Witness Statement Ref. No. 309/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Bridget Rippey (formerly O'Rawe)

Title: Mrs

Present position and institution: PRINCIPAL CONSULTANT/OWNER – BRIDGE HR CONSULTING (SOLE-TRADER CONSULTANCY)

Previous position and institution: Director of Corporate Affairs; 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]

Nil for any formal statutory committees or bodies.

However I have been a member of the following internal groups: SLT Trust Board(1997-2005);SLT Clinical & Social Care Governance Committee(2000-2005);SLT Senior Management Team 1996-2005;SLT Joint Health & Safety Committee 1998-2005; SLT Scrutiny Committee for Medical Negligence Claims; WEHRF(Western Equality & Human Rights Forum) 2000-2005;Regional Complaints Procedure Review Group 2002-03; Regional Risk Network 2003-2004(?).

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
No statements nor depositions made.
I was responsible for collating a small number of briefing reports for the Trust Board and the Clinical & Social Care Governance Committee in years subsequent to Lucy's death and her family's complaint. These include files: 033-064-180; 033-093-245; and 033-78-215. The latter was drafted on behalf of the Chief Executive. This was a confidential briefing note. The previous 2 files were briefing papers for the Trust Board I believe. These were derived from the earlier report of the ASD. I also drafted a Briefing note file 033-073-206 which set out steps taken by the Trust in its handling of the case.

Additionally, as a result of allegations/inferences around the nature of my involvement in the Trust's response to Lucy's death, I was obliged to institute personal defamation proceedings against a local newspaper, which were concluded in my favour, following hearing in November 2010.
The judgment, laid down by Judge Gillen, is on record.

It is my understanding that my lawyer made the judgement available to the Inquiry team at that time.

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

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 to your statement.

(1) Please provide the following information:

(a) State your qualifications as at April 2000.

Bsc Hons Sociology and PG Diploma in Health Management

(b) State the date when you were appointed Director of Corporate Affairs for Sperrin Lakeland Trust.

August 1997

(c) Describe your career history before and since you were appointed to the position of Director of Corporate Affairs of the Sperrin Lakeland Trust.

June 1983-1985 Clerical Officer, RVH
Sept 1985-1987 National Management Trainee, NHS
1987-1989 Senior Administrative Officer, MD/OD, WHSSB
1989-1991 Principal Administrative Officer, Units administration/Unit General Manager's office, Altnagelvin Hospital
1991- 1995 Unit Personnel Manager, Westcare Business Services, Working with Omagh & Fermanagh Unit of management
1995-1997 acting Director of Corporate Affairs ,SLT
Appointed substantively august 1997, remained in post until leaving the Health Service under a redundancy arrangement in May 2006.
Between Sept 2006-08 I returned to college to undertake further professional studies. I set up my Human Resources consultancy in Nov 2008.

(d) Describe your duties and responsibilities as Director of Corporate Affairs in the year 2000 and provide a copy of your job description.

A Job Description should be available through Western Health & Social Care Trust (WHSCT). Essentially the role of Director of Corporate Affairs incorporated responsibility for the management and oversight of a range of Corporate administrative functions in support of the Trust Board and Trust executive Directors. The position was one of 4 support directors. I was a member of the Senior Management team which was made up of all the Directors. The support directors including my post were non-voting members of the Trust Board, attending all meetings of the Board but with no voting rights.

In 2000 the Administrative functions included: secretariat to the Board and its committees; Public relations & communications including the press office; General Risk management ;Health& safety including Chairing the Joint H&S Committee, and oversight of the accident/untoward incident reporting system; Complaints management system; Equality & Human Rights, including the Chairmanship of the joint Western Area E.H.R Forum; Litigation services including liaison with the Trust Legal services ; Quality systems oversight such as Chartermark awards . I managed a small admin team based at HQ in fulfilling these functions.

In the main, duties involved the development and maintenance of systems, procedures and processes relating to the above activities of the Trust interpreting related policy directives from the Dept. of Health and related legislative developments.
In addition in 1999 upon return from maternity leave the CE asked that I undertake to provide support to the Medical Director in introducing systems to assist the Trust in developing arrangements for the emerging Clinical & social care governance agenda given the interface with the general risk management/controls assurance agenda.

(e) Please explain what role, if any, you had in developing policies, procedures, or guidance in relation to clinical governance in the Trust in the period 1998-2000.

I was not personally responsible for the development of strategy or policy in this regard. This was the remit of the MD, to whom I provided support as the need arose, such as the coordination of workshops, as referred to below , and other related initiatives.
Between February 1999- September 1999 I was on maternity leave. Prior to taking leave the concept of Clinical governance was emerging in GB. The Trust lead was the then Medical Director(MD). Upon return from maternity leave in September 1999, I was asked to become involved in providing support to the Medical Director in setting up a committee structure to provide governance for the Trust in matters relating to clinical &social care governance(cscg). This entailed working with the MD in devising the committee agenda format, and in coordinating awareness raising workshops for clinical & professional staff. The inputs to these workshops were provided by the Medical Director and a colleague from the Department of Health. I believe these occurred during the early summer months of 2000. The MD developed a Clinical & Social Care Governance strategy document which was presented to the Board for endorsement in September 2000. This is on file 033-011. This informed the shape of the agenda for the Governance Committee.

(f) Please explain what role, if any, you had in developing policies, processes or guidance in respect of clinical incident reporting in the Trust in the period 1998 - 2000.

I did not have responsibility for the development of policy, process or procedure in respect of clinical incident reporting in 1998-2000. To the best of my knowledge/recollection no formal internal reporting system existed at that time. The development of a Regional clinical incident reporting system took place in later years. I believe direction was issued from the Department of Health in 2004.

(g) When were you first informed of the death of Lucy Crawford?

I became aware of Lucy's death within a number of days of her death in April 2000. I was advised by the CE that an unexpected death of a child had occurred. This was in my role in respect of PR/Communication in order that a Trust response could be formulated by our press officer, in the event of possible press enquiries at that time. I believe a short statement was issued at that time to confirm that a young child had died at that time.

(2) **By letter of 22 September 2000 addressed to you [Ref: 033-041-139] Mr Neville Crawford invoked the *"Formal Complaints Procedure"* in relation to the *"inadequate and poor quality care provided to my daughter Lucy following her admission to Erne Hospital on Wednesday 12 April 2000 and prior to her transfer to Royal Belfast Hospital for Sick Children on 13 April 2000."* Arising from this please answer the following questions.**

(a) Where a complaint in relation to clinical care was made to the Trust in 2000, what were your particular responsibilities and where did those responsibilities derive from?

All complaints raised with the Trust were handled under the NI HPSS Complaints procedures and the Trusts own administrative procedures. These documents should be available to the Inquiry. The only exception to this related to Child protection (under the Children's Order- social care) issues which had separate procedures.
In relation to complaints about clinical care the general process was as follows- and this was the process followed.
As the Complaints manager under the Trusts procedures I was responsible for acknowledging the complaint; explaining as necessary the process; initiating, by referral to the appropriate Investigating Officer(IO), the investigation of the concern(s);keeping the IO advised of the timescale for response; ensuring receipt of investigation report/outcome; liaising as necessary with the complainant and other parties where applicable & if appropriate; finally collating the Trust's reply, based upon reports received, on behalf of the CE for his review and for his signature.

(b) Please fully describe the key features of the complaints procedure in the Sperrin Lakeland Trust in 2000.

The following has been worked up from memory in the absence of a copy of the procedure to work from. There does not appear to be a copy of the procedure in the files made available to me.

The procedure as set out sought to comply with the HPSS Statutory Complaints Procedures in terms of timescales for response and right to Independent Review. The Trust operated on the basis that the DCA(myself) acted as the Complaints manager with responsibility for the oversight of the complaints process and administrative procedures. The Trust at that time relied upon an agreed network of Investigating Officers. Effectively these were the service managers within the Trust. All IOs had been offered training in the procedure and their responsibilities. Where a particular IO was directly or indirectly implicated in a complaint either a higher level manager or another service manager would be asked to coordinate the investigation.

IOs were required to provide a full report of their investigation to the Complaints manager within the timescales of 4 weeks. The response to the complainant was primarily based upon these reports and where relevant with reference to related documents or policy. At the time the process set out that the response was drafted by the complaints manager for the Chief Executive to review and sign off.

I believe the procedure also made provision for consideration to be given to all measures thought beneficial to resolving a complainant's concerns. This may have included meeting with the complainant, and/or facilitating some type of mediation. Such initiatives were coordinated through the Complaints manager. This was an approach which had been used successfully in a number of instances.

The procedure was supported by a bespoke database which enabled the complaints team(myself and my then personal secretary/complaints assistant) to record and track action taken and report on same to the Trust Board meetings.

Statistics were collected regarding the numbers and types of complaints received. This was shared with the Trust Board at regular meetings and conveyed to the WHSSB and the DHSSPS as part of a performance target.

The procedure was underpinned by the principles of openness, respect, confidentiality and a commitment to use patients/clients' experience to inform future practice. The Independent Review process involved referral to the WHSSB where a complainant remained unhappy with the Trust response. The complainant had the opportunity to request this within a set period of the response. I believe this was 1 month.

(c) **Starting from the time when you received this complaint outline chronologically all of the steps which you took in the exercise of your responsibilities in order to deal with the complaint made by Mr Crawford.**

File 033-049 is helpful in recording the steps taken within the process of complaints handling. The following is based upon a review of the files available through the Inquiry and recollection. In general I would state that my principle objective in addressing the concerns of a complainant was to endeavour to ensure that the principles of the procedures were complied with in terms of timeliness, thoroughness, and sensitivity.

- Complaint letter from Mr Crawford received and acknowledged by complaints assistant 29/9/00
- Referred to Acute services director(ASD), as most senior officer, for investigation 2/10/00
- Deadline for response set 27/10/00
- ASD advised me by phone, I believe, that a clinical review had taken place during the summer months. Given the enormous sensitivity of this case, it was suggested by the ASD that the family be offered a meeting to be appraised of the review findings prior to receiving a formal written reply. This was an approach used in other situations and appeared reasonable.
- Letter of 11/10/00 was drafted and sent via Mr Stanley Millar Western Health Social Care Council,as the family's nominated advocate, inviting family to meet with Trust clinical team
- I cannot recall the date but at some stage in this period I had a discussion regarding the Crawford family's concerns with Mr Millar. This conversation took place after a formal meeting in the Tyrone County Hospital, about another matter. Mr M expressed his view that the family needed reassurance that they had not failed their daughter in any way in terms of not getting her to hospital quick enough. Whilst this was never referred to in any correspondence it did leave an impression in my mind which informed how I

continued to seek to encourage the Crawford's to take part in the proposed meeting.

- 2/11/00 family declined the offer to meet, conveyed by Mr Millar. ASD informed that family wish to see the review report.
- 6/11/00 letter from Mr Crawford requesting copy of Review. This was cced to the ASD and MD for consideration
- 22/11/00 I wrote to Mr Crawford in response to the concern he had expressed regarding why the family had not been involved in the review. I wrote to explain the nature of the clinical review, as I understood it, and why the family had not been involved .(File 033-098-253)
- 27/11/00 Given that the family had continued to decline to meet I asked the Complaints assistant to email ASD requesting that the key findings of the Review be set out to enable a letter to be formulated to send to Mr Crawford. File 033-029 refers.
- 12/12/00 Mr Crawford wrote again asking for the Trust's formal response- this was cced to ASD
- 29/12/00 A Reminder sent to ASD from the complaints assistant in an effort to progress the process.
- Subsequently a summary report was provided by the ASD. File 033-
- 10/1/01 letter sent to Mr Crawford enclosing a copy of ASD Report. This was sent as an attachment to a letter from Mr Mac Crossan in lieu of the CE who was abroad on leave. I drafted this letter as per procedures. The letter included further encouragement to meet with the Trust.
- There was no contact between Jan- march 2001
- 21/3/01 Mr Crawford wrote to the CE indicating that they were unhappy with the Trust reply
- 23/3/01 Mr Stanley Millar contacted my office asking me to meet with him on 27/3/01
- This meeting took place in Mr Millar's office. We discussed next best steps in resolving the family's concerns. I believe based on my recollection that Mr Millar remained of the view that a meeting with the family would be the most appropriate way to move forward. I accepted his view and agreed that given the loss they had suffered that face to face discussion would be best. (With the benefit of hindsight I no longer consider that this was the best course of action.)
- 30/3/01 CE wrote to Mr C again inviting him to meet with representatives of the Trust. No reply was received.
- 30/4/01 the Trust received a solicitor's letter on behalf of the family instigating legal proceedings. All relevant documentation was then passed by the complaints team to the Trusts legal advisors.

This ended the management of Mr Crawford's concerns through the Complaints

Procedures as he had not chosen to avail of the Independent Review route.

I continued however to be involved through my role in the Trusts scrutiny committee for medical negligence claims, liaising with our Westcare litigation team and the legal advisors at the Directorate of Legal Services. Files 033a-009 and those listed refer. This concluded with settlement in 2003. An apology was finally given to the family in 2004 subsequent to the Inquest.

(3) In your letter of 22 November 2000 to Mr Crawford (Ref: 033-098-253) you stated;

"I felt it might be helpful to clarify for you the process referred to in my letter to Mr Millar in respect of a clinical review. This process is one which has been introduced by the Trust in the last 2 years or so and is in the main undertaken where there has been a sudden unexpected death or where the clinicians and professionals involved identified unusual complications or difficulties arising during the management of a patient's care. This process is undertaken as an internal review by the Trust and in this instance does not tend to involve members of the patient's family."

Arising from this please answer the following questions.

(a) Was the process of clinical review in the Trust, which you described to Mr Crawford in this letter, contained in a document(s)?

To the best of my knowledge this process was not set out in any document at that time. It was from memory documented in the Trust Clinical Governance strategy document in September 2000 as a corner stone of the Trusts philosophy.

(b) If the process was contained in a document(s) please identify the relevant document(s) and, if available to you, provide a copy.

See above.

(c) If the process was not documented please identify the source(s) of the information about the process which you gave to Mr Crawford in your letter of 22 November 2000.

I was aware that the Medical Director had been instrumental in seeking to introduce a process where untoward clinical incidents would trigger a review process as part of a "learning" strategy. I understand this emerged during my absence on maternity leave. I had been informed by the Acute Services Director that this process had been initiated in respect of Lucy Crawford's death.

(d) By what means was this process introduced by the Trust in the 2 years preceding your letter?

I do not know how this process was introduced to the clinical personnel of the Trust. I relied on information provided to me by colleagues at the time that this process had been, I understood, developed during the period of my maternity leave. It was my understanding that this formed part of the evolving strategy for introducing clinical governance across the Trust. I also understood that no other Trust in Northern Ireland

at that time had such an approach.

(e) Did the process *"not tend to involve members of the patients family"*? If it did not what were the reasons for that?

As I was not personally responsible, nor involved in, clinical reviews I am unable to comment further. My understanding of what had occurred and why the family had not been involved was based upon advice given to me by the Acute services Director at the time. I do recall that the ASD indicated that it had been intended as part of the post review recommendations to meet with the family but that this had not occurred by the time the formal complaint was received at the end of september. I had no reason to question that I had been provided with the correct information in this regard, and this is what I passed on to Mr Crawford.

(f) Was it Trust policy not to involve family members in the clinical review process?

I cannot say what policy was in this regard. My observations shared with Mr Crawford were based on advice from the ASD, who along with the Medical Director and Social Care Director as lead professionals were responsible for this aspect of the Trusts business.

(g) Please describe fully the policy and process of clinical incident review as they existed in the Trust in the year 2000 in so far as you are aware.

My understanding of the protocol developed by the MD was based upon advices received from the Acute services director and discussions with the MD upon my return from maternity leave regarding how he envisaged the CSCG agenda being taken forward. My understanding at the time was that in the event of an untoward clinical incident that the MD or relevant professional lead (the Trust had 3 leads: the chief nurse, medical director & Director for social work)would instigate an internal review to establish any issues of concern. It was my understanding that whilst not involving the family in the actual review that the review process allowed for the family, or affected individuals, to be informed at the conclusion of any findings.

(4) Please provide any further points and/or comments that you wish to make, together with any documents, in relation to:

(a) The investigation of Lucy Crawford's death and the complaint by her parents.

On a personal level and having reflected upon the experience I certainly consider that the Trust as a public body failed to offer the Crawford family an effective, timely and fulsome examination of Lucy's death. With the benefit of hindsight we persisted too greatly in the desire to facilitate a meeting with Lucy's parents. I now believe this was not in the best interests of the family and wholly understand that it became a source of considerable frustration for them. I can only properly comment upon my own role and I continue, whilst recognising the inadequacies of the system at that time, to believe that I acted at all times in good faith and with integrity.

(b) Lessons learned from her death.

I am aware that clinical guidelines were issued regarding hyponatraemia in 2003 I believe. As I no longer work in the service I am unable to say whether Lucy's death has resulted in positive

changes to clinical care and how it is administered. Before I left the service I did sense that increased priority was being given to the governance agenda across the service generally. One would hope that lessons on how health care organisations respond to families when such circumstances arise have now been overhauled and better resourced.

Whilst not involved in the clinical aspects of the the case I now wholly appreciate that the circumstances of Lucy's death, the problems regarding Solution 18, and the fact that others had suffered similar consequences before and after her demonstrate the inadequacy of the systems in place at that time to ensure that the medical and clinical profession effectively reviewed and learnt from unexpected/untoward outcomes.

(c) Current Protocols and procedures

Prior to my departure from the HPSS in 2005/6 new guidelines were issued for the introduction of robust CSC Governance and clinical incident reporting. It is my view that the leadership from the Department of Health failed to give sufficient priority to this agenda in those earlier years. These guidelines were issued well after our English counterparts. I left the service before these were fully implemented.

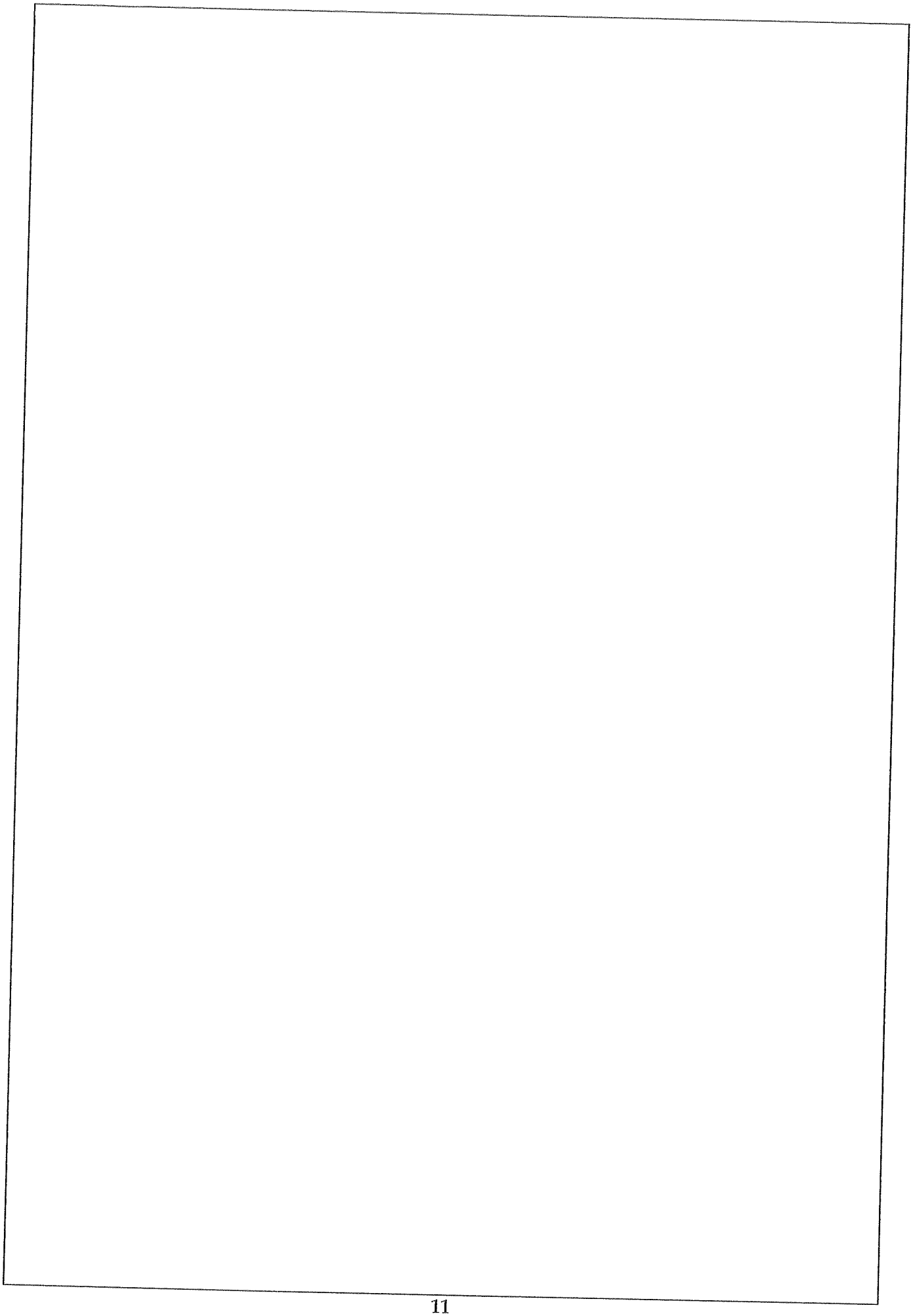
(d) Any other relevant matter you may wish to make.

I am aware that the Inquiry team are concerned to examine and establish whether the SL Trust or any of its officers deliberately, or by omission, were responsible for a "cover-up" of the cause of Lucy's death as asserted by the media coverage in around 2004. Whilst I found myself wrongly implicated in this assertion by the media I can categorically state that I never knowingly took part in any effort to hide the truth. I acted within the parameters of my role and responsibilities to my employer the Trust at all times and relied upon the integrity and knowledge of my colleagues in whom I had faith, to inform the Crawford's at all stages of the complaints procedure .

Once I became aware that the accuracy/efficacy of Dr Quinn's opinion was in doubt through the Scrutiny Committee/medical negligence process, I along with the MD, recommended to the Chief Executive that the case be settled with the family and an apology be offered. This shift in perspective resulted I believe from the expert paediatric opinion which the Legal team had sought regarding Lucy's case and in particular fluid management and possible liabilities. This opinion differed from Dr Quinns opinion and questioned the fluid management of Lucy's care which up until that point I had basedupon Dr Quinns report understood had been accepted and safe clinical practice. I cannot recall precisely when this occurred but believe it was during 2002 or the early part of 2003. However the legal advice at the time did not fully support an approach to concede the case at that time and whilst a settlement was finally reached in around April 2003 no apology from the Trust was offered to the family until after the conclusion of the Inquest in 2004.

Files 033-066 reflect this.

To this day I cannot state knowingly if any deliberate intention existed on the part of any individual or individuals to prevent the true cause of Lucy's death becoming known.



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

Signed: [signature] **Dated:** 19/3/2013