Witness Statement Ref. No. 287/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Eugene Fee

Title: Mr

Present position and institution: retired

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:
[Identify by date and title all of those between January 2000 - December 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:

Ref:	Date:	
WS-290/1	06-Nov-2012	Inquiry Witness Statement

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 to your statement.

I. FURTHER QUESTIONS ARISING FROM YOUR WITNESS STATEMENT TO THE INQUIRY WS-287/1

(1) In your answer to question 6 of WS-287/1 you have said that prior to the establishment of clinical governance structures, clinical incidents were managed through committees.
My response to question 6 was that clinical governance issues at the time of Lucy's death was managed through a range of committees and that clinical governance arrangements were not established until after the adoption of Best Practice Best care in N. Ireland in 2002. By way of example I identified Infection Control. I was the chair of that committee.

Please address the following matters:

(a) Were the issues which arose from Lucy Crawford's clinical incident managed by a committee?
I don't recall the details of the arrangements for managing clinical incidents or whether or not the issues arising from Lucy Crawford's clinical incident was managed by a committee.

(b) If so, what was the name of that committee, and who made up its membership?
I am unable to answer questions b - d.

(c) Describe the steps that were taken by that committee in relation to Lucy Crawford's clinical incident.

(d) Please make arrangements for the Inquiry to be provided with any documents which may have been generated by any committee's consideration of the Lucy Crawford clinical incident.

(2) In your answer to question 7 of WS-287/1 you have referred to various meetings. Please address the following matters:

(a) What was the purpose of the meeting which took place on the 10 May 2000 with Mr. Bradley. Fully outline what was discussed at that meeting and please refer the Inquiry to any record of that meeting.
I don't have notes of the meeting but think it may have been the monthly meeting held with the WHSSB commissioners.

(b) What is your understanding of Mr. Bradley's purpose in meeting you and visiting staff on the ward on the 12 May 2000? Fully outline what was discussed at this meeting, identify the staff whom he met, and please refer the Inquiry to any record of that meeting/visit.
I think Mr. Bradley's visit was to gain a further insight into the events surrounding Lucy Crawford's death and meet the staff available in the Children's Ward. I don't

have any notes of the visit. I cannot recall which staff he met during his visit or what was discussed.

(c) **What was the purpose of the meeting which took place on the 9 June 2000 with Dr. O'Donohoe. Fully outline what was discussed at that meeting and please refer the Inquiry to any record of that meeting.**
I don't have notes of this meeting and don't recall its purpose.

(3) **The question at number 24 of WS-287/1 erroneously refers to Nurse Swift writing to you on the 18 May 2000, whereas in fact it was Nurse T. Jones who had written to you. The Inquiry apologises for this error. If necessary, please revise the answer which you have provided in light of this clarification.**
Yes, I believe the content of the Nurse Jones letter did satisfactorily clarify for me the volume of fluid administered to Lucy Crawford over the period concerned.

(4) **In your answer to question 28 of WS-287/1, you have stated that you don't recall whether the doctors were asked to provide information relating to Lucy's fluid management etc. The question in fact asked you to address whether you or any colleague considered it important to obtain this information from the doctors. Please address this particular question.**
I don't recall whether or not it was considered important to obtain this information from the doctors at the time.

(5) **In your answer to question 33 of WS-287/1, you have stated that you were reassured at the time that the fluids administered were within acceptable limits. Please address the following matters:**

(a) **Indicate by reference to Dr. Quinn's report or any other material, how you were reassured that the fluids which were administered were within acceptable limits?**
Dr. Kelly and I travelled to Altnagelvin Hospital and met with Dr. Quinn to discuss with him the verbal feedback received by telephone on 2 May 2000 (appendix 5 of review) The issue of fluid management had been included in the brief sent to Dr. Quinn. In his written report of 22 June 2000 (appendix 1 of review) he addressed the issue of fluid management in pages 2 and 3. In this he stated that the use of Solution 18 was appropriate, he set out calculations that he had outlined during our meeting. He confirmed that that there was a degree of dehydration and that he would have been surprised if the volume of fluids could have produced gross cerebral oedema causing coning. Dr. Kelly and travelled together to the meeting and I am sure that we discussed Dr. Quinn's opinion on our return journey.

(b) **Did you subsequently become aware that the fluids administered to Lucy (whether type, rate or volume) were not within acceptable limits?**
Yes

(c) **If so, state the date when you became aware that the fluids administered were not within acceptable limits?**
When I attended the inquest on 17th and 19th February 2004, I listened to the evidence given by a range of clinicians involved in Lucy's care and the various experts who gave evidence. In summary the inquest concluded that Lucy had been given too much of the wrong solution.

(d) **If applicable, how did you first become aware that the fluids administered to Lucy were not within acceptable limits?**
As above.

(e) **If applicable, what specific steps did you take when you became aware that the fluids administered to Lucy were not within acceptable limits?**
I briefed the Chief Executive for the Trust during the Inquest and wrote "Issues for consideration arising out of Mr. Fee's observations of the proceedings during the inquest at the Coroner's Court, Belfast on 17 & 19 February 2004. The late Lucy Crawford. This document dated 23rd February 2004 was sent to the Chief Executive and led to the development of an action plan within the Trust. (I could not trace the document on the range of documents contained on the disc supplied by the Inquiry, but I now attach a copy of same.)

(6) **At your meeting with Dr. M. Quinn on the 21 June 2000 it would appear that the contents of the post mortem report were discussed [Ref: 036a-047-101]. Please address the following matters:**

(a) **Indicate the steps that you took to obtain the post mortem report;**
Dr O'Donohoe obtained the Provisional Anatomical Summary from the Crawford family GP and provided Dr Anderson with a copy along with his report (cover letter dated 3rd May 2000).

(b) **Identify the person who provided it to you;**
I don't currently have a record of how the full PM report was obtained or the date it was received, but the report which is dated 13.6.00 was available when Dr. Kelly and I met with Dr. Quinn on the 21/6/2000. It may have been Dr. Kelly who received the full report. It is contained in file 036-007.

(c) **State the date on which you received it.**
See response to 6a & 6b.

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

Signed: **Eugene Fee** **Dated: 19/1/2013**

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SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ISSUES FOR CONSIDERATION
ARISING OUT OF MR FEE'S OBSERVATIONS
OF THE PROCEEDINGS DURING THE INQUEST
AT THE CORONER'S COURT, BELFAST
ON 17 & 19 FEBRUARY 2004
THE LATE LUCY CRAWFORD

These issues could be divided into at least three categories:

- ✓ *Clinical*
- ✓ *Organisational*
- ✓ *Regional*

in code of practice for pg. staff.

- *The need to listen to the patient or the parent in respect of the presenting condition.*
- *The need to concentrate on the patient and not to engage in social or private conversations during period of contact with the patient. The can be perceived as showing disinterest.*
- *The need to consider the parents wishes in respect of being present during the care of children including emergency services resuscitation care.*
- *The need to keep the parent or family briefed in respect of what is happening particularly during or after a response to a sudden deterioration in the patients condition.*
- *The need to advise the patient or family at an early stage of the Trust's intention to carry out a clinical review and to seek their contribution particularly in relation to the description of any significant events such as the one that happened to Lucy in the presence of her mother at around 2.55am on 13/4/00.* opening.
- *To consider how the outcome of any review is communicated with the patient or family.* *legal view tends to cut against
- *There is a need to consider carefully how external reviewers are chosen. Perhaps there could be a regional list for relevant specialties and disciplines.*

develop 'review team' concept.

- The need to consider whether or not Trust Managers should consider having more than one independent opinion of cases where there are complex issues such as those associated with Lucy's death.

- The need to further strengthen the network arrangements between local clinical teams and those of the region or area units. This networking needs to be supported by suitable technology for communication and transfer of information including examinations or test results.

Link to Reg. adverse inc reviews by Deloitte.

- The need to have some structured method regionally to share significant clinical instances and the outcome of any reviews.

- The need for some standardised approach in respect of the communication between referring and receiving hospitals including the approach to the transfer of case notes.

- The need for formal feedback between regional or area services to local clinicians, in such cases where death or unexpected outcomes arise so that local clinicians are aware of what information has been shared with families and to afford them having the maximum amount of information available when meeting families in respect of any feedback on care given.

- The need for Post Mortem Reports to be copied as a matter of routine to relevant clinicians within the referring hospital, where a patient has died beyond transfer and the case has warranted a Post Mortem.

- The absolute need to have a clearly documented prescription in respect of all treatments. In the event of an emergency this should be done as soon as it is practical beyond the commencement of treatment.

- The need for clear and accurate documentation of all treatment administered including the accurate documentation of fluid intake and output. This documentation should particularly in small children include as accurate as possible calculation of fluid loss through vomiting or diarrhoea.

RCD guidelines for neonates.

- The need for a detailed assessment to be undertaken in respect of patients particularly in relation to the calculation in respect of dehydration and what fluid replacement and maintenance volumes had been identified.

- The need to document within the care plans the nature and type of routine observations. This may include the frequency that electrolyte balance should be assessed through laboratory testing.

- The need for the continued display and adherence to rehydration guidelines.

- The need for nursing staff to have sufficient understanding of the principles, the relevant uses of the various fluid replacements and the normal volumes so as to be in a position to alert medical colleagues to

Trg + education needed

situations where it appeared to them that the volume or type of fluid was inappropriate to a given patients clinical condition.

- The need to create an action plan arising out of the deliberations of relevant clinical managerial staff in respect of this case. The action plan should include an agreed process for sharing the learning out of this case to all relevant staff and externally with other organisations.

- The need to standardise the monitoring arrangements in respect of patients on fluid replacement therapies including how this should be managed in respect of patients who are sleeping or unconscious.

- The need for a mechanism for services in Northern Ireland to share lessons learnt from such circumstances with the wider HPSS family. Dr Evans (expert witness, Cardiff) was unaware of the guidance developed by Dr Campbell and her team.

- There is a need to consider the requirements for legal advice in respect of correspondence to complainants when replying to issues of a serious nature.

- There is a continuing need to work towards a regional retrieval service to support Paediatric Services particularly at the periphery of the Province.

- The need to further consider the availability of a helipad at the RVH to facilitate air transportation of patients in some circumstance.

- The need for agreement in respect of how many attempts a Junior Doctor should have in respect gaining an IV line before requesting support from a more senior colleague.

- In respect of the allegation that a member of nursing staff and a doctor engaged in social conversation during a part of the treatment. It should have been clarified that there had been at least one other member of staff involved in the patients assessment. This reference may have been relevant to a nurse rather than the individual accused.

- There is a need for nursing staff to consider the risks associated with documenting elements of care or proposed care based on information provided by colleagues.

- In preparing for the Coroner's Court, the Trust should have available a full set of information including case notes or copies of case notes in relation to the patient from other hospitals.

- Consideration needs to be given as to whether or not there is the need to prepare a full set of papers for all Trust staff who will be appearing at such Hearings.

- *There is a need to consider the risks to the professional standing of members staff and where these risks are apparent they need to be made aware that the Trust's legal team are representing the Trust's interests and of their right to have separate independent legal council.*

- *Staff needs to be made aware of the provisions within the Coroner's Act especially Rules 9 and 17.*

- *There is a need to keep relevant Directors updated on progress and outcome of any litigation.*

- *The need to ensure that proper Occupational Health support is available to assist staff in respect of coping with the stress of such Hearings, where they feel the need.*

- *The need to give further consideration in relation to the handling of the media in respect of portraying the Trust's position based on the information available at any given time throughout the process.*

- *There is the need to have in place arrangements to ensure that other relevant individuals and departments are kept updated in respect of the outcome of such Hearings. This will include Non-Executive Directors, Commissioners for Services and the DHSS&PS.*

The key issues which were subject of debate at the Inquest were:

- *The inappropriate use of solution 18*
- *The inappropriate volume of fluid replacement*
- *The failure to have a properly completed prescription*
- *The communication difficulties and confusion amongst staff*
- *The poor record keeping including the accuracy of the fluid balance recording*
- *The level of observation during the infusion period and:*
- *The inconsistency between the decision taken by the Trust as reflected in the letter of 30 March 2001 and the later settlement of litigation.*

Suggested attendance list for the review meeting

As many of the nursing and medical staff from the Paediatric Department as were available to attend and wish to participate. Consideration will need to be given to the support required for individuals involved in the care and the Coroner's Inquest
Clinical Directors
Service Directors from all Directorates
Dr Kelly
Dr Diana Cody (Acting Medical Director)
Mr Fee (Director of Acute Hospital Services)
Ms B O' Rawe (Director of Corporate Affairs)
Mr G McLaughlin (Director of Human Resources)

An invitation should be extended to Mr G Carey and Mr V Ryan, Mr K Martin (Chairperson of the Clinical & Social Care Governance Committee)
Another Non-Executive Director ?Mrs J Irwin?
Dr Campbell (CMO) or her Representative
Mrs M Kelly (Chief Nurse, WHSSB) or her Representative
Ms M Reilly (Chief Officer, WHSSC)
Mr H Mills (Chief Executive & Chair of the Review Meeting)

Consideration will also need to be given as to how feedback on our Review and other relevant issues are related to the General Practitioner family.

The purpose of the Review should be to reflect on the issues surrounding the care of the Late Lucy Crawford. Identify the learning points and develop an Action Plan, which would include the dissemination of relevant information to relevant groups and organisations.

Eugene Fee
DIRECTOR OF ACUTE HOSPITAL SERVICES

23/2/04

? not directly involved.

? Anne O'Brien may be able to facilitate reg. DS. to QA, provide confidence + process.

How we convey this publically