033-102-295.

(15) **Between the 17 and 18 April you and Dr. Anderson met with various members of the nursing and medical team which had cared for Lucy. You also met with Sister Edmunson [Ref: 033-102-285].**

(a) **What did you tell staff during these meetings?**

I do not recall the detail of the discussions but the purpose of the meetings was to advise them of the intent to conduct a review and to offer them support.

(b) **At those meetings did you learn any more about the circumstances of the deterioration in Lucy's condition, and what might have caused it? If so, what did you learn?**
I don't recall if any further details about the circumstances was learnt at the meeting.

(c) **It would appear that Sister Edmunson was not part of the team that treated Lucy in the Erne Hospital? If that was the case, what was the purpose of meeting with her on the 17/18 April?**
Sister Edmunson was the Night Sister for the hospital on the night concerned and had visited the Children's Ward during Lucy's care.

(16) **It would appear that on the 19 April that you and Dr. Anderson met to review the case notes and to agree an action plan [033-102-285 &-286].**

Arising out of that process please address the following:

(a) **Please clarify whether each of the steps which you recorded as forming part of that action plan were in fact carried out?**
Yes, I believe that all the actions were carried out.

(b) **Please outline how you carried out any that was taken as part of the action plan, and state the date by which each such step was taken and completed.**
The detail of dates for the various actions is outlined at No. 7

(c) **If any particular step of the action plan wasn't carried out, please explain the omission to do so.**

(d) **What conclusions did you and Mr. Fee reach from the review of the case notes?**

Dr Anderson and I concluded that we needed a Paediatrician opinion on the treatment given in particular relating to the appropriateness of the fluids given during Lucy's admission.

(17) **Mr. Mills has recorded the following entry for the 20 April:**

"Mr. Fee advised that the patient's notes recorded a comment from Dr. O'Donoughoe (sic) that he was uncertain about the instructions he gave staff about the rate of flow of i.v. fluids. Child had been given 100 mls per hour for four hours. He states he meant this to be 100 mls per hour for the first hour and 30 mls per hour thereafter. However, when child collapsed anaesthetic support had prescribed more fluids. Post mortem results indicated cerebral oedema. Mr. Fee felt he required advice from a paediatrician." **[Ref: 030-010-017]**

Arising out of this note please address the following:

(a) **Does the note accurately record what you told Mr. Mills?**
I am not sure if it records the exact wording, but from memory it reflects the issue discussed.

(b) **Did you at any time speak to Dr. O'Donohoe about the comment recorded by him in Lucy's notes? If so, what did you ask him about the comment recorded in the notes and how did he respond?**

Dr. O'Donohoe provided his report to Dr. Anderson. I don't have any recollection of speaking to Dr. O'Donohoe about this issue

(c) **Did you at any time ask Dr. O'Donohoe to provide you with his understanding of the implications of giving Lucy fluids of 100mls/hr when he claimed that he had intended that fluids would be infused at a lower rate? If so, when did you ask him about this and what did he say?**
I don't recall having asked Dr. O'Donohoe for an opinion on this matter.

(d) **Please explain how you reached the conclusion that it was anaesthetic support that prescribed more fluids? If your conclusion was informed by any particular note or record, please identify that note or record.**
I don't recall and I do not currently have records to confirm the source of this information, but I note that there are some references in the case notes and fluid balance sheet (043-039) to the fact that normal saline was commenced at 3.00am on 13/4/2000.

(e) **How were you informed of the post mortem results showing cerebral oedema?**
Dr. O'Donohoe submitted a summary of the PM results with his report to Dr. Anderson. I understand he acquired this from the GP.

(f) **Please explain why you felt that you needed advice from a paediatrician?**
I think the main reason was that Dr. Anderson and I felt that we did not have the expertise to make a judgment on the appropriateness of the prescribed treatment.

(18) **Describe your understanding of the role and responsibilities of Dr. Quinn within the Review process?**
To undertake a review of the case notes and offer an opinion on the issues set out in the letter of 21 April 2000

(19) **Mr. Mills' note for the 20 April 2000 went on to record that you had agreed to make contact with a manager so that the Crawford's health visitor could be identified [030-010-018].**

Please address the following matters:

(a) **Did you and Mr. Fee reach any view in relation to what the Health Visitor would be expected to communicate to the family about the nature of the Trust's examination of the circumstances of the death?**
To offer the family support, advise of the intended review and propose to arrange a meeting with relevant clinicians later to share information

(b) **Was the Health Visitor given any particular "message" or information to pass on to the Crawford family?**
Yes, See above

(c) **What is your understanding of what the Health Visitor actually told the family about the nature of the Trust's examination of the circumstances of the death?**
I don't know what the Health Visitor actually told the family but believe it reflected the intended information as set out at 19 (a).

(20) **The briefing letter that you sent to Dr. Murray Quinn on the 21 April 2000 can be found at [Ref: 033-102-296]. Please address the following:**

(a) **Who drafted this briefing letter?**
I drafted the briefing letter.

(b) **If you drafted the briefing letter, were you provided with any assistance in doing so? If so, who provided this assistance?**
I believe that I discussed the contents with Dr. Kelly Medical Director and Dr Anderson.

(c) **What did you mean when you used the phrase "initial review of events"? In particular please explain whether you envisaged that some further steps would be taken after an initial review of events?**
I don't recall why I used these words, but suspect that at the time we were unsure of what other action would be required until we received his opinion.

(d) **Identify the person(s) who identified as relevant the issues which were raised for Dr. Quinn's consideration set out at 1, 2 and 3 of this briefing letter?**
I think it was Dr. Anderson and Dr. Kelly and I.

(e) **Please explain your understanding of why those particular issues (1, 2 and 3) were isolated and raised for Dr. Quinn's consideration.**
I don't recall exactly, but at that stage we had become aware that the post mortem had identified cerebral oedema.

(21) **Did Dr. Quinn indicate to you or any colleague that he was not prepared to perform any of the following tasks as part his involvement with the Review:**
No, but he was not asked to prepare the report for medical/legal purposes

(a) **Prepare a report for a complaints procedure;**

(b) **Prepare a report for medical/legal purposes;**

(c) **Interview the doctors involved;**

(d) **Interview the nurses;**

(e) **Interview the family.**

If he did raise with you any of these restrictions around his involvement, please state when he did so, state what reasons he gave and indicate what response, if any, you made to him.
I don't recall him raising any of the above restrictions.

(22) **Dr. Quinn told the Police Service of Northern Ireland that he recommended to the Trust that it should obtain an opinion from a Consultant Paediatrician from outside the Western Health and Social Services Board area [Ref: 115-041-002], if it required a Paediatrician to interview staff and prepare a medico-legal type report.**

Was this view expressed to you?
I don't recall this being raised with me and there is no reference to such a recommendation contained in his medical report dated 22 June 2002.

(23) **Having raised for Dr. Quinn particular questions in relation to the implications of the fluids which had been administered to Lucy, please clarify what steps, if any, were taken as part of the**

Review to establish the following information and provide it to Dr. Quinn, and refer to the document from which Dr. Quinn could have extracted that information:

I believe that Dr. Quinn was provided with a copy of all the care records relating to that admission including the fluid balance chart. I also believe that the footnote contained on the record of the verbal feedback from Dr. Quinn (033-102-287) was communicated to Dr. Quinn.

(a) The time when the infusion of Solution 18 commenced

(b) The rate at which the Solution 18 was administered

(c) The time at which Solution 18 was stopped

(d) The total volume of Solution 18 that had been given

(e) The time at which Normal Saline commenced

(f) The rate at which Normal Saline was administered

(g) The total volume of Normal Saline that had been given

(h) Whether Lucy was 'shocked'

(i) The time at which Lucy's pupils were first found to be fixed and dilated

(j) The time at which bloods were taken for electrolyte analysis and sent to the lab

(k) The time at which biochemistry results were available on the ward

(24) Nurse Swift wrote to you on the 18 May 2000 [Ref: 033-102-320] in relation to the entries that were made on the Daily Fluid Balance Chart. Please explain whether Nurse Swift's report satisfactorily clarified for you the volume of fluid administered to Lucy? If not, did you or any colleague take any further steps to clarify the position with Nurse Swift or any other member of the nursing or the medical teams?

Having reviewed Nurse Swift's letter again, she has stated what she understood as the instruction to be in relation to the intended volume of fluids to be administered. The volume of fluids administered for the first 4 hours is identified in the fluid balance chart (043-039).

(25) In a note of a meeting which took place between you and Dr. Quinn on the 2 May 2000, it is recorded,

***"10. How much normal saline was run in?"* [Ref: 033-102-287]**

In his report Dr. Quinn expressed the view that he could not be certain how much normal saline had been run in [Ref: 033-102-273].

Please explain what steps were taken to clarify this issue for Dr. Quinn, and why this issue was left un-clarified at the time of his report?

The note referred to above relates to telephone feedback received from Dr Quinn on the 2 May 2000. I see a footnote on this page that states nursing staff advised that normal saline was commenced at 3.15am and 250mls had been administered by 4.00am. The dose then was reduced to 30ml/hr for the next 2hours.

(26) In a note contained at [Ref: 033-102-287] you have recorded:

"Nursing Staff advise that Normal Saline was commenced at 3.15am and 250 mls had been administered by 4.00am. The dose then was reduced to 30ml/hr for the next two hours."

(a) **Which member(s) of the nursing staff provided you with this information?**
I don't have a record that confirms which nurses provided this information.

(b) **When was it provided to you?**
I don't have a record to confirm when this information was provided to me

(c) **Did you or any colleague obtain a written report/statement from the nurse(s) who provided this information? If so, please refer to the document. If not, please explain the omission to do so.**
I don't recall if this information was provided in writing and cannot explain the omission if the information was not confirmed in writing.

(d) **Did you or any colleague take any steps to ascertain the accuracy of what you had been told by nursing staff? If so, what steps were taken?**
There are a number of records that state the fluid balance records were reviewed but I have no record to confirm the accuracy of what was told by nursing staff.

(e) **Did you or any colleague inform Dr. Quinn that you had been told that 250 ml of Normal Saline had been given by 4.00am? If so, when was he informed of this? If he was not informed, please explain the omission to do so.**
I think he would have been advised of the above but I don't have a record to confirm this belief.

(27) **During the review you obtained statements/reports from a number of doctors and nurses, some of whom were involved with Lucy's care on the 12/13 April 2000. You appear to have written to the nursing staff involved [Ref: 033-102-302]. You wrote a different letter to Sister McManus raising specific questions about the fluid management in Lucy's case [Ref: 033-102-300].**

Arising out of the foregoing please address the following:

(a) **Did you or any colleague enter into correspondence with the medical staff involved in Lucy's care, similar to that which was sent to the nursing staff? If so, please provide copies of this correspondence.**
From memory Dr. Anderson linked with the medical staff concerned in relation to their reports. I do not recall whether or not he made these requests in writing.

(b) **If you or any colleague did not write to the medical staff involved, please explain why this didn't happen.**

(c) **Whether or not medical staff were written to in similar terms to nursing staff, please clarify whether you or anyone else asked the medical staff to address the issues relating to the fluids received by Lucy in their reports for the Review? If they weren't asked to address the fluids issues, please explain the omission to do so.**

I do not have any information to confirm whether or not the medical staff were asked to address the issues relating to the fluids received by Lucy.

(28) **The reports provided for the purposes of the Review by Dr. Malik [033-102-281], Dr. O'Donohoe [033-102-293] and Dr. Auterson [Ref: 033-102-316] did not address the issues surrounding Lucy's fluid management and the fluids actually received by Lucy.**

(a) **Did you or any colleague consider it important to obtain from the doctors involved, information on the issues surrounding Lucy's fluid management and the fluids actually received by Lucy, and their views on the appropriateness of the fluids that were given? Please provide reasons for the answer that you give.**
I don't have any recollection of whether or not these issues were addressed with the medical staff listed above.

(b) **Did you or any colleague take any steps to ask the doctors to address these omissions in their statements? If so, please explain the steps that were taken.**

(c) **Why did you conclude the Review without receiving from the doctors any written account in relation to the issues surrounding Lucy's fluid management and the fluids she actually received?**

I cannot explain this.

(29) **At any time, whether as part of the Review or otherwise, did you or any colleague ask the medical staff involved in Lucy's care (in particular Doctors Malik, O'Donohoe or Auterson) to explain ,**

(a) **The fluids which were in fact administered to Lucy**

(b) **Their view of why she was given those fluids and the appropriateness of the fluid regime which was in fact administered to her**

(c) **Their view of the possible implications of the fluid regime which was used?**

I do not have any recollection of asking the medical staff listed about the issues listed a-c.

In the case of each doctor mentioned above, if you or any colleague did ask them these questions, please address the following matters

(i) **When were these questions asked?**

(ii) **In what form were these questions asked (whether in writing or orally)?**

(iii) **What was the response to these questions?**

(iv) **Was their response recorded? If so, please refer to the document where the response is recorded. If the response wasn't recorded please explain the omission to do so.**

(30) **If you or any colleague did not ask the doctors to explain to you the fluids administered, their view of the appropriateness of the fluid regime which had been applied to Lucy, and the possible implications of the fluid regime which was used, please explain the omission to do so?**
I don't recall if this issue was raised with the doctors.

(31) **At any time, whether as part of the Review or otherwise, did you or any colleague ask the medical staff involved in Lucy's care (in particular Doctors Malik, O'Donohoe or Auterson) to**

explain their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000?
I don't recall if these issues were asked of the medical staff listed above.

In the case of each doctor mentioned above, if you or any colleague did ask them this question, please address the following matters:

(a) When was this question asked?

(b) In what form was this question asked (whether in writing or orally)?

(c) What was the response to this question?

(d) Was the response recorded? If so, please refer to the document where the response is recorded. If the response wasn't recorded please explain the omission to do so.

(32) If you or any colleague did not ask the doctors to explain to you their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000, please explain the omission to do so?
I don't recall if these doctors were asked to explain their views of what happened to cause the deterioration in Lucy's condition.

(33) Why did you conclude the Review without receiving from the doctors any written account in relation to their view of what happened in order to cause the deterioration in Lucy's condition at and after 03.00 on the 13 April 2000?
I don't recall if such accounts were available either verbally or in writing and I do not have a record of any being available. The review was completed on the basis of the information available including the report from Dr. Quinn. Dr. Kelly and I had met with Dr. Quinn to explore his analysis and were reassured at the time that the fluids administered were within acceptable limits.

(34) Did you or any colleague carry out an interview with any of the doctors mentioned above after they submitted statements/reports for the purposes of the Review?
I don't recall if the doctors were interviewed after they submitted their statements/reports.

If interviews were carried out with any of the doctors please address the following matters:

(a) Who was interviewed?

(b) When did the interview take place?

(c) What was the purpose of each interview?

(d) What was discussed at each interview?

(e) Did you or a colleague make a record of what was discussed at each interview? If so, please refer to the document in which the record is contained. If a record was not made of each interview please explain the omission to do so.

(35) If you or any colleague did not carry out interviews with each of the doctors referred to above when they submitted statements/reports for the Review, please explain the omission to do so?
I don't recall if the doctors were interviewed after they submitted their statements/reports.

(36) Mr. Mills' note for the 23 May, 2000 recorded that you told him that you and Dr. Kelly would be meeting with Dr. O'Donohoe "the next day" [Ref: 030-010-019].

I don't have any record of the meeting and don't recall the issues to be discussed. There is a reference to the notes of a meeting between Dr. Kelly and Dr. O'Donohoe in the index for the folder 036a at 036a-060, but the notes do not appear in the papers nor to be on the disc supplied. I would require a copy of the said notes to consider points (a) to (d) below.

Please address the following matters:

(a) Did you and Dr. Kelly meet with Dr. O'Donohoe on the 24 May?

(b) If so, what was the purpose of this meeting and what was discussed?

(c) If a record of this meeting exists, please provide a copy.

(d) If the meeting did not take place, please explain why it didn't take place.

(37) Dr. O'Donohoe wrote to Dr. J. Kelly (Medical Director) to provide a comment in relation to the autopsy report:

"I don't quite know what to make of the bronchopneumonia and particularly the suggestion it may have been of some duration." **[Ref: 036a-051-114]**

(a) Were Dr. O'Donohoe's views in relation to the autopsy report brought to your attention at any time before or after you had concluded the Review?

(b) If so, how were his views made known to you, and did you take any steps to speak to Dr. O'Donohoe about his views?

In relation to (a) and (b) above I don't recall any reference to this comment. I believe that the autopsy report was prior to the conclusion of the review. I don't have any recollection of speaking to Dr. O'Donohoe about the content of his comment to Dr. Kelly on the cover note dated 26 June 2000.

(38) As appears from Appendix 11 of the Review of Lucy Crawford's Case, you spoke to Sister Traynor [Ref: 033-102-295]. Please address the following matters:

(a) Did Sister Traynor have any involvement with the care of Lucy?
No

(b) Please explain why you interviewed Sister Traynor in relation to the care which had been provided to Lucy?
She was the Ward Sister for the Children's Ward

(c) Sister Traynor expressed opinions in relation to the fluids which had been provided to Lucy. Did you regard her as a person with sufficient expertise to be expressing opinions on the fluid management of a child who had died? If so, please clarify what expertise she held.
She was a Children's trained nurse with many years of experience

(d) **Did you ask Sister Traynor to explain the factors relied upon by her to support her opinion that the fluid replacement volume was not unusual in a child of this age given her condition, and that there did not appear to be evidence of overload of fluids? If so, what did she say to support the views she was expressing?**
I don't recall if I asked Sister Traynor to explain the factors she relied upon.

(e) **Was Sister Traynor asked to provide a statement/report in writing to set out and explain her opinions, and did she provide one? If she wasn't asked, please explain why?**
I don't recall, but don't think she provided a statement.

(f) **Did you take any steps to ascertain whether the opinions expressed by Sister Traynor were correct? If so, what steps did you take?**
I don't recall.

(g) **To what extent did Sister Traynor's opinions inform your overall conclusions in the Review?**
I don't recall, but believe that we would have used Dr. Quinn's opinion to inform our overall opinion.

(39) **Having obtained statements/reports from those involved in Lucy's care, please clarify whether you provided this material to Dr. Quinn?**
I don't recall if it was provided to Dr. Quinn

If you did not provide this material to Dr. Quinn, please explain why you didn't?

(40) **What steps were taken to involve Lucy's parents in the process of the Review and to obtain information from them? If no steps were taken, please explain why this omission occurred?**
Arrangements were made to make Lucy's parents aware of the review, but they were not involved in the review, nor was information obtained from them. I believe it was not the practice at the time to involved parents in such internal reviews. I am now of the view that this was mistake.

(41) **At the time of carrying out the Review were you provided with any of the following materials in respect of Lucy:**

(a) **A discharge letter from the Royal Belfast Hospital for Sick Children;**

(b) **Autopsy request form;**

(c) **A death certificate?**

I don't recall having any of the above available at the time.

(42) **Please clarify whether any of the following persons/organisations were notified that a Review was taking place, and explain any omission to do so:**

(a) **The Department of Health and Social Services;**

(b) **The office of the Chief Medical Officer;**

(c) **The Coroner's Office;**

(d) **Clinicians or management at the Royal Belfast Hospital for Sick Children;**

(e) **The pathologist who performed the autopsy (Dr. Denis O'Hara).**

I was not involved in notifying any of the above. The Trust did keep the WHSSB informed.

(43) **During the Review what steps were taken to ask the treating clinicians at the Royal Belfast Hospital for Sick Children for their views in relation to the cause of the deterioration in Lucy's condition and the cause of her death?**
I did not seek views from clinicians at the RVH. Following discussion with the Chief Executive of the Trust an external opinion was sought from Dr. Quinn, Altnagelvin Trust. From memory I think a view was taken to seek an opinion from a clinician who had not been involved in Lucy's care.

If no steps were taken in these respects, please explain why this omission occurred?
See response above.

(44) **What steps were taken to obtain a report from Dr. Asghar for the purposes of the Review? If no steps were taken, please explain why this omission occurred?**
I don't believe Dr. Asghar was asked for a report. I don't believe that Dr. Asghar had any contact with Lucy or input into her care during her hospital stay at the Erne Hospital.

(45) **In your letter to Mr. T. Anderson dated 5 July 2000 [Ref: 033-102-261] enclosing the draft Review report you made the following comments:**

"I know Dr. Kelly met with Dr. O'Donohoe on Wednesday 28 June 2000, to give him feedback on our meeting with Dr. Quinn...

"I understand that the family, in addition to the meeting held with Dr. O'Donohoe, also met with Dr. Hanrahan, the Paediatrician in Belfast, and that the final autopsy report was shared with them by Dr. O'Hara and Mr. Stanley Millar, Western Health and Social Services Council. This meeting, I understand, was held on 16 June 2000."

Arising out your letter to Mr. Anderson, please address the following matters:

(a) **Did you and Mr. Anderson conduct any analysis of the material which the Review had received before you produced a draft report for his attention? If so, please outline how this analysis was conducted.**
Yes. Yes we met on a number of occasions to consider the review and the information available as outlined at response to 7. The analysis was conducted by reviewing the information collected and the findings agreed at our meeting held on 30 July 2000.

(b) **Please explain why you and Mr. Anderson did not write a joint report?**
I don't recall the reason, but it was probably for practical reasons. Dr. Anderson was responsible for delivering a clinical service and was also the Clinical Director at the time.

(c) **Please explain why Dr. Kelly met with Dr. O'Donohoe in circumstances where the Review had not been completed?**
I don't recall the reason. Perhaps Dr. Kelly could explain.

(d) **What is your understanding of what "feedback" Dr. O'Donohoe was given by Dr. Kelly?**
I don't think I was at the meeting but think the feedback may have related to the report from Dr. Quinn. Dr. Kelly may be able to clarify.

(e) **Who told you that a meeting had taken place between the family and Dr. Hanrahan?**

I think it was Mr. Millar of the WHSC Council.

(f) **Did you take any steps to ascertain what had been said to the family at this meeting by Dr. Hanrahan?**
I don't recall if I learnt the details at the time.

(g) **Who told you that the final autopsy report was shared with the family by Dr. O'Hara and Mr. Millar?**
I think it was Mr. Millar.

(h) **Did you also discover that the family and Mr. Millar had met with Dr. O'Hara? If so, who told you about this and what were you told about the meeting that took place?**
I don't recall, but probably did learn that the meeting had taken place from Mr. Millar. If I did learn that the meeting had taken place I don't recall what I was told.

(46) **Mr. Anderson wrote to you on the 17 July 2000 to comment on the draft Review report [Ref: 033-102-262].**

(a) **Please clarify whether you and Mr. Anderson met to review/analyse all of the information gathered as part of the Review before the final report was published?**
In the notes available to me of the sequence of inputs into the review I note that Dr. Anderson and I met on the 31 July 2000 to finalise the report. (See response to no. 7)

(b) **If you did meet for this purpose please state when you met, what was discussed and what conclusions were reached. If you did not meet, please explain why you did not meet.**
I don't recall the details, but the conclusions would be contained in the final report.

(47) **Having completed the Review report, please explain what steps were taken by the Sperrin Lakeland Trust to examine its findings, and state:**

(a) **Who was the report sent to?**
From memory the report was given to Mr. Mills, Chief Executive.

(b) **Was the report considered at Trust Board level?**
I don't recall.

(c) **What action was taken by Trust management in relation to the findings of the Review and its recommendations?**
I don't recall.

(d) **Were you involved in any discussions with regard to the findings of the Review to the extent that they concerned the cause of the deterioration and death of Lucy?**
I don't recall.

(e) **If so, who did you discuss these findings with, what was discussed, and was any action taken on foot of these discussions?**
N/A

(48) Did the Trust consider the report of Dr. Quinn to determine whether it contained any factual inaccuracies?
I don't recall.

If so, what steps were taken in relation to this? If no steps were taken, please explain the omission to do so.
N/A

(49) As appears from the report of Dr. Quinn,

"[he] found it difficult to be totally certain as to what occurred to Lucy in and around 3.00am, or indeed what the ultimate cause of her cerebral oedema was." **[Ref: 033-102-273]**

(a) In circumstances where Lucy's death remained unexplained, as at the start of the Review, did the Trust give any consideration to carrying out a further investigation to determine what caused the cerebral oedema?
I don't recall.

(b) If so, what consideration was given to this, and what conclusions were reached?

(c) What consideration did you or any colleague give to reporting Lucy's death to the Coroner in circumstances where the cause of the cerebral oedema could not be established?

I don't recall, but we would have expected that the death would have been reported to the Coroner by the RVH. Information that was available later confirmed that the death had been reported.

(d) Did anyone at the Trust check with the Coroner's Office or with clinicians at the Royal Belfast Hospital for Sick Children to ascertain whether an inquest would be held? If no check was made, please explain why.
I don't recall but I do have a memory of becoming aware at some stage that an inquest was not planned.

(50) Were the objectives of the Review as explained at [Ref: 033-102-264], satisfied in all respects? Identify any objective that wasn't satisfied, explain why it wasn't satisfied, and state whether any remedial action was considered or taken to address this.
At the time we considered that the objectives were met. However with the information that became available later at the inquest conducted in 2004 it became clear that the review had led to incorrect conclusions. I attended the inquest, listened to the various evidence presented and the conclusions reached. I recorded my observations and made a list of recommendations (034-051) that was shared within the Trust. Mr. Mills CE and I met with Dr. H. Campbell on 27/4/2004 to brief her (032-059). My observations and recommendations were considered at Trust Board and an action plan was developed that included training Root Cause Analysis (RCA) methodology of investigating such cases and the Trust planned to re-investigate the case using the RCA approach (031-039)

(51) Please refer to the following documents:

- **The report of Dr. M. Stewart on behalf of the RCPCH [Ref: 036a-025-052]**

- **The notes of a meeting between Dr. Kelly and the report's author, Dr. Stewart [Ref: 036a-027-067]**

- **The report of Dr. John Jenkins [Ref: 013-011-038]**

- **The report of Dr. M. Stewart and Dr. Boon on behalf of the RCPCH [Ref: 036a-150-312]**

(a) **Were you provided with a copy of any of these documents?**
I don't recall whether or not I was provided with a copy of the reports listed above.

(b) **If so, please identify which of the documents you were provided with and state when you received them.**

(c) **Whether or not you received a copy of any of these documents, were the conclusions in these documents with regard to the treatment and death of Lucy Crawford discussed with you at any time?**

They may have been but I do not recall them having been discussed.

(d) **If so who discussed these matters with you, and when were these matters discussed?**

(e) **If you were aware of the conclusions reached in any of these documents with regard to the treatment and death of Lucy Crawford, did you express any opinion to colleagues about what action the Trust should be taking? If so, what opinion did you express and who did you express it to?**

(f) **Did you take any action on foot of receiving any of these documents or when you were apprised of their contents? If so, what action did you take?**

III. Other Matters

(52) **Are you now satisfied with the Review which you and Dr. Anderson conducted and the conclusions which were reached? Please fully explain the answer that you give.**

The approach taken to conduct the review was consistent with the approach used in N. Ireland at that time. The Root Cause Analysis method was introduced later with training being provided.

I am not now satisfied with the review we conducted or the conclusions we reached given the findings of the inquest. On reflection we should have involved the family at the outset; the review should have been conducted using more systematic approach such as a Root Cause Analysis. The Team selected would probably have benefited from the inclusion of a Paediatrician and an experienced paediatric nurse and perhaps the Medical Director. We probably relied too much on the external opinion without having the expertise to examine the opinion offered. The case should probably have been jointly reviewed or investigated by the two hospitals involved in Lucy's care.

(53) **Have you 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.**

I think I learnt more as a result of attending the inquest into Lucy's death. I drafted a list of issues for consideration (034-051) and recommendations following my attendance at the inquest that were shared at Trust, WHSSB and Department levels. This stimulated the development of an action plan within the Trust and the introduction of the use of a Root Cause Analysis methodology for investigating such adverse outcomes. I have been retired since 2005 so I am not in a position to comment on current practice.

I do not know what factors contributed to the Coroner's office deciding that an inquest was not required at the time, but had it been conducted at the time, perhaps the relationship between the use of solution 18 and hyponatraemia in children may have led to changes in practice earlier.

(54) How would you categorize the quality of care which was provided to Lucy Crawford at the Erne Hospital? In addressing this question please refer to each of the factors which have caused you to reach this view.

There were a number of deficits in the quality of care provided to Lucy at the Erne Hospital identified in the review conducted following her death, particularly the absence of a prescription for the fluids to be administered, the level of clarity in communication among the staff involved and poor documentation of the fluid balance at the time. Having attended the inquest I accept that there was too much of an incorrect fluid administered to Lucy at the Erne Hospital.

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

I have no other comments to make.

(a) The cause of Lucy's death;

(b) The role performed by you, the Sperrin Lakeland Trust or any other body when reviewing or investigating issues relating to the cause of Lucy's death;

(c) The procedures which were followed when reviewing or investigating issues relating to the cause of Lucy's death;

(d) Lessons learned from Lucy's death and how that affected your practice or your approach to management;

(e) Any other relevant matter.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: [signature] Dated: 1/11/12

H.S.S TRUST

JOB DESCRIPTION

TITLE: DIRECTOR OF NURSING

REPORTS TO: CHIEF EXECUTIVE

ACCOUNTABLE TO: CHIEF EXECUTIVE/BOARD CHAIR

1.0 Job Summary

The Director of Nursing is the senior nursing professional on the Trust Board. He/she will be responsible for the provision of professional direction and leadership across the full range of nursing services within the Trust. The Director of Nursing is accountable to the Chief Executive for fulfilling the corporate responsibilities associated with membership of the Trust Board and its Senior Management Team.

In addition to the professional responsibility, the post holder will carry accountability for Acute Hospital Services. A separate role description has been written to reflect the associated responsibilities.

2.0 Key Professional Responsibilities

2.1 To provide professional nursing advice to the Trust Board Chief Executive and relevant Programme Directors.

2.2 To participate in the disciplinary procedure in relation to professional nursing issues in liaison with the respective Programme Director.

2.3 To advise the Chief Executive and Programme Directors on the implications for nursing standards of the Corporate and individual Directorate Business Plans.

2.4 To develop, implement and keep under review professional nursing policies which support and further the Trust's strategic aims and objectives.

2.5 To establish and chair a forum involving key senior nurse managers and practitioners, as a means of securing appropriate responses to National and Regional policy and strategy imperatives.

2.6 To have corporate responsibility for under graduate education, post graduate training and continuing professional development of nurses in the Trust.

2.7 To have corporate responsibility for ensuring the maintenance of professional standards and statutory requirements as laid down in the current rules of nurses, midwives and health visitors and the United Kingdom Central Council Code of Professional Conduct.

2.8 To encourage the development and maintenance of relationships with the voluntary and private sectors to foster constructive and collaborative working relationships.

3.0 General Management Responsibilities

As referred to in paragraph 1.0 above the responsibilities associated with the Acute Hospital Services Directorate have been detailed separately.

NOVEMBER 1996

429A

SPERRIN LAKELAND HEALTH AND SOCIAL SERVICES TRUST

ROLE DESCRIPTION

TITLE: **DIRECTOR OF ACUTE HOSPITAL SERVICES**

REPORTS TO: **CHIEF EXECUTIVE**

ACCOUNTABLE TO: **CHIEF EXECUTIVE/TRUST CHAIR**

This role description has been drafted to facilitate the initial appointment of the Executive Directors, it therefore should be read in conjunction with the Job Description for the Executive Director of Nursing.

1.0 Summary of Role

The Director of Acute Hospital Services will be responsible/accountable to the Chief Executive for the management and development of the provision of acute hospital, maternal and child health services across the Trust. He/she will be responsible for ensuring that whilst services reflect the needs of the community, that account is taken of purchaser requirements and National/Regional priorities. He/she will have responsibility for site and facility management associated with the acute hospital sites and the long stay geriatric hospitals, and the coordination of site services including the Estate Control Plan across the complete range of Trust facilities.

He/she will be accountable to the Chief Exectuive for fulfilling the corporate responsibilities associated with membership of the Trust Board and Trust's Senior Mangement Team.

2.0 Key Corporate Responsibilities

2.1 Ensure that appropriate assessment of need is undertaken to inform the priorities for Acute Hospital, Maternal and Child Health Services within the Trust.

2.2 To evaluate on an ongoing basis the effectiveness of services in meeting the need.

2.3 Participate in developing and securing contracts in conjunction with the Directorate of Business Planning and Information and Medical Director with purchasers and regularly evaluating and assessing performance against contracts.

3.8 Assisting in the development, implementation and evaluation of a comprehensive, multi-disciplinary quality assurance programme.

3.9 Developing effective operational arrangements for liaison with other senior colleagues in the planning and delivery of services.

3.10 Ensuring the development and implementation of a strategy for the introduction of information systems in conjunction with the Directorate of Planning, Contracts and Information which will facilitate the effective management and provision of services and provide for future needs.

3.11 Providing information of services activity to the Chief Executive and Trust Board as required.

3.12 Ensuring that the major emergency plans are updated in conjunction with other senior colleagues and personnel as appropriate.

4.0 Key Human Resource Responsibilities

4.1 Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

4.2 Ensures that the review of performance identified in 4.1 above is performed for all levels of staff for whom he/she has management authority.

4.3 Ensures the maintenance of positive staff relationships and morale across the Acute Directorate.

4.4 Reviews the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives and recommends change where appropriate.

4.5 Delegates appropriate responsibility and authority to Clinical Directorates and other managers within his/her remit, consistent with effective decision-making, whilst retaining overall responsibility and accountability for results.

4.6 Participates, as required, in the selection and appointment of staff reporting to him/her in accordance with the Trust's appointments.

4.7 Takes such action as may be necessary in disciplinary matters in accordance with the Trust's disciplinary procedures.

4.8 The establishment and promotion of effective communication with staff.

4.9 Promotes and instils a sense of teamwork and cooperation across the Directorate.

This job description will be subject to review in the light of changing circumstances and may include any other duties and responsibilities as may be determined in consultation with the job holder. It is not intended to be rigid and inflexible, but should be regarded as providing guidelines within which the individual works.

Whilst the job/role description sets out the framework for the individual's responsibilities, annual performance targets will be agreed and set between the postholder and the Chief Executive reflecting immediate operational and strategic objectives.

NOVEMBER 1996

461A