Witness Statement Ref. No. 293/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Hugh Mills

Title: Mr

Present position and institution: Chief Executive, Independent Health and Care Providers

Previous position and institution: Chief Executive of Sperrin Lakeland 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 – September 2012]
No relevant appointments to Advisory Panels and Committees

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
Interview by PSNI on 7th April 2005

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 professional qualifications, and the date on which they were obtained.
B. Sc (Econ) 1973
M. Sc (Pol. Anal) 1987

(b) State the date of your appointment to the post of Chief Executive of Sperrin Lakeland Trust, 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.
1st April 1996 Appointed to CE Sperrin Lakeland Trust
For List of previous posts see attached Appendix A

(c) Provide a copy of your job description.
Please find attached.

(d) 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? If you had no direct responsibility for clinical governance, please explain how those with such responsibility were expected to interact with you.

In late 1999 and during 2000 the Sperrin Lakeland Trust was preparing for the introduction of clinical and social care governance arrangements. Clinical Audit and the reporting of adverse incidents were well established within the Trust. I was aware of the developing need for an organization to promote learning from incidents and this required an open approach with a 'no blame' culture as a lot of situations were the result of systems failures rather than individual mistakes. The formal commencement of Clinical and Social Care Governance took place with the first meeting of the Trust Clinical and Social Care Governance Committee on 23rd November 2000. This was in advance of the DHSSPS policy which followed the implementation of 'Best Practice, Best Care' which was launched for consultation on 11th April 2001 until 18th July 2001. When Clinical and Social Care Governance was introduced as Chief Executive for the Trust I had overall responsibility and linked with professional advisers to lead, promote and monitor the arrangements. Dr. Jim Kelly, Medical Director was the Trust lead director for Clinical and Social Care Governance.

(e) 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?

In respect of Lucy Crawford, she did not die in the Erne Hospital.

However, in response to the above question, I would require to be informed of an unexpected/unexplained death. I would seek an assurance that it had been reported to the Coroner's office. I would also seek an assurance that appropriate next of kin were informed and request the provision of a written report detailing the circumstances. Subsequently I would ensure that information on the circumstances was conveyed to the main commissioners (Western HSSB) and the Chair of the Trust as soon as appropriate.

These responsibilities were derived from legislation, DHSSPS, Board and Trust policies and circulars. (I do not have access to those documents current at the time.)

For further clarification the Sperrin Lakeland Trust was formed from the Omagh and Fermanagh Hospitals and Community Services Unit of Management which had responsibility for the Erne Hospital. The Unit of Management was directly managed by the Western Health and Social Services Board. There were well established arrangements for reporting untoward incidents including unexpected/unexplained deaths to the Western HSSB.

(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,**

No

(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?**

(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,**

No

(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?**

II. STEPS TAKEN BY YOU OR THE SPERRIN LAKELAND TRUST FOLLOWING THE DEATH OF LUCY CRAWFORD

(4) **Fully describe the key features of the Trust's arrangements for clinical governance as they applied in 2000, identify any personnel, groups or committees which exercised clinical governance functions, provide any documentation which recorded those arrangements, and state,**

The first meeting of the Trust's Clinical and Social Care Governance Committee took place on 23rd November 2000. Prior to this there was a period of preparation with an awareness seminar held in September 1999 (attended by 150 delegates - see Trust Board Minutes 23rd Sept 1999 attached) and Trust Board and Senior Management Team discussions on the structures and arrangements for the introduction of Clinical and Social Care Governance.

(a) **Did those arrangements apply in Lucy's case, and if so, why did they apply?**
Lucy's death was prior to this date, however there was an awareness developing of clinical governance and its application.

(b) **If applicable, how were those arrangements applied in Lucy's case? In particular, what steps were to be taken pursuant to the arrangements for clinical governance?**
Whilst no formal arrangements were in place there was a decision to follow the practice of obtaining an external peer review of Lucy's care and treatment in the Erne Hospital.

(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.**
Incidents of this nature were reported by clinical directors or clinical services managers to the Trust Medical Director (Dr. Kelly) and/or the Trust Director of Acute Hospital Services (Mr. Eugene Fee). Dr. Kelly or Mr. Fee would have informed myself. Statements would be obtained from the staff involved and depending on the circumstances a review of the incident would take place. These arrangements were instigated following the death of Lucy.

(5) **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.**
A summary of the main actions taken by myself in respect of Lucy Crawford's death is as follows;

14 April 2000	Advised Western HSSC Board of the adverse incident within 24/48 hours.
14 April 2000	Informed Trust staff responsible for quality / complaints / litigation / communications.
17 April 2000	Informed Trust Chairman
20 April 2000	Arranged for external Paediatrician (Dr. Quinn) to examine the circumstances of the case.
20 April 2000	I sought advice if Dr. O'Donohoe should continue to see patients
20 April 2000	Agreed arrangements to request health visitor to make contact with the Crawford family
21 April 2000	Informed Western HSS Board of the appointment of Dr. Quinn
03 May 2000	Informed General Manager of the Western HSS Board
04 May 2000	Requested Dr. Kelly, Medical Director to convene meeting to review report, once received, and determine the way forward
15 May 2000	Agreed change of duties for Dr. ODonohoe regarding Fermanagh community paediatrics

26 May 2000	Reminded Dr. Kelly to convene meeting and agree way forward in providing information to parents.
08 June 2000	Wrote to Dr. Asghar responding to his letter of 05 June 2000 setting up meeting in respect of harassment claim and review of Dr. O'Donohoe's clinical competence
14 June 2000	Advised General Manager (Western HSS Board) of issues being raised by Staff Grades in Paediatrics regarding Dr. O'Donohoe
30 March 2001	Sent letter to Mr. Crawford following up earlier letters issued on Trust's behalf offering meetings; ➢ 11 October 2000 – letter via Western HSS Council ➢ 10 November 2000 – letter via Western HSS Council ➢ 22 November 2000 – letter direct to Mr. Crawford ➢ 10 January 2001 – letter direct to Mr. Crawford
14 March 2003	Letter to Mr and Mrs Crawford responding to an approach to Dr. William Holmes, Consultant Anaesthetist
28 March 2003	Letter dated 7th March 2003 from Mrs. Crawford with copy of letter from GP. Trust arranged for patient advocate to contact GP to ensure needs of family being met.
28 April 2003	Letter to Mr. and Mrs. Crawford acknowledging on going legal proceedings and indicating the opportunity to meet once these had been concluded
19 March 2004	Letter of apology to Mr. and Mrs. Crawford
30 March 2004	Letter to Mr. and Mrs. Crawford offering meeting with the conclusion of legal and inquest proceedings
30 March 2004	Letter to Murnaghan & Fee (Solicitors) acting on behalf of Mr. and Mrs. Crawford conveying a copy of Dr. Quinn's report to the Trust

(6) Please indicate the role that you played in establishing the *Review of Lucy Crawford's Case* and state:

In discussion Dr Kelly, he advised of the need to establish a Review and we agreed that this should be conducted by Mr Fee and Dr Anderson

(a) Did you obtain any external advice or guidance in relation to how the Review should be conducted?
No

(b) Did you give any instruction, advice or guidance to Dr. Anderson or Mr. Fee in terms of how they should conduct the Review?
The draft terms of reference for the Review were drawn up by Mr Fee and were shared and agreed with Dr. Kelly and myself.

(7) State precisely your understanding of why the Sperrin Lakeland Trust decided that it was appropriate to carry out a Review in respect of Lucy Crawford's death?

A young child had collapsed and subsequently died following transfer to the Royal Belfast Hospital for Sick Children (RBHSC). There was uncertainty about what had caused this and some confusion expressed about the fluid management regime. The Review was necessary to establish the facts around what took place, who was involved and was the treatment appropriate.

(8) Was the Review carried out by following (or by reference to) any guidance, instruction or protocol, whether written or unwritten? If so, please describe the guidance, instruction or

protocol that was followed or which was referred to, and if it was contained in a written document, please provide a copy.

The Review was based on the agreed terms of reference. Due to the passage of time I do not recall if these were based on any guidance or instruction.

(9) When you were interviewed by the PSNI you were asked about the Review, and you said:

"...I received information and I took advice from various professional people within our organization..." **[Ref: 116-049-007]**

Please address the following matters:

(a) Which persons within your organization did you take advice from?
Mr Fee the Trust Director of Acute Hospital Services and Director of Nursing
Dr Kelly the Trust Medical Director

(b) On what matters did you seek advice, and what advice were you given?
The terms of reference for the Review

(10) Describe your role and responsibilities in the conduct of the Review, or with respect to the Review report following its completion?

I had no direct role in the conduct of the Review. Due to the passage of time I do not recall specific details however I believe I received regular updates on the progress of the Review. On completion of the review Report, I believe I would have considered its contents and recommendations and ensured the report was shared with appropriate staff in the Trust and at the Western HSS Board. I would also have ensured that the contents of the report were shared with Lucy's parents.

(11) Please clarify whether you or any of your colleagues notified any of the following persons/organisations that a Review was taking place, and explain any omission to do so:

I can only answer this question in respect of my own involvement. The context for the Review was that staff had reported uncertainty about the cause of Lucy's collapse and confusion about the fluid management. The Review was required to assist with establishing clarification of the facts.

(a) The Department of Health and Social Services;
No. It was not suggested by others or considered by myself
(b) The office of the Chief Medical Officer;
No. It was not suggested by others or considered by myself.
(c) The Coroner's Office;
No. It was not suggested by others or considered by myself.
(d) Clinicians or management at the Royal Belfast Hospital;
No. It was not suggested by others or considered by myself.
(e) The pathologist who performed the autopsy (Dr. Denis O'Hara).
No. It was not suggested by others or considered by myself.

(12) The following entry is contained in your notes for the 14 April 2000:

"Dr. Kelly advised me of an adverse incident regarding the illness of Lucy Crawford. He advised that there could be a situation where the wrong drug or incorrect dose/level of fluids may have been prescribed, although blood tests were not confirming this. Child had been transferred to Royal Belfast Hospital for Sick Children, however, was reported as "brain dead". Dr.

O'Donoughoe (sic) has been advised to obtain a copy of the patient's notes. I agreed I would advise Dr. McConnell.

"Advised Ms O'Rawe through Janet Hall given adverse incident and potential for press interest. Provided information to Dr. McConnell, who stated he would advise Martin Bradley." **[Ref: 030-010-017]**

Arising out of that record please address the following matters:

(a) **Explain what you understood by the term "adverse incident".**
Any untoward incident, including a 'near miss' or unexpected/unexplained death of a patient

(b) **Insofar as you are aware, what was Dr. Kelly's source for the information he was conveying to you?**
The consultant medical staff in the Erne Hospital involved in caring for Lucy Crawford

(c) **What was the role and responsibility of Dr. Kelly in circumstances where an adverse incident leading to the death of a child had occurred?**
Dr. Kelly was the Medical Director for the Trust and provided advice on medical professional issues to myself and the Trust Board. Medical staff would be required to report to their Clinical Director and Medical Director any adverse incident they were aware of.

(d) **In terms of his relationship and interaction with the Sperrin Lakeland Trust or Erne Hospital, what was the role and responsibility of Dr. W. McConnell?**
Dr. McConnell was the Director of Public Health and senior medical officer at the Western HSS Board the main commissioners of services at the Erne Hospital

(e) **In terms of his relationship and interaction with the Sperrin Lakeland Trust or Erne Hospital, what was the role and responsibility of Mr. Martin Bradley?**
Mr. Bradley was the Director of Health Care and Chief Nursing Officer at the Western HSS Board the main commissioners of services at the Erne Hospital

(f) **Confirm that you contacted Dr. McConnell on the 14 April, and clarify whether this was before or after Lucy's death?**
At the time I was informed by Dr. Kelly on Friday 14th April at 9.00am, I understood that Lucy Crawford was still alive, although reported as 'brain dead'. I conveyed this information to Dr. McConnell.

(g) **Why did you report the adverse incident concerning Lucy to Dr. McConnell?**
It was normal practice for adverse incidents involving medical issues to be reported to Dr. McConnell

(h) **What did you tell Dr. McConnell about the circumstances of the adverse incident?**
The information that I had received from Dr. Kelly about Lucy

(i) **What was Dr. McConnell's response to your report about the adverse incident?**
Due to the passage of time I do not recall the detail of his response. As this was an initial report there would be an expectation that as further information emerged this would be conveyed to Dr. McConnell.

(j) **What was your understanding of the role and responsibilities of the Western Health and Social Services Board in circumstances where an adverse incident leading to the death of a child had occurred?**
The Western HSSB would receive and consider the information about an adverse incident and advise the Trust on any details they required or action they wished the Trust to take.

(k) **Who advised Dr. O'Donohoe to obtain a copy of Lucy's notes, and state why he was advised to do so?**
I do not know who advised Dr. O'Donohoe. It is advisable to take this action as when a patient is transferred to another hospital in an emergency it is not always possible for a copy of their notes to be retained. The Review panel would require these given the reported confusion about the fluid management regime.

(13) **The following entry is contained in your notes for the 19 April 2000:**

"Met with Martin Bradley and advised him of the issues. Dr. McConnell also advised circumstances were still being examined." **[Ref: 030-010-017]**

Arising out of that record please address the following matters:

(a) **Fully describe the issues which you brought to the attention of Mr. Bradley.**
Due to the passage of time I do not recall the exact detail, however I would have informed Mr. Bradley on the information known to me at the time.

(b) **What was Mr. Bradley's response to the issues you brought to his attention?**
Due to the passage of time I do not recall the detail of his response. As this was an initial report there would be an expectation that as further information emerged this would be conveyed to him.

(c) **Was any action taken on foot of your discussion with Mr. Bradley?**
I did not record any specific action, however the situation was still developing and as further information emerged this would be conveyed to Mr. Bradley.

(14) *The following entry is contained in your notes for the 20 April 2000:*

"...Post mortem results indicated cerebral oedema. Mr. Fee felt he required advice from a Paediatrician. I agreed I would arrange this... We discussed how best we should communicate with the family to advise that the circumstances were still being examined. We agreed it would be preferable if the family's health visitor could call with the parents rather than send a letter. Mr. Fee agreed to contact manager to identify relevant health visitor.

I spoke with Dr. Murray Quinn, Altnagelvin Hospital, who agreed he would look at the notes and provide advice."[Ref: 030-010-018]

Arising out of that record please address the following matters:

(a) **Insofar as you are aware, how were the post mortem results obtained?**
I do not know how the post mortem results were obtained

(b) **Did Mr. Fee explain to you why he required the advice of a paediatrician? If so, what did he say?**
Mr. Fee required a paediatrician to advise the Review Panel on the medical treatment prescribed and administered to Lucy.

(c) **How did you select Dr. Murray Quinn for the role of advising Mr. Fee?**
In April 2000 requests for an external opinion in the absence of a complaint or litigation were fairly unusual. I considered the request from Mr. Fee to be a proactive approach, demonstrating the Trust's willingness to pursue openness in our examination of the issues and therefore I supported facilitating the identification of a suitable paediatrician. Given the involvement of RBHSC in the care of Lucy, it was felt it was appropriate to seek an opinion from elsewhere.

I had worked with Dr. Murray Quinn in the past and had confidence in his clinical knowledge. I was conscious of the sensitivities for both medical and nursing staff. Prior to the introduction of the new paediatric services to the Erne, Dr. Quinn had provided clinical support for the paediatric service in the Erne, so he was known to nursing staff. I therefore expected that both nursing and medical staff at the Erne would also be confident in his clinical knowledge.

(d) **Did you identify any other paediatricians for the role of advising Mr. Fee, before deciding to make contact with Dr. Quinn?**
No. If he had not agreed to provide his opinion on the medical treatment then we would have considered other paediatricians.

(e) **What steps did you take to satisfy yourself that Dr. Quinn was a suitable paediatrician to advise Mr. Fee?**
I had worked with Dr. Quinn and his expertise as a paediatrician was valued by his colleagues and other staff. I discussed with Dr. Quinn the circumstances of Lucy's treatment and he did not indicate he had any problems with examining the issues concerned.

(f) **How did you make contact with Dr. Quinn?**
By telephone

(g) **What did you tell Dr. Quinn about the circumstances of Lucy's death, and what response, if any, did he make to this?**
I outlined the circumstances that I knew about Lucy's care, however as the reason we required his involvement was the uncertainty that existed, further details would only emerge from his review of the issues. Dr. Quinn agreed to examine the case.

(h) **What did you tell Dr. Quinn about the issues he would be expected to address, and what response, if any, did he make to this?**
I agreed to arrange for the terms of reference for the Review to be forwarded to him and that Mr. Fee would provide him with further information. Dr. Quinn agreed he would await these.

(i) **What did you tell Dr. Quinn about the role he would be expected to perform, and what response, if any, did he make to this?**
I agreed to arrange for the terms of reference for the Review to be forwarded to him and that Mr. Fee would provide him with further information. Dr. Quinn agreed he would await these.

(j) **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?**

The health visitor would provide the family with support at the time of their loss; she would also be able to advise the family about the Review and if they required any further support or information from the Trust.

(k) **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?**
Due to the passage of time I do not recall these details.

(l) **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?**
The Review was primarily to establish the clinical facts given the uncertainty which existed. Prior to meeting with the family it would be important to establish the facts so questions could be addressed. The outcome of the Review would be shared and discussed with Lucy's parents.

(15) **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:**
I can only answer this question in respect of my own involvement.

(a) **Prepare a report for a complaints procedure;**
No. This was not the purpose of the Review.
(b) **Prepare a report for medical/legal purposes;**
No. This was not the purpose of the Review.
(c) **Interview the doctors involved;**
No
(d) **Interview the nurses;**
No
(e) **Interview the family.**
No
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.

(16) **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?
No. This was not the purpose of the Review.

(17) **The following entry is contained in your notes for the 21 April 2000:**

"Rang Dr. McConnell, left message to advise I had requested Murray Quinn to provide the Trust with advice on the case."[Ref: 030-010-018]

Arising out of that record please address the following matters:

(a) **Did you receive any comment or feedback from Dr. McConnell with regard to the decision to seek the assistance of Dr. Quinn? If so, what did he say?**
I recall that at the time that Dr. McConnell was satisfied with the Trust approaching Dr. Quinn to provide his views on the case and no objections were raised.

(b) **Apart from advising Dr. McConnell that Dr. Quinn had been asked to provide the Trust with advice on the case, did you or any of your colleagues otherwise advise him of how the Review would be conducted? If so, what was he told, and did he provide any comment or feedback?**
I do not recall if either I or my colleagues provided Dr. McConnell with further information on how the Review would be conducted.

(18) The following entry is contained in your notes for the 3 May 2000:

"Provided briefing to Mr. Frawley on issues."[Ref: 030-010-018]

Arising out of that record please address the following matters:

(a) **It is the Inquiry's understanding that Mr. Frawley was the General Manager of the Western Health and Social Services Board. Please confirm that this was the case.**
Agreed.

(b) **In terms of his relationship and interaction with the Sperrin Lakeland Trust or Erne Hospital, what was the role and responsibility of Mr. Frawley**
The Western HSSB was the main commissioner of the services in the Erne Hospital. I had monthly meetings with Mr. Frawley which provided regular opportunities to discuss issues in respect of services provided by the Trust.

The Sperrin Lakeland Trust was formed from the Omagh and Fermanagh Hospitals and Community Services Unit of Management which had responsibility for the Erne Hospital. The Unit of Management was directly managed by the Western HSSB. There were well established arrangements for reporting untoward incidents including unexpected/unexplained deaths to the Western HSSB.

(c) **Why did you brief Mr. Frawley?**
It was a requirement of the Western HSSB that significant issues occurring within the Trust were reported and discussed.

(d) **What did you tell Mr. Frawley about the circumstances of Lucy's death, and identify the "issues" that you brought to his attention?**
Due to the passage of time I do not recall the specific details, however I would have shared with Mr. Frawley the information known to me at the time.

(e) **What was Mr. Frawley's response to what you told him?**
Due to the passage of time I do not recall the detail of his response. He confirmed that he was already aware of the death of Lucy. As this was at an early stage there would be an expectation that as further information emerged this would be conveyed to the Board.

(19) The following entry is contained in your notes for the 4 May 2000:

"Discussed case with Dr. Kelly. Requested that when reports were available that he should convene a discussion involving Dr. Quinn, Mr. Anderson, Mr. Fee and himself to decide the way forward. Dr. Kelly advised he was asking for reports on tests carried out in connection with post mortem."[Ref: 030-010-018]

Arising out of that record please address the following matters:

Note document 036a-046-099. Letter dated 15th May 2000 from Dr. Kelly to Dr. McConnell (page 2 penultimate para) advises of the plan to hold this meeting.

"Next stage is full analysis of the investigation report from Dr. Anderson and Eugene Fee with a planned review meeting on the case with Murray Quinn."

(a) **What purpose did you believe that such a meeting would serve?**
There was a range of information from various sources and I felt that this meeting would ensure that Dr. Quinn and the Review Panel members (Mr. Fee and Dr. Anderson) were aware of all the reports and information that Dr. Kelly had obtained.

(b) **Insofar as you are aware did Dr. Kelly comply with your request to convene a meeting between himself and Messrs Fee, Anderson and Quinn?**

I recall there was a delay in obtaining all the reports and documentation. I also recorded the following in my notes; 030-010-018+9
11th May *"Confirmed with Mr. Fee my request to Dr. Kelly."*
26th May *"Reminded Dr. Kelly that once reports were received he should convene the meeting with Dr. Quinn, Dr. Anderson and Mr. Fee to agree the way forward in responding to parents"*
5th June *"Dr. Kelly advised he was co-ord date for meeting. Dr. A on leave + Mr. F going on leave."*

I was advised that Dr. Kelly and Mr. Fee went to meet with Dr. Quinn. I believe a separate meeting took place involving Dr. Kelly, Mr. Fee and Dr. Anderson.

(c) **If such a meeting did take place, did you receive feedback in relation to it? If so, what were you told?**
In respect of the meeting with Dr. Quinn I understand he agreed to complete his report and send to Mr. Fee.
In respect of the meeting with Mr. Fee and Dr. Anderson I believe they were to finalise the Review and submit to Dr. Kelly.

(d) **Please provide a record of the meeting, if one exists.**
All the documentation in respect of Lucy's care has been submitted to the Inquiry and I am not aware of a record of these meetings.

(e) **If such a meeting did not take place, please explain why it did not take place.**
See above.

(20) **There is a further record of your meeting with Dr. Kelly on the 4 May 2000 at [Ref: 030-052-070]:**

"4. Untoward Death

Dr. O'Donohoe – JK worried about
Criminal investigation could be a possibility if initiated by Coroner
? date with family
Reports awaited
Meeting – Trevor, Jim, Eugene +Murray Quinn to consider + report on the circumstances."

Arising out of that record please address the following matters:

(a) **Did you ascertain why Dr. Kelly was worried about Dr. O'Donohoe?**

I believe that this records the view that Dr. Kelly expressed to me about concerns he had about the stress on Dr. O'Donohoe at this time. I was informed that Dr. O'Donohoe felt he was responsible for Lucy's death.

(b) **Why was it considered that a criminal investigation "could be a possibility?"**
This note records the view expressed to me by Dr. Kelly. It would be a matter for the Coroner to decide if this was necessary.

(c) **What factors suggested to you that a criminal investigation "could be a possibility"?**
This note records the view expressed to me by Dr. Kelly. I had no information to suggest that a criminal investigation could be a possibility and it would be a matter for the Coroner to decide if this was necessary.

(21) **As appears from these records for the 4 May 2000, it was part of your role as Chief Executive to request that particular meetings should be arranged. Did you give any consideration to tasking Dr. Kelly, Mr. Fee or Dr. Anderson with the responsibility to contact clinicians at the Royal Belfast Hospital for Sick Children to seek their opinions on the cause of Lucy's deterioration and death? If so, what consideration did you give to that issue, and what steps, if any did you take?**
From the information I had at the time I understood that Dr. Kelly and Mr. Fee were in receipt of all the reports and information available or were in the process of obtaining those required from the clinical staff at RBHSC. The purpose of my request for the proposed meeting was to ensure Dr. Quinn and the members of the Review Panel had access to all the information and reports from both locations where care was provided for Lucy.

(22) **The following entry is contained in your notes for the 11 May 2000:**

"Mr. Fee still awaiting one report from a member of staff. Dr. Quinn had provided verbal advice that fluids may not have been excessive. Confirmed with Mr. Fee my request to Dr. Kelly."
[Ref: 030-010-018]

Arising out of that record please address the following matters:

(a) **Did you ask Mr. Fee to explain Dr. Quinn's view that "fluids may not have been excessive?"**
I noted the information, however felt it would be better to await Dr. Quinn's report.

(b) **Did Mr. Fee explain Dr. Quinn's view that "fluids may not have been excessive?" If so, what did he say?**
This was an initial report from a telephone discussion Mr. Fee had with Dr. Quinn and I do not recall any further detail being provided.

(c) **What degree of reassurance did you take from what Mr. Fee was reporting to you?**
This information provided a significant degree of reassurance, however there were concerns about the recording and rate at which fluids were administered and it would be important that we awaited the receipt of Dr. Quinn's report.

(23) **The following entry is contained in your notes for the 23 May 2000:**

"Mr. Fee advised that Dr. Kelly and he were meeting with Dr. O'Donoughue (sic) the next day."
[Ref: 030-010-019]

Arising out of that record please address the following matters:

(a) **What was your understanding of the purpose of that meeting?**
Ref. 030-010-019. Dr. Duffy met with me on Mon. 15th May. See note as follows;
"Dr. Duffy raised issues about community paediatrics. Agreed if Dr. Sharma covered Fermanagh, Dr. O'Donoughoe could cover hospital services whilst vacant post remained unfilled"
Dr. Duffy was a Staff Grade doctor in Fermanagh paediatrics. The consultant paediatrician who covered the Fermanagh community had retired and a vacancy existed. Dr. Duffy was concerned about the senior cover for the community service, particularly with the situation regarding Dr. O'Donohoe who had supervisory responsibilities for her work. Dr. Sharma was the community paediatrician in the Omagh sector of the Trust.
My note dated 19th May is also associated with this matter.
"Mr. Fee confirmed he had discussed with Dr. Sharma and was sending her a letter of offer to cover Fermanagh community."
The purpose of the meeting was to consider Dr. O'Donohoe's health and to advise him of the implementation of the change in responsibility for Fermanagh community paediatrics.

(b) **Insofar as you are aware, did the meeting between Messrs. Kelly, Fee and O'Donohoe actually take place?**
Yes. I understood it took place.

(c) **If such a meeting did take place, did you receive feedback in relation to it? If so, what were you told?**
Ref. 030-010-019. See second part of my note dated Thurs 26th May
"Mr. Fee and Dr. Kelly also advised me of defensive position adopted by Dr. O'Donoughoe in respect of Fermanagh Community Paediatrics."

(d) **Please provide a record of the meeting, if one exists.**
I am unaware if a record of this meeting exists.

(e) **If such a meeting did not take place, did you receive an explanation or do you know why it didn't take place?**
See above.

(24) **Please translate the handwritten note which appears at [Ref: 030-010-019].**
"Dr. K on leave" refers to the fact that Dr. Kelly had taken leave on some days between 26th May and 5th June.
"5th June Dr. Asghar" Refers to the letter dated 5th June Ref 035-049-138 I received from Dr. Asghar when he met with me in my office.
"Dr. K advised he was co-ord date for meeting. Dr. A on leave + Mr. Fee on leave." - See answer to Question 19b above
"12th June Dr. Asghar further letter Mr. Fee advised meeting with Dr. K" Refers to the letter dated 12th June 2000 from Dr. Asghar referring to case (UG). The report of the meeting held by Dr. Kelly and Mr. Fee with Dr. Asghar on 12th June can be found at Ref 036a-101-217
"14th June Briefed Mr. Frawley info. Coming forward" Refers to meeting with Mr. Frawley held on 14th June Ref 036b-002-002

(25) **Please refer to the "Programme" for a meeting with Mr. Clive Gowdy at Trust Headquarters on 14 June 2000 at [Ref: 030-009-016].**

Arising out of that document please address the following matters:

(a) **The "Programme" refers to an agenda for a meeting at 2.30pm. Please provide a copy of this agenda.**
I do not have access to this document.

(b) **What was the purpose of the meeting with Mr. Gowdy?**
Clive Gowdy would have made visits to the Trusts and met with staff in services and facilities

(c) **Was Mr. Gowdy given any information regarding the circumstances of the death of Lucy Crawford, and the fact that the Trust was undertaking a Review? If so, what was he told, and who provided him with information on these matters.**
Due to the passage of time I do not recall

(d) **If Mr. Gowdy was apprised of any of these matters, how did he respond?**
Due to the passage of time I do not recall

(26) **The following entry is contained in your notes for the 15 June:**

"L. Crawford – fluid near miss but not direct cause - Belfast. Other views from a distance." **[Ref: 030-008-015]**

(a) **Please clarify whether this note relates to a meeting which took place on the 15 June 2000.**
It is either a meeting or telephone conversation

(b) **Who attended this meeting and what was the purpose of the meeting?**
This information was provided to me by Dr. Kelly

(c) **Please explain what each aspect of this note means or was intended to convey.**
The note records the views that Dr. Kelly had collated at this time.

(d) **To the extent that the note reflects the opinion of a person(s) that Lucy's case involved a fluid *"near miss"* but that this had not been responsible for causing the cerebral oedema, please indicate who advanced this opinion, and explain where the information come from to support this opinion.**
Dr. Kelly advised me that this was the view he had obtained. My reference to "Belfast" suggests the opinion was from the clinicians who cared for Lucy in RBHSC but I cannot be certain. The reference to "Others. Views from a distance" reflects the information Dr. Kelly was providing on the issues being raised by junior medical staff.

(27) **Please explain what steps were taken by the Sperrin Lakeland Trust when the Review report was finalized, and address the following additional matters:**

(a) **Who was the report sent to?**
I believe the report was sent to Dr. Kelly, Dr. McConnell, Mr. Bradley and myself. There were recommendations in the report to share and discuss the findings with (a) "the team members involved in the care of the child, on the night in question" and (b) "it would be appropriate for another meeting with the family to appraise them of all of the knowledge and opinions we have at this point. Whilst we are not in a position to give them definite answers we may at least be able to demonstrate our openness and show to them the measures that have been taken to analyse the care of Lucy's admission."

(b) **Was the report considered at Trust Board level? If so, identify those who considered the report at Trust Board level, and provide any record of any meeting at which the report was considered.**
I believe the report was shared and discussed with the Trust Chairman.

(c) **What action was taken by Trust management in relation to the findings of the Review and its recommendations?**
The findings of the Review and the introduction of the recommendations were to be taken forward by Mr. Fee and Dr. Kelly on behalf of the Trust.

(28) **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]**

(a) **What response, if any, did you personally make to the Review report?**
I noted the findings. I was more reassured that the action taken by staff had not led to causing Lucy's death.

(b) **Having read the Review report and the conclusion set out above, did you discuss it with anyone else? Who did you discuss it with and what was discussed? Please provide a record of any such discussion s which may exist.**
I believe I discussed it with Dr. Kelly, Mr. Fee and the Chair of the Trust.

(c) **How satisfied were you with a report that could not provide an "absolute explanation" for the deterioration in Lucy's condition?**
At this time I had been involved in health and social care management for almost 27 years. It would not have been an unusual outcome for some medical situations not to have an "absolute explanation".

(d) **In the absence of an "absolute explanation" for the deterioration in Lucy's condition did you give any consideration to reporting the death to the Coroner? If so, what consideration did you give to this issue and what conclusions did you reach. If you did not give consideration to this issue, please explain why?**
It was my understanding at this time that the death of Lucy had already been reported to the Coroner.

(e) **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.**
It was my understanding at this time that the death of Lucy would be the subject of an inquest.

(f) **In the absence of an "absolute explanation" for the deterioration in Lucy's condition, did you give any consideration to what further steps the Trust could take to address this issue? If so, what consideration did you give to this issue, and what conclusions did you reach? If you did not give consideration to this issue, please explain your omission to do so.**
At this time the Trust were taking forward an external review commissioned from the Regional Adviser from the Royal College of Paediatricians of a number of cases which had been drawn to our attention. These cases included that of Lucy's, so a further examination of her care would be taking place.

(29) **What response, if any, did the Western Health and Social Services Board make to the Review report? In particular please account for any discussions which you held with representatives of the WHSSB, and any correspondence entered into.**
Due to the passage of time I do not recall the specific response by the Western HSS Board to the Review report. I had informed Mr. Frawley Ref 036b-002-002 of the concerns that had been raised and how we planned to take them forward.

(30) **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.**
The Review was useful in tracing the actions of the staff involved in the treatment and care for Lucy from her admission to the Erne Hospital until she was transferred to RBHSC. There was an external opinion provided that the fluids administered to Lucy should not have resulted in her deterioration. The Review identified short comings in respect of prescribing and recording and the importance of standard protocols being readily available in the ward against which treatment can be compared.

I do not recall having any views that the objectives of the Review were not satisfied.

(31) **Are you now satisfied with how the Review was conducted by Mr. Fee and Dr. Anderson and the conclusions which were reached? Please fully explain the answer that you give.**
I do not understand the relevance of this question. See my answer to question 30 above.

(32) **Did you consider the report of the Review to satisfy yourself as to its conclusions and to ensure that it had been conducted to a good standard? If so, please explain the steps that you took and the conclusions which you reached.**
I do not recall having any view which would have questioned that the Review was not conducted to a good standard.

(33) **If you weren't responsible for considering the report to satisfy yourself as to its conclusions and to ensure that it had been conducted to a good standard, whose responsibility was it?**

I would not have had sole responsibility. I did not receive any views at this time from Dr. Kelly or any other parties that the conclusions or the standard of the Review were unsatisfactory.

(34) **Mr. Neville Crawford was sent a copy of the Review report under cover of letter dated 10 January 2001 [030-056-076]. Please address the following matters:**

(a) **Why was there a delay in providing Mr. Crawford with a copy of the report?**
The recommendation in the Review 9(d) stated *"it would be appropriate for another meeting with the family to appraise them of all of the knowledge and opinions we have at this point. Whilst we are not in a position to give them definite answers we may at least be able to demonstrate our openness and show to them the measures that have been taken to analyse the care of Lucy's admission."*
I understood that this recommendation would be taken forward by clinical staff involved to-gether with Dr. Anderson and Mr. Fee. However this did not take place and earlier attempts to set up this meeting (See letters via the WHSS Council 11th Oct 2000 and 10th Nov 2000 and directly to Mr. Crawford 22nd Nov) were not taken up by Mr. Crawford.

(b) **Why was Mr. Neville not provided with a copy of the appendices which attached to the Review report, including the report prepared by Dr. Quinn?**
I presume this should be Mr. Crawford. I was on leave at the time the report was sent to Mr. Crawford and cannot comment on why the report from Dr. Quinn was not included with the letter.

(35) **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?**
Yes.

(b) **If so, please identify which of the documents you were provided with and state when you received them.**
I have seen all these documents except the notes of the meeting between Dr. Kelly and Dr. Stewart.
I note receiving Dr. Stewart's report at a meeting with Dr. Kelly on 27th June 2001. Ref 030-040-052
I do not recall the dates on which I read the other documents

(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?**
Yes

(d) **If so who discussed these matters with you, and when were these matters discussed?**
Dr. Kelly discussed the report from Dr. Stewart with me Ref 030-040-052

(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?**
At the time of receipt of these reports the case had gone to litigation and I would have sought assurance that the reports were shared with the Trust's legal representatives for their advice.

(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?**
At the time of receipt of these reports the case had gone to litigation and I would have sought assurance that the reports were shared with the Trust's legal representatives for their advice.

(36) **State the date on which you first became aware that an Inquest was not planned in relation to Lucy's death, and explain the circumstances in which you were given this information, and identify who advised you of this.**

This information was obtained from the Trust's legal representatives who enquired from the Coroner's office when the inquest would be held. I subsequently understood this was made known to the Trust on 12th Oct 2001. I do not recall who advised me of this.

III. OTHER MATTERS

(37) **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.**

The medical reports the Trust received from Dr. Quinn and Dr. Stewart identified the shortcomings in care provided to Lucy, in respect of the recording and prescribing of fluids. There was some debate, even up to the time of the inquest among medical professionals about the type of fluid which was appropriate.

(38) **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.

There have been changes to practice initiated across the NI Health and Social Care system with the introduction of clinical and social care governance in respect of the following

- The withdrawal of solution No.18
- The reporting of adverse incidents
- The use of root cause analysis in the investigation of incidents
- The involvement of relatives in the examination of adverse incidents

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

I have no further points to make at this time.

(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 approach to management;**

(e) **Any other relevant matter.**

Appendix A

Question 1(b) Employment History

February 2009 to date – Consultant (P/T)
Supervision of Befriending and Victims Groups on behalf of Community Relations Council

May 2006 to date - Chief Executive, Independent Health and Care Providers (P/T)
Appointed to the role of Chief Executive to provide leadership and strategic direction for the organisation

Nov 2005-April 2006-Director of Development for Independent Health and Care Providers
Commenced on a part time basis for two years supporting members from the independent sector in promoting their interests with Government and its agencies, membership development and communications.

1996-2005 Chief Executive - Sperrin Lakeland Health and Social Care Trust
This was a new provider organisation established in April 1996. Amongst the achievements in this post were the effective establishment of the organisation and its Headquarters function, the development of community care alternatives in service delivery, improvements in children's services, managing the response to major terrorist incidents, planning major capital developments such as new hospitals and establishing clinical and social care governance arrangements.

1995-1996 Unit General Manager - Sperrin Lakeland Management Unit, Western Health and Social Services Board (WHSSB)
This post was established in August 1995 to lead the merger of two organisations and apply for Trust status.

1990-1995 Unit General Manager – Omagh and Fermanagh Management Unit, WHSSB
As a new organisation which amalgamated services in two communities which were previously in separate and competing districts this was a challenging post which involved major organisational and service change.

1990 Assistant Unit General Manager, Altnagelvin Area Hospital, Londonderry. WHSSB
A brief appointment following the introduction of general management to the health service in N. Ireland.

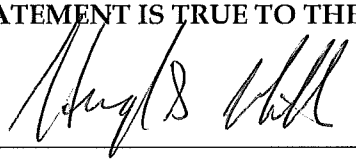
1987-1990 Deputy Group Administrator, Londonderry, Limavady and Strabane Group
Responsible for the administrative functions at Altnagelvin Area Hospital, Londonderry and the support service functions in the Londonderry, Limavady and Strabane Group.

1973-1987 Various appointments in health service administration in N. Ireland
Following selection as a graduate trainee in health service administration, with training at Manchester Business School, I held a number of appointments at hospital and social care management level.

Personal Appointments Held

1997-2003 Member of the UK National Council of the NHS Confederation
2000-2003 Member of the Board of Trustees of the NHS Confederation
2005-2007 Independent Panel Member of the Special European Union Programme Body
2006-2009 Executive Committee Member Age Concern (Northern Ireland)
2009-2012 Trustee of Age NI

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

Signed:  Dated: 16th Nov 2012

SPERRIN LAKELAND HEALTH AND SOCIAL CARE TRUST

JOB DESCRIPTION

TITLE: CHIEF EXECUTIVE

REPORTS TO AND ACCOUNTABLE TO: CHAIRMAN

The term "he" has been used throughout the job description for ease of reference; it should be taken as meaning "he/she".

Job Purpose

The Chief Executive will be personally accountable to the Chairman for the effective management of the entire business of the Trust delivering services in accordance with quality specifications and within contract income. He will be expected to demonstrate clear leadership across the Trust and in particular to maximise the potential for multi-professional, inter programme and inter agency working.

The Chief Executive will fulfill corporate responsibilities as a member of the Trust Board and leader of the Trust's Senior Management Team.

Principal Responsibilities

1.1 To provide Executive Leadership and deliver high performance in all aspects of Trust activity.

1.2 To initiate strategies, policy development and service programmes that are meaningful, timely and serve the interests of the Trust.

1.3 To ensure effective development, implementation and monitoring of the Trust Business Plans.

1.4 To manage change and ensure that the Trust and its activities continue to meet the challenge of the Government reforms, the needs of purchasers and consumers and retain a competitive edge.

1.5 To ensure that an effective management and clinical organsiation exists with the capacity to deliver health care and business objectives of the Trust.

1.6 To ensure the continued financial viability of the Trust through the negotiation of appropriate contracts, the maximisation of income, control of costs and the development of management capability.

1.7 To build a positive image for the Trust through the development of a sensitive and responsive Communications Strategy and effectively managed programmes of action.

1.8 To develop the capabilities of individuals within the Trust through a sensitive and performance orientated Human Resource Strategy.

1.9 To ensure effective internal communication processes exist and are used.

1.10 To develop effective partnerships and strategic alliances with other agencies to support and enable effective health care programmes.

1.11 To act as principal adviser to the Chairman and Non-Executive Directors.

1.12 To monitor all activities of the Trust and take corrective/reinforcing action wherever appropriate.

Corporate Responsibilities

2.1 To ensure compliance of the Trust's Standing Orders and Standing Financial Instructions and ensure effective Corporate Governance.

2.2 To promote actively achievement of the Trust's health care and management objectives.

2.3 To contribute to the Corporate decision making of the Trust and team working of the Board.

2.4 To ensure that the Trust's objectives and decisions are effectively communicated to staff.

2.5 To promote a positive image for the Trust with appropriate external agencies.

2.6 To contribute to the effective delivery of the Trust's Quality Management Strategy and programmes.

2.7 To promote the effective use of the Trust's financial, physical and human resources and contribute to cost improvement and value for money programmes.

Context and Organisational Relationships

The Sperrin Lakeland Health and Social Care Trust aims to be the Provider of health and social care for the people of West Tyrone and Fermanagh and surrounding communities.

The Trust is committed to providing the best possible service, in the most effective way, within its available resources. The postholder will liaise with the following to meet agreed objectives and secure the success of the Trust:

- Chairman of the Trust
- Non-Executive Directors
- HSS Executive
- Western Health and Social Services Board
- Other Purchasing Organisations
- Provider Organisations
- MPs/Councillors
- General Practitioners
- Clinicians
- Local Authorities
- Voluntary Organisations
- Community Groups
- Media
- Trade Union Officials
- Western Health and Social Services Council

Accountabilities

The postholder will be directly accountable to the Chairman of the Trust and, as Chief Executive, has a personal responsibility to guide the Chairman and Trust Board members on matters of good practice and corporate/personal accountability. He will also be answerable to the Chief Executive of the HPSS Management Executive in respect of the "accounting officer" responsibilities in line with Government Accounting for Northern Ireland.

The duties outlined in this job description serve as a guide to the current and major responsibilities of the post. The duties and obligations associated with the post will inevitably vary and develop and the job description will be reviewed on a regular basis. Changes will be subject to consultation with the postholder.

NOVEMBER 1996

York. The Chairman wished to congratulate and convey the Trust Board's continued good wishes to Mr Kaluskar, Miss Law and the organisers of the event.

Clinical Governance Seminar

Friday 17 September had seen the Trust host a very well attended seminar on the theme of clinical governance. Over 150 delegates from Trust staff, and other Trust's, GP Practices and Purchaser organisations had attended the seminar. The Chairman noted that clinical governance had already been introduced on the mainland. He felt it was useful to learn the experience from England including Dr Gabriel Scally Regional Public Health Director of the South West Region. It was expected that Northern Ireland would adopt similar principles as early as next year. The Chairman noted the Trust would know more detail when the HPSS launched the Quality Paper promised in 'Fit for the Future', and he was delighted that Mr Brian Grzymek from the department responsible for the quality strategy was one of the speakers at the seminar. The Chairman wished to congratulate the Trust staff who had organised the successful event.

Omagh Street Drinkers Initiative

The Chairman advised that the mental health service within Sperrin Lakeland Trust had been instrumental in raising awareness and organising action in relation to individuals with chronic alcohol or drug dependency problems, often referred to as 'street drinkers'. He noted the group did not currently fit into mainstream services, though had above average risk of poor physical, mental health and social problems.

The Trust had led an inter-agency group made up of a number of voluntary and statutory organisations who had assessed the needs of this particularly deprived group of people. The Chairman was pleased to note that a bid submitted to the Omagh District Partnership for funding under EU Special Support Programme for Peace and Reconciliation to develop outreach services for street drinkers in the Omagh area had been approved. The project, which was funded for one year, had recently appointed a project co-ordinator who would be responsible for providing advice, information and help in accessing accommodation and other support services for the vulnerable group of people.

On behalf of the Trust Board, the Chairman wished to extend the Trust's congratulations to the staff from the mental health service who had been involved in the initiative and achieved the very positive outcome.

Primary Care Developments

The Chairman advised that within the Mental Health and Elderly Directorate of the Trust, there had been an ongoing commitment to promote better understanding, communication and collaborative working within the secondary mental health service and the primary care sector including General Practitioners.

The Chairman noted that initiatives earlier in the year had included the introduction of a mental health service directory, and the development of a training package on the recognition and management of depression for primary care staff. A further