Witness Statement Ref. No. 293/2

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 - December 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]

WS-293-1 November 2012

Interview by PSNI on 7th April 2005

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

Ref:	Date:	
WS-293-2	16-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. QUERIES ARISING FROM YOUR STATEMENT TO THE INQUIRY WS-293/

(1) Arising out of your answer to question 1(d) of WS-293/1, please address the following matters:

(a) Explain the procedures regulating clinical audit in the Sperrin Lakeland Trust as of April 2000.

I do not have access to the guidance regarding clinical audit. As I recollect the proposals for topics for clinical audit would be agreed by Clinical Directors and senior consultants and reports would be shared at clinical audit meetings, mainly attended by medical staff. Information on clinical audits was collated by the Trust Medical Director and a number of audit reports were presented to senior management and Trust Board members. Occasionally I would have attended clinical audit meetings to hear presentations.

(b) Was Lucy Crawford's case evaluated under the Trust's arrangements for clinical audit? If so, outline the steps that were taken under the clinical audit arrangements with respect to Lucy's case.

No, Lucy's case was not evaluated as part of clinical audit.

(c) Explain the procedures regulating the reporting of adverse incidents in the Sperrin Lakeland Trust as of April 2000.

See Clinical Incident Report form Ref: 036a-045-096. I do not have access to guidance or advice notes in respect of completion of this form.
Also see my answer to Question 3 below.

(d) Outline each step which was taken in Lucy's case pursuant to the procedures governing the reporting of adverse incidents within the Trust.

Please see the response I provided to Question 5 of WS-293/1

(2) **Arising out of your answer to question 1(e) of WS-293/1, although Lucy did not die in the Erne did you nevertheless seek an assurance that Lucy's death had been reported to the Coroner's Office? If so, were you given that assurance and by whom?**

As far as I can recall I believe I was advised that Lucy's death had been referred to the Coroner's Office. I expected that in due course a Coroner's inquest would be held. I don't have a record of when I received this information, but it would have been around the time of Lucy's death and I expect the information was provided by either Dr Kelly or Mr Fee.

(3) **Also arising out of your answer to question 1(e) of WS-293/1, please arrange for the Inquiry to be provided with the title of the legislation you are referring to, as well as copies of the polices and circulars which you say were relevant to your responsibilities as a Chief Executive of the Trust.**

The relevant legislation is the Coroner's Act 1957 and the Health and Personal Social Services (NI) Order 1991.

The Trust has copies of the following procedures which may be relevant to the Inquiry.

1. Circular P.1/86 WHSSB, Notification of Untoward Events/Unusual Occurrences To Board Headquarters 3rd Feb 1986
2. Circular ADM1 9/96 Sperrin Lakeland HSC Trust Procedures for Recording and Notifying Accidents, Untoward Events and Unusual Occurrences on Trust Premises February 1997

(4) **Also arising out of your answer to question 1(e) of WS-293/1, where you have referred to well established arrangements for reporting untoward incidents to the WHSSB, please address the following matters:**

(a) **Fully describe the arrangements for reporting untoward incidents to the WHSSB, and clarify whether those arrangements formed part of a set of policies or procedures which were committed to writing. If committed to writing please arrange for the Inquiry to be provided with a copy of same.**

In my response to question 1(e) I explained the origins of Sperrin Lakeland Trust. I had previously been the Unit General Manager in a directly (by the WHSSB) Managed Unit and there was in place requirements to report untoward incidents to the WHSSB. The Trust continued with these arrangements.

Circular P.1/86 WHSSB, Notification of Untoward Events/Unusual Occurrences To Board Headquarters 3rd Feb 1986 describes these arrangements.

The formal process for the reporting of clinical incidents was being introduced as part of clinical governance arrangements. Clinical incidents were reported by Clinical Directors or Clinical Service Managers to the Trust Medical Director (Dr Kelly) and/or the Trust Director of Acute Services (Mr Fee). They would inform myself and I would ensure the General Manager of the WHSSB was informed. Statements would be obtained from the staff involved as part of the Review.

(Also See 036a-046 first para and 030-050-064 Point 2 "Critical Incident reporting slowly getting of the ground. Pushing into Directorates.")

The DHSSPS introduced a formal procedure for reporting adverse incidents in acute hospital services in autumn 2004.

(b) **Explain your understanding of whether there was a requirement to report untoward incidents to the WHSSB, and if so, the basis for and the purpose of that requirement.**

Yes. I understood there was a requirement to report untoward incidents to the WHSSB. They were our main commissioner of our services and we were continuing with arrangements in place prior to becoming a Trust. Apart from this the senior officers at the Board were involved in directly managing the outcome of

adverse incidents before 1996 and brought significant expertise and advice from this and their awareness of situations elsewhere.

(c) **Explain your understanding of whether there was a requirement to report untoward incidents to the DHSSPS.**
My understanding was that if senior officers at the WHSSB felt an untoward incident should be reported on to the DHSSPS they would either forward the report or request the Trust to do so.

(5) **Arising out of your answer to question 10 of WS-293/1, please explain how you went about ensuring that the contents of the report were shared with Lucy's parents, and address the following questions:**
One of the recommendations of the Review was that there should be 'another meeting with the family to appraise them of all of the knowledge and opinions that we have at this point'. The parents had met with Trust staff (Dr O'Donohoe, Paediatrician and Mrs Doherty, Health Visitor). It was the intention that Dr O'Donohoe and Mr Anderson were to meet with Mr and Mrs Crawford however this meeting did not take place. (Ref: 030-048-061)
However Mr and Mrs Crawford prior to the completion of the Review (See note of meeting with Dr Kelly dated 25th July 2000. Ref: 030-050-064) had already engaged with Mr Stanley Millar Chief Officer of the Western Health and Social Services Council (WHSSC). I viewed this as helpful as the Council provided advocacy services on behalf of patients and relatives. A letter of complaint dated 22nd September 2000 (Ref: 033-041-139) was received from Mr Crawford on 29th Sept 2000. A letter dated 11th Oct 2000 Ref: 033-039-135) was sent to Mr and Mrs Crawford seeking a date to meet with a number of staff to share the contents of the Review. It is a matter of some regret that the Trust did not reach a suitable agreement with the parents that would enable them to meet with Trust staff. Following an exchange of letters, the Review was sent as an attachment to the letter dated 10th January 2001(Ref: 033-021-037) from the Trust. A further offer to meet with Mr and Mrs Crawford was made in my letter dated 30th March 2001 (Ref: 033-018-034)

(a) **Identify the "*appropriate staff*" in the Trust with whom the report was shared?**
The medical and nursing staff who were involved in the treatment of Lucy at the Erne Hospital. Dr Kelly, Medical Director, Ms O'Rawe, Director of Corporate Affairs

(b) **When did you share the report with those members of staff?**
Mr Fee made the arrangements to share the outcome of the Review with the above staff.

(c) **What was your purpose in sharing the report with those members of staff?**
Staff were involved in the care of Lucy and should be aware of the outcome of any investigation and lessons to be learnt.

(d) **Did you share with those members of staff a full copy of the report, inclusive of appendices? If you did not do so, please explain the reasons for withholding any part of the report from staff members.**
I understand Mr Fee met with staff to share the contents of the Review

(e) **Which members of staff in the WHSSB was the report shared with?**
Dr McConnell and Mr Martin Bradley

(f) **What was your purpose in sharing the report with members of staff at the WHSSB?**

There was a requirement for the Trust to provide a written report to the Board, following the initial verbal reporting of the incident.

(g) **Did you share with those members of staff at the WHSSB, a full copy of the report, inclusive of appendices? If you did not do so, please explain the reasons for withholding any part of the report from WHSSB staff members.**
Mr Fee arranged for the Review to go to the WHSSB.

(h) **When did you share the contents of the report with Lucy's parents?**
The Review was sent to Lucy's parents with a letter signed by Michael MacCrossan on 10th January 2001 (Ref; 033-021-037). I was on annual leave at this time.

(i) **How did you share the contents of the report with Lucy's parents?**
See answer to (h) above.

(j) **Did you disclose to Lucy's parents a full copy of the report inclusive of appendices? If you did not do so, please explain the reasons for withholding any part of the report.**
I understand that the Review sent to Lucy's parents did not include the appendices. I was on leave at this time and do not know the reasons the appendices were withheld.

(6) **Arising out of your answer to question 12(c) of WS293/1, please address the following matters:**

(a) **Clarify where the requirement for medical staff to report their knowledge of any adverse incident is derived from? eg. is this requirement set out in Trust policies or procedures, or are you referring to a particular professional obligation?**
Clinical governance, professional obligation and Trust procedures See Clinical Incident Report form Ref: 036a-045-096

(b) **In Lucy's case identify by name those medical staff who ought to have made a report of an adverse incident to their Clinical Director and Medical Director?**
Dr O'Donohoe

(c) **In circumstances where a requirement to make an adverse incident report was triggered, what kinds of information should have been conveyed to the Clinical Director or Medical Director?**
Name of patient, date, time, location, patient's age, circumstances, treatment and medication provided and outcome.

(d) **Were the reporting requirements fully complied with in Lucy's case?**
Yes.

(7) **Arising out of your answer to question 12(j) of WS-293/1, did the WHSSB advise the Trust in relation to action which it wished the Trust to take? If so what action was advised, and was this advice followed?**
Due to the passage time I do not recall if the WHSSB advised the Trust of any specific action. As this was an initial report there would be an expectation that as further information emerged this would be conveyed to the WHSSB.

(8) **Arising out of your answer to question 21 of WS-293/1, state precisely the reports and information which you understood Dr. Kelly and Mr. Fee were obtaining from staff at the RBHSC, and address the following:**
The Post Mortem Report and any other clinical notes which would be relevant information for Dr Quinn and the Review Panel.

(a) **Who at the Sperrin Lakeland Trust was responsible for liaising with the RBHSC in order to obtain the necessary reports and information?**
Dr Kelly and Mr Fee

(b) **What reports and information did the Sperrin Lakeland Trust obtain from the clinical staff at RBHSC?**
Post Mortem Report

(c) **Did you give any consideration to whether the Sperrin Lakeland Trust had obtained sufficient information from the RBHSC about Lucy's case? If so, what consideration did you give to this issue and what conclusions did you reach?**
I considered that this was a matter for the Review Panel.

(9) **Arising out of your answer to question 27(a) of WS-293/1, please address the following matters:**

(a) **What steps were taken to share and discuss the findings of the report with the team members who were involved with the care of Lucy?**
This was conducted by Mr Fee

(b) **Who conducted these discussions?**
Mr Fee

(c) **Which team members participated in the discussions?**
I do not know

(d) **What was the outcome of the discussions?**
Due to the passage of time I do not recall

(e) **If any particular team member did not participate in the discussions please identify him/her by name, and explain why they did not participate?**
I am unable to comment

(f) **What steps did you take to assure yourself that the findings of the report were shared and discussed with team members? If you sought and received assurances, please provide full details of the assurances you got.**
Mr Fee advised me that a meeting was held with staff involved.

(10) **Arising out of your answer to question 27(b) of WS-293/1, please address the following matters:**

(a) **Who was the Trust Chairman?**
Mr Richard Scott

(b) **Who shared the report with the Chairman?**
Myself

(c) **What date was the report shared with the Chairman?**
I do not recall this information. The Chairman was advised of Lucy's death on Monday 17th April Ref: 030-010-017. There is also a reference to the Chairman being advised about the report sought from the Royal College of Paediatricians (see notes of meetings with Dr Kelly on 9th Oct 2000 Ref: 030-048-061)

(d) **Did the Chairman receive the full report including appendices? If he did not receive the full report, please explain the omission to provide the full report to him.**
I do not recall.

(e) **Who discussed the report with the Chairman?**
Myself

(f) **On what date was the report discussed with the Chairman?**
I do not recall.

(g) **Please make arrangements for the Inquiry to provide any record of the discussions with the Trust Chairman.**
All information held regarding discussions with the Chairman was made available.

(h) **What was the outcome of the discussions with the Chairman?**
I do not recall any requirements raised by the Chairman following the receipt and discussions on the Review. The Chairman would have also been briefed about the letter from Dr Ashgar and the steps being taken to convene a further report on a number of cases including Lucy's care from the Royal College of Paediatricians. (Ref: 030-048-061) Note response to (c) above.

(11) **At question 30 of WS-293/1, you are asked whether the objectives of the Review satisfied in all respects, and you are asked to identify any objective which wasn't satisfied etc. Please review your answer and address these particular aspects of the question.**
I do not recall having any views that the objectives of the Review were not satisfied.

(12) **In answer to question 30 of WS-293/1, you have summarised your understanding of the shortcomings which the Review had identified. Please address the following matters arising out of your answer:**

(a) **Did you subsequently become aware that mismanagement by staff at the hospital may have contributed to the cause of Lucy's cerebral oedema?**
I became aware of more definitive information that the potential for the amount and type of fluid administered to Lucy may have contributed to the cause of Lucy's cerebral oedema. This was received following the death of Raychel Ferguson in Altnagelvin Area Hospital.

(b) **If so, state the date on which you first became aware of this, and explain how you became aware of this?**
I don't have the specific date, however Dr Kelly advised me of this following a regional meeting of Medical Directors where he heard of Raychel's death.

(c) **If applicable, what specific steps did you take when you became aware that mismanagement by hospital staff may have contributed to the cause of her cerebral oedema?**

This new information received from Dr Kelly, required consideration. Legal proceedings had commenced (27th April 2001) in respect of Lucy's death and medical reports were being obtained for this purpose. I understand the new information was shared with Dr Jenkins who was advising the litigation team.

(13) Arising out of your answer to question 35(e) of WS-293/1, please explain whether you took any steps on behalf of the Trust to apprise the Coroner of the findings contained in the reports of Dr. Stewart, Dr. Jenkins, or Drs. Stewart/Boon. If you did not take any such steps, please explain why you did not do so.

I did not take any steps to apprise the Coroner. I understand that Dr Jenkins report was prepared for the Inquest. I do not know if the other two reports were shared with Dr Jenkins or the Coroner.

(14) Arising out of your answer to question 34(b) of WS-293/1, please address the following matters:

(a) When did you first realise that the Review report was sent to Mr. Crawford without the report of Dr. Quinn or the other appendices?

I believe this was when the Crawford's solicitor wrote to the Trust seeking a copy of the report and appendices.

(b) Did you discuss with anyone the failure to send the Crawford family the full report? If so, who did you discuss this with and what action was taken following any such discussion?

Due to passage of time I do not recall

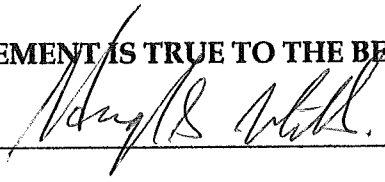
(c) Please explain why you did not take steps to provide Mr. Crawford with a copy of the full Review report?

I was on leave at the time the Review was sent to Mr Crawford and cannot comment on why the report from Dr Quinn and appendices were not included with the letter.

(15) Arising out of your answer to question 36 of WS-293/1, identify the other Trust employees who were made aware on or from the 12 October 2001 that an Inquest into Lucy's death was not planned?

Dr Kelly, Ms O'Rawe, Mr Fee

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

Signed:  **Dated:** 11/3/2013