STATEMENT OF WITNESS

STATEMENT OF: STANLEY ELWOIN MILLAR
Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* OVER 18

To be completed when the statement has been written

I declare that this statement consisting of 5 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 25 day of APRIL 2005

R Hall
SIGNATURE OF MEMBER by whom statement was recorded or received

ROSEMARY HALL, D/CONSTABLE
PRINT NAME IN CAPS

Stanley E Millar
SIGNATURE OF WITNESS

In 1991 I was appointed Chief Officer of the Western Health and Social Services Council. One of the roles of the Council was to assist people who wished to make a complaint about the quality of Health and Social Care provided in the Western area. The council has a totally independent role of both the Sperrin Lakeland Trust and the Western Board. Over the years since my appointment I have assisted many people in having their complaints investigated. I must make it clear that the Council does not investigate the details of a complaint. The role instead is to help people to record their complaint on paper and provide the details necessary for a Trust investigation. The NHS Complaints Procedure is such that the Trust must investigate a complaint made against it. There are time scales that should be followed and the process is structured at various levels from a local investigation to the NI Ombudsman. Early in May 2000 I had contact from Mr and Mrs Crawford, who wished to meet me regarding a complaint. On 5 May 2000 I met Mr Neville and Mrs Mae Crawford in Hill Top, Tyrone and Fermanagh Hospital, which is the office of the council. The Crawfords shared with me the events which led up to the death of their daughter, Lucy in the previous month, that is April 2000. They had three questions at that time. 1. Why did Lucy die? 2. Could her death have been prevented? And 3. Was someone responsible for her

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death? I readily offered my support to help them gain answers to these very reasonable questions. In order to obtain the facts I put together a process. The first step was on 16 June 2000 when I accompanied Mr and Mrs Crawford to a meeting in the mortuary of the Royal Victoria Hospital in Belfast. We met Doctor Denis O'Hara who conducted a hospital post-mortem examination on Lucy following her death. Doctor O'Hara went through a nine page initial post-mortem report and explained that from his examination he considered the causes of death to be pneumonia, dehydration, gastroenteritis and cerebral oedema. Whilst we were pleased to have an opportunity to meet the Pathologist, we were still left with unanswered questions and I certainly was left with a query as to why Lucy had collapsed within hours of being admitted to the Erne Hospital with a relatively common tummy upset. The second stage of the investigation was to request Lucy's case notes from RBHSC on 19 July 2000. I arranged a follow up meeting with Mr and Mrs Crawford in the Aisling Centre in Enniskillen. We examined the case notes in some detail and I felt it was important that I should contact Miss Colhoun who was the local Coroner. This action was triggered by a comment recorded in the case notes, which suggested a Doctor Curtis in the Coroner's Office had been contacted by a Doctor Hanrahan, RBHSC when Lucy's death was discussed. I felt it was odd that a Coroner's post-mortem had not been agreed. Instead it was accepted that a hospital post-mortem was appropriate when Lucy's heart valves following permission from her parents were removed. I understand that during this period a meeting was arranged for Mr and Mrs Crawford to meet with Doctor O'Donohoe in Enniskillen. I was not present or aware of the details of that meeting. The third stage of my investigation was to request the GP case notes from a Mrs Hazelton, Practise Manager in Erne Health Centre. Having obtained sight of the case notes I felt there was sufficient information to proceed with a request for formal complaints:

1. Mr Crawford completed a patient consent form, which was forwarded to Bridget O'Rawe, Complaints Manager in Sperrin Lakeland Trust. The basis of the complaint

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was, "Inadequate and poor quality care following admission of Lucy Crawford to the Erne Hospital".

2. A letter to Mrs Hazelton to invoke the practise complaints procedure for the reason of "Inadequate and poor quality care, prior to Lucy's admission to Erne Hospital". The Trust complaint was sent on 22 September 2000 and the practise complaint on 3 October 2000.

On 11 October 2000 I received a letter from the Trust when they had proposed a meeting with Mr and Mrs Crawford to discuss the complaint. On 30 October 2000 I received a letter from the Crawford's which included a complaint that the family did not have any input into the Trust's Review of events. I arranged to meet the Crawfords again on 1 November 2000 in Enniskillen in order to make a decision on the invitation to meet the Trust. The Crawfords did not attend the meeting. I received a further letter from the Crawfords on 30 October 2000 when they requested a copy of the Trust's Review document, which they insisted on having sight of before any meeting with Trust Managers. I wrote to Bridget O'Rawe on 1 November 2000 pointing out that the Crawfords did not have any input to the Review and further requesting a copy of the Review outcomes. A further letter was received from the Trust on 10 November 2000 encouraging the Crawfords to attend a meeting in order to take the complaint forward. A further letter from the Trust on 22 November 2000 offered an explanation of the report process, but did not include a copy of the report. On 24 November 2000 a letter was sent to Bridget O'Rawe saying the Crawfords were still awaiting the Trust's response. I reminded Bridget O'Rawe in January 2001 that the Crawfords still had not received a formal response to their complaint of September 2000. Mr Eugene Fee on behalf of the Trust on 10 January 2001 wrote again to the Crawfords with an invitation to meet. It did appear to me very clearly that at this stage the Crawfords were unwilling to consider any invitation to meet with Trust representatives without first having sight of the report completed by the Trust on the investigation they had instigated following Lucy's death. Without such a meeting there appeared little prospect of a resolution of the matter.

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During the period January to March there were several overtures to the Crawford's to encourage the setting up of a meeting. Following the anniversary of Lucy's death on 24 May 2001 I contacted the Crawford family again to seek further instructions. On 29 June 2001 Mr Neville Crawford came to see me in the Hill Top. He confirmed that he had given instructions to the family solicitor to instigate legal proceedings on account of very slow progress on the part of the Trust investigation. I regretted his decision and explained that it meant that the matter would follow a legal process between the Trust and the family and in these circumstances, whilst I still offered any help that was appropriate, it did mean that in future the procedure would be followed through by correspondence between two sets of legal people. Early in 2003 I received a report of the death of Raychel Ferguson in Altnagelvin. The parents again asked me for help. In these circumstances I advised them to contact the family solicitor and follow the legal route rather than the NHS procedure. On 19 February 2003 I, with my chairman and members of the WHSSC, attended a meeting in Altnagelvin Hospital when Doctor Geoff Nesbitt provided a review of the conclusions as to why Raychel had died. I was struck by the similarities of the circumstances of Lucy's death three years earlier and was confident that the similarities were too obvious to be dismissed. On 27 February 2003 I wrote to Mr John Leckey, Coroner of Greater Belfast to point out my concerns and I asked did he consider that there were direct parallels in the events leading up to the deaths of both girls and whether an Inquest in 2000/2001 following Lucy Crawford's death may have led to a broader medical understanding of the phenomena of hyponatraemia, which could have led to Raychel Ferguson's life being saved. I was delighted with the thorough matter in which Mr Leckey responded to my letter and the prompt recruitment of expert witnesses. I wish to make it clear that in no way was I a party to any cover up on the part of the Trust to have Lucy's death covered over otherwise I would not have contacted Mr Leckey. I have been shown a copy of a letter marked WRC68 by D/Constable Hall and I can confirm that this is the letter I sent to Mr Leckey. D/Constable Hall has asked me who told me that an Inquest was not necessary. I contacted

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Ms Colhoun, the Coroner for Omagh/Enniskillen area, enquiring about an Inquest into Lucy's death. That letter was dated 31 July 2000. Ms Colhoun informed me that an Inquest was not necessary. The circumstances suggested it was probably a death from natural causes.

C-Inquiry Witness 326

STATEMENT OF WITNESS

STATEMENT OF: Stanley Elwoin Millar
Name Rank

AGE OF WITNESS (if over 18 enter "over 18"): Over 18

TO BE COMPLETED WHEN THE STATEMENT HAS BEEN WRITTEN

I declare that this statement consisting of pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 25 day of April 2005

SIGNATURE OF MEMBER by whom statement was recorded or received

SIGNATURE OF WITNESS

On 1991 I was appointed Chief Officer of the Western Health and Social Services Council. One of the roles of the Council was to assist people who wished to make a complaint about the quality of Health and Social Care provided in the Western area. The Council was a totally independent role of both the Sperrin Lakeland Trust and the Western Board. Over the years since my appointment I have assisted many people in having their complaints investigated. I must make it clear that the Council does not investigate the details of a complaint. The role instead is to help people to record their complaint on paper, and provide the details necessary for a Trust investigation. The NHS complaints procedure is such that the Trust must investigate a complaint made against it. There are time scales that should be followed and the process is structured at various levels from a local investigation to the NI Ombudsman.

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Early in May 2000 I had contact from a Mr and Mrs Crawford who wished to meet me regarding a complaint. On 5 May 2000 I met Mr Neville and Mrs Mae Crawford in Hill Top, Tyrone and Fermanagh Hospital which is the office of the Council. The Crawfords shared with me the events which lead up to the death of their daughter Lucy in the previous month, that is April 2000. They had 3 questions at that time, 1 Why did Lucy die? 2, Could her death have been prevented? and 3, Was someone responsible for her death? I readily offered my support to help them gain answers to these very reasonable questions. In order to obtain the facts I put together a process. The first step was on 16 June 2000 when I accompanied Mr and Mrs Crawford to a meeting in the Mortuary @ the Royal Victoria Hospital in Belfast. We met Dr Denis O'Hara who conducted a Hospital Post Mortem examination on Lucy following her death. Dr O'Hara went through a nine page initial post mortem report, and explained that from his examination he considered the causes of death to be pneumonia, dehydration,

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gastro intirities and ~~case~~ cerebral oderema. Whilst we were pleased to have an opportunity to meet the pathologist, we were still left with unanswered questions and I certainly was left with a query as to why Lucy had collapsed within hours of being admitted to the Hospital with a relatively common tummy upset. The second stage of the investigation was to request Lucy's case notes from RBHSC on 15 July 2000 I arranged a follow up meeting with Dr and Mrs Crawford in the Aisling Centre in Enniskillen. We examined the case notes in some detail and I felt it was important that I should contact Miss Colhoun who was the local Coroner. This action was triggered by a comment recorded in the case notes which suggested a Dr Curtis in the Coroners office had been contacted by a Dr Hanrahan RBHSC when Lucy's death was discussed. I felt it was odd that a Coroners post mortem had not been agreed. Instead it was accepted that a hospital post mortem was appropriate when Lucy's heart valves following permission from her parents were removed. I understand that during

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Mrs Jeeves a meeting was arranged for Mr and Mrs Crawford to meet with Dr O Donohoe in Enniskillen. I was not present or aware of the details of that meeting. The next step of my investigation was to request the GP case notes from a Mrs Hazelton practice manager in Erne Health Centre. Having obtained sight of the case notes I felt there was sufficient information to proceed with a request for formal complaints 1, Mrs Crawford completed a consent form which was forwarded to Bridge O'Rourke complaints manager in Sperrin Lakeland Trust. The basis of the complaint was "inadequate and poor quality care following admission of Lucy Crawford to the Erne Hospital".

2. A letter to Mrs Hazelton to invoke the practice complaints procedure for the reason of "inadequate and poor quality care prior to Lucy's admission to Erne Hospital". The Trust complaint was sent on 22 Apr 2000. and the practice complaint on 3 October 2000. On 11 October 2000 I received a letter from the Trust where they had proposed a meeting with Mr and Mrs Crawford to

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discuss the complaint. On 30 Oct 2000 I received a letter from the Crawfords which included a complaint that the family did not have any input into the Trusts Review of events. I arranged to meet the Crawfords again on 1 Nov 2000 in Enniskillen in order to make a decision on the invitation to meet the Trust. The Crawfords did not attend the meeting. I received a further letter from the Crawfords on 30 Oct 2000 when they requested a copy of the Trusts Review Document which they insisted on having sight of before any meeting with Trust Managers. I wrote to Bridget O'Kane on 1 Nov 2000 pointing out that the Crawfords did not have any input to the Review and further requesting a copy of the Reviews outcomes. A further letter was received from the Trust on 10 Nov 2000 encouraging the Crawfords to attend a meeting in order to take the complaint forward. A further letter from the Trust on 22/11/2000 offered an explanation of the report process but did not include a copy of the report. On 24 Nov 2000 a letter was sent to Bridget O'Kane saying the Crawfords were still awaiting the Trusts response. I reminded Bridget O'Kane in January 2001 that the Crawfords still had not

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received a formal response to their complaint in September 2000. Mrs Eugene Fox on behalf of the Trust on 10 Jan 2001 wrote again to the Crawfords with an ~~invitation~~ invitation to meet. It did appear to me very clearly that at this stage the Crawfords were unwilling to consider any invitation to meet with Trust representatives whatever their having sight of the report completed by the Trust on the investigation they had instigated following Lucy's death. Without such a meeting there appeared little prospect of a resolution of the matter. During the period Jan to March there were several overtures to the Crawfords to encourage the setting up of a meeting. Following the anniversary of Lucy's death on 24 May 2001 I contacted the Crawford family again to seek further instructions. On 29 June 2001 Mrs Neville Crawford came to see me in HILLTOP. She confirmed that he had given instructions to the family solicitor to instigate legal proceedings or account of very slow progress on the part of the Trust investigation. I respected his decision and explained that it meant that the matter would pass to a legal process between the Trust and the family, and in these

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circumstances where I should offered any help that was appropriate it did mean that in future they the procedure would be followed through by correspondence between two sets of legal people.

Early in 2003 I received a report of the death of Rachel Ferguson in Altnagelvin. The parents again asked me for help. In these circumstances I advised them to contact the family solicitor and follow the legal route rather than the NHS procedure. On 19 Feb 2003 I with my Chairman and members of the ~~West~~ WHSSC attended a meeting in Altnagelvin Hospital when Dr Geoff Nesbitt provided a review of the conclusions as to why Rachel had died. I was struck by the similarities of the circumstances of Lucy's death 3 years earlier and was confident that the similarities were too obvious to be dismissed. On 27 Feb 2003 I wrote to Mr John Leckey Coroner of Great Belfast to point out my concerns and I asked did he consider that there were detailed parallels in the events leading up to the deaths of both girls and therefore our request in 2000/2001 following Lucy Crawford's death may have lead

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to a broader medical understanding of the ~~Anaesthesia~~ Pneumonia or hypothermia. Which could have lead to Gaynor Ferguson's life being saved. I was delighted with the thorough matter in which Dr Leckey responded to my letter and the prompt recruitment of expert witnesses. I wish to make it clear that in no way was I a party to any cover up on the part of the RUC to have Lucy's death covered over otherwise I would not have contacted Dr Leckey. I have been shown a copy of a letter marked WRC 68 by D/Constable Neeld and I can confirm that this is the letter I sent to Dr Leckey. D/Constable Neeld has asked me who told me that an Inquest was not necessary. I contacted Mrs Colhoun, the Coroner for Omagh, Enniskillen area, enquiring about an Inquest into Lucy's death. That letter was dated 31st July 2000. Mrs Colhoun informed me that an Inquest was not necessary, ~~as it was death by natural causes~~ the circumstances suggested it was probably a death from natural causes.

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