POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC104

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

LDV 38/051

Master Tape Seal Number(s):

T100705A

PERSON INTERVIEWED: EUGENE FRANCIS FEE

ADDRESS: SPERRIN LAKELAND TRUST

DOB: [redacted]

PLACE OF INTERVIEW: PSNI, OMAGH

DATE OF INTERVIEW: 16/03/2005

TIME COMMENCED: 1346 HOURS

TIME TERMINATED: 1430 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT PSNI

2 D/CONSTABLE HALL, CARE UNIT, ENNISKILLEN

3

OTHER PERSON(S) PRESENT:

1 [redacted]

2

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MADE BY: D/SERGEANT CROSS

Tape Number and Tape Times:

Introductions made, reasons for the interview explained, PACE 10 completed and rights as a voluntary attender explained. Caution given and explained. Mr Fee was invited to state his experience, qualifications and role.

Mr Fee: ...My formal title is Director of Acute Hospital Services and also the Professional Director for Nursing...I am almost 35 years in the Health Service and I started off my working life eh as a Student Nurse, originally training in Mental Health and then progressing to training General Nursing. I worked approximately ten years in Clinical Practice at both Staff Nurse level and Charge Nurse level. Done a bit of project work during that time. I then moved to a post as Nursing Officer which is a post really that is responsible for a number of clinical areas at the Belfast City Hospital. My main responsibilities there were for mental health in the form of Windsor House and Shaftesbury Square which is a General Acute Psychiatric Admission

Ward or Wards and Shaftesbury Square Addiction Unit and I was also responsible for the development of Paediatric or Child Adolescent Services at University Gardens... For a period of approximately the last nine months of my post in the City Hospital I was acting as Senior Nursing Officer with responsibility also for Paediatrics, ENT and Dermatology as well as the original area that I was responsible for in Mental Health. So that... brought me up to 1990. Just in terms of qualifications and experience... later in life I started studying again. I went to Queens and done a part-time degree in BA and eh I followed that up with a DMS and MBA at University of Ulster, so for a period of about 13 years or so I was working and I was also a part-time student, which is I suppose is what a lot of people done at that time. In 1990 I moved to a post in Omagh, based in Omagh as an Assistant Unit General Manager with responsibility for Mental Health. I effectively was responsible for managing the Mental Health Services for Strabane, Omagh and Fermanagh areas including the Tyrone and Fermanagh Hospital. In 1995 then I was appointed to the post of Director of Acute Hospital Services and have been in that post since, almost 10 years, in fact at the end of May this year I will be 10 years in the post... I suppose in terms of wider experience in the context of why we are here today, I would have been involved in some reviews in the past of some events I suppose, the two most significant was following the rather tragic death eh in the psychiatric field a young man [redacted].. in the Strabane area... and following the eh 1998 bombing in Omagh I was the officer responsible within the Trust for reviewing the Trust's response to that sad event. So that basically is I suppose a thumbnail description of me and my previous history.

D/Sgt Cross: You mentioned... you did some project work, what do you mean by that?

Mr Fee: I would have been involved in things like nurse allocation...curriculum planning for pre-registration Nursing Programmes...and...introducing ...criteria for care which is about deciding on the acuity of patients and tying that with staffing requirements. I would have done a bit of teaching from time to time.

D/Sgt Cross: And then Mr Fee in 1995 you came to your present post where you are Director of Acute Hospital Services. What...does that entail... and particularly in April 2000?

Mr Fee: I suppose my responsibilities could be divided into three sub-sectors. I have a corporate responsibility with my fellow Directors of the Trust to manage the Trust as an organisation, so I'm a Trust Board Member and an Executive Director of the Trust, so I'm a voting member of the Trust Board...I'm the Operational Director for Acute Hospital Services...basically the responsibility for all services within the ...two Acute hospitals and...a couple of places that sit outside the Acute hospitals...Other places that fall under my wing is some Community Child Health Services and Community Midwifery and one ward, the long stay ward, at the Tyrone and Fermanagh Hospital... The main clinical are...managed within Clinical Directorates which is a fairly common model within the NHS...for example, in terms of Paediatrics, Paediatrics fell within the Woman and Children Directorate and Doctor Trevor Anderson was the Clinical Director at that time and Mrs Esther Millar was the Service Director for that particular division. Other divisions include medicine, surgery and anaesthetics and imaging or radiology... The third responsibility clearly is the professional lead for the profession of nursing across the Trust...operational responsibilities is £43 and a half million pounds of service delivery...

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D/Sgt Cross: Mr Fee if we go on then to what happened in April 2000, our understanding is that during the night an adverse incident occurred on the ward and as a result of that Lucy is taken to Belfast. Doctor O'Donohoe went with her and returned back about half ten in the morning and possibly referred the matter to Doctor Kelly. Now we haven't spoken to either of those gentlemen yet, but that is my understanding of what happened. Could you take it on from there... what happened from then on and how you became involved?

Mr Fee: Right well I'm not exactly sure of the timing of some of those things, I need to speak to Doctor Kelly and Doctor O'Donohoe about them but basically as I understand that Doctor Kelly in turn spoke to the Chief Executive who is Mr Mills. They decided given the, I suppose, unexpected outcome that some form of review should take place. They had also decided that...I should lead that along with Doctor Anderson. So on the Friday the 14th morning at approximately 9 or maybe shortly after 9, Doctor Kelly rang me to my office in the Erne... He rang me...saying that this incident that happened, that there was a sudden deterioration in a young child that had been admitted and that he had spoken to the Chief Executive and there should be a review and he had asked me to lead the review along with Doctor Anderson...The first action that I took after that was to arrange to meet Doctor Anderson that day...we had a chat I suppose about what we were going to do. The first thing that we thought we should do was to obviously start finding out who was involved in the care of Lucy and eh start by getting their comment on what was, eh you know what had happened, you know some sort of factual account of what had happened. We also decided that we eh would need to review the case notes of Lucy and we agreed to meet on the Wednesday I think it was of that week...The indications were... that Lucy had been admitted with some sort of viral type of infection, that

there had been some vomiting, diarrhoea and so on. So gastroenteritis rotavirus was the sort of query, although in fact when we looked at the case notes it looked as though the GP had referred the child thinking that maybe it was a urinary tract infection had been the cause of this so I wanted to start informing myself... So I spoke to people like Marion Martin...who's our infection controller, to seek some information...on...those types of conditions...I wanted to try and establish who was involved with the family in a community setting...some days later I spoke to...Marion Murphy who is the Health Visiting Manager to try and establish what Health Visitor was involved in the case and I then spoke to...Marion Doherty who was actually the Health Visitor... to find out first of all was she aware that Lucy had died and...asking her to go and visit the family, to offer support. Now it transpired in that conversation that she was aware and she had already visited the family but undertook to visit them again. So those were some of the initial actions that were being taken. Doctor Anderson and I met on the Wednesday and we looked at the notes and...some of the documentation clearly wasn't as good as one might have expected. It was also I suppose an issue around the level of prescription in respect of fluids and there was an issue around the fluid balance: it appeared on the surface that Lucy had had approximately 400 mls of IV fluid and I suppose the question for me not knowing was that right or was it not right... we really needed some external help...Following that I had a discussion then with the Chief Executive to update him...and to also say to him that we believed that we needed some opinion from somebody suitably qualified, paediatrician... in terms of fluid management regime. He did then come back to me and suggested that...Doctor Murray Quinn would be asked for an opinion. He was actually going to make contact first. Murray Quinn was an individual whose name I may

have heard of, but he is somebody I didn't know... I then, and again the date of this I think it was the 21st maybe I think it was... I spoke to Murray Quinn on the telephone following Mr Mills' initial contact with him. I told him verbally basically what we knew about the case at this stage and asked him would he be happy to review the case for us and he said he would, so I wrote to him then formally and I enclosed a copy of the notes and raised a number of questions in the... letter to him, which again is documented in the letter saying that, you know, just ask for his opinion on the issue of the type, volume of fluid, what may have led to the drop in the sodium, which it was you know one of the things was identified in the case note review that sodium level was at one stage 137 and then at the stage that things appeared to be going drastically wrong was 127, what might have led to that. We had the summary of the PM report at that stage and it was known... that cerebral oedema was a feature in the post-mortem examinations. ...So that... was the initiation of some external opinion on this front. I think it might be useful maybe if you don't mind to regress for a moment.

Just to put this in context of what might have been the norm at the time... These types of things would follow under an umbrella, which is now entitled Clinical and Social Care Governance. That structure as it was and legal responsibility as it is now existent, didn't exist at that at that point in time and in fact it has only existed in Northern Ireland since... 2003. However there was the development of Clinical Governance arrangements in England and the legislation came in in England some four years or so earlier than it did in Northern Ireland. So I mean the service as a whole was starting to think about how they actually deal with a range of things including when things maybe don't go as planned... That is some of the background. There wasn't a standard process or pro forma to actually work to at the time and in

fact I have to say to you, there is still not. Although we as an organisation have developed arrangements of our own.

D/Sgt Cross: You mean the Trust as opposed to the Health Service?

Mr Fee: Yes. Yes. The Trust has. So in the year 2000 we had a situation where a Clinical Governance and the responsibility placed on the Chief Executive was emerging in England, it didn't emerge here until, well there was a consultation paper came out called Best Practice Best Care in 2001, beyond the consultation paper then there was legislation put in place which was enacted in April 2003. So this was an evolving sort of structure around I suppose...how things were dealt with at that...time. I would also say to you it wasn't commonplace to either have a formal review or indeed to have an external opinion in such cases prior to that...You may have five or six cases in a year that you would want an external opinion and that would be fairly common now to think of an external opinion...it wouldn't have been an automatic response in 2000. In the year 1998 I suppose the Trust was first thinking about the Erne Governance arrangements...That culminated in a conference being held in our Trust in the year 1999 and then we engaged a girl from the Department of Health, so I suppose in some respects we were trying to get our house in order, based on the experience that was happening in England but in many respects, trying to lead in Northern Ireland, we were actually at the first conference and people like Doctor Gabriel Scally from the South of England came to speak at the conference and so on. Out of that came a range of workshops that basically start looking at the processes within our organisation and there was a Mrs Mary Hynd from the Department of Health actually assisted us in that process to look at you and what arrangements have you in place for dealing with, for example we had

an Infection Control Committee which I actually chair and that is part of the governance arrangement. So there was an arrangement in place to deal with that. I was looking at where the gaps were. So in the beginning of the year 2000 I suppose we were starting to think about the need and what arrangements we could put in place, first of all to have people identify areas of concern, clinical areas of concern, whether that be based on something that actually happened or they could have happened, you know, the type of incidents, near miss type thing. In fact our first arrangement... piloted in the Acute Directorate... was brought to our first Clinical Governance Committee Meeting, which was held in November 2000. It was further refined in the year 2002 and again further refined in 2005 beginning of this year here. Now on a regional level, and I think you probably need to see this in the context of what was happening regionally... the Department commissioned a review of clinical incidents arrangements throughout Northern Ireland in the year 2003... I was one of the people that they came to see... The department issued interim guidance in July 2004, so that's the stage we are at regionally. There has been no further progress beyond that...

D/Sgt Cross: Fair enough, so what you are saying Mr Fee is that you had an adverse incident, there was no sort of standard response... to guide the Trust. You were in the process of developing it, but it hadn't crystallised as yet. So you, it's sort of ad hoc, you discuss among yourselves what's the best way forward, talk to Hugh Mills about it and that's why you then go and look for an external opinion, even though it was very rare at the time, uncommon.

Mr Fee: That's right, that's correct.

D/Sgt Cross: Right, you're aware that the TV made an issue of the independence of Murray Quinn, because while he's from Altnagelvin, it appears he did a clinic once a week. Have you any comment to make on why he was chosen and I accept you are saying that it was Mr Mills who chose him, but I'm sure you were party to discussions.

Mr Fee: ...There was no system in place then or is there yet, to actually go to some independent external group to say to them we need an opinion on obstetrics or A&E or whatever the case may be, could you supply an independent name and appoint them to look at this for us. With the exception maybe with the Royal Colleges, without going to the Royal Colleges, and you're probably aware that the Royal Colleges did have a look at arrangements on related issues... So Mr Mills suggested Murray Quinn. I personally didn't know Murray Quinn, but I knew he was a Senior Paediatrician in the Province. I knew he was based at Altnagelvin. I knew that historically... there were no paediatric services resident in Sperrin Lakeland Trust up unto 1994. So in terms of speciality, it was a relatively new speciality within our Trust...the Trust...had the opportunity to invest in paediatrics and employ their own paediatricians, so prior to that establishment in 1994 paediatrics would have been...cared for...General Physicians, including Care for the Elderly Physicians with a visit on a weekly basis or thereabouts from Paediatricians from Altnagelvin. At the time that the paediatrics were established independently, the initial team was small...with the continuation of some support from Altnagelvin and indeed that was the way it happened up until I think it was about 1998 when ultimately Altnagelvin withdrew... So going back to...Murray Quinn, he was a Senior Paediatrician, I didn't know him personally and I didn't have any reason to think as to why he wouldn't give an objective opinion.

D/Sgt Cross: Right, in your experience had he ever been used before to give an external opinion?

Mr Fee: I've no knowledge...

D/Sgt Cross: What would your knowledge be if any, of his relationship with Jarlath O'Donohoe?

Mr Fee: I couldn't really say, but... Jarlath O'Donohoe joined us from a London Trust. So he came from England in the late 1990s, so I suspect their knowledge of each other would have been very superficial at best but... I don't know.

D/Sgt Cross: You never heard of any reason to suspect that they were particularly friendly, socialise together, holiday together anything like that?

Mr Fee: No.

D/Sgt Cross: ...Did Doctor O'Donohoe have any input into the selection of Murray Quinn?

Mr Fee: None.

D/Sgt Cross: Right, right, well then could I ask, maybe firstly could I ask, sorry ...

Solicitor: Can we stop the tape please for a minute, is that possible?

D/Sgt Cross: It's not really Caroline it would be difficult. Do you want to discuss, if you want to talk to Mr Fee about something we can leave the room, we will turn the tapes off and you can talk to Mr Fee.

Solicitor: Turn it off, turn it off for one minute then, yes, that's fine, thanks.

D/Sgt Cross: On my watch it is now 1420 and we will stop the tapes briefly.

D/Sgt Cross: It's 1422, it was just a brief discussion there during which time nobody left the room and if I could just remind you Mr Fee that the interview proceeds still under caution and I would like you to clarify for the purpose of the tape that while the tape was stopped we didn't ask you any questions further in relation to these issues. It was a discussion really with your solicitor about clarification?

Mr Fee: That's correct.

D/Sgt Cross: Right, well if I, if I could just go back to the last question because that's what we were discussing. What I'm endeavouring to I suppose investigate here is the independence and the reason that Doctor Quinn was chosen in case there was something suspicious in this and clearly there would be something suspicious if it came to our attention that for instance Jarlath O'Donohoe had suggested to you or to one of your colleagues, "I would like you to get Murray Quinn because he is a good friend of mine", that's what I'm looking for. So the question is Mr Fee to your knowledge had Jarlath O'Donohoe any input into the selection of Murray Quinn as an external opinion?

Mr Fee: To be clear about the answer, Mr Mills chose Murray Quinn, but to the best of my knowledge Jarlath O'Donohoe had absolutely no input into that recommendation.

D/Sgt Cross: Could I ask Mr Fee - there are two things here...there's the review that Doctor Anderson and you were doing and as a...part of that there's the case note review that Doctor Quinn is going to do for you. So your review is the bigger piece of work, but Doctor Quinn is going to assist you by providing an expert opinion or an independent opinion, isn't that correct?

Mr Fee: That's correct.

D/Sgt Cross: Now, could I ask...what actually was the purpose of your review...?

Mr Fee: Maybe if I could just refer to notes because it's actually documented in the review itself in terms of the purpose, which was really around I suppose trying to establish what had happened. The real stimulus to this review was we didn't expect Lucy Crawford to have died. So that would have been the real stimulus for the organisation to establish the review, but I did document within the review itself the actual purpose. It was really to establish...whether there was any connection between our activities or actions and the progression and outcome of Lucy's condition - that was the first objective that we were

trying to establish. The second was whether or not there was any omission in our actions or treatment, which may have influenced the progression and outcome of Lucy's condition and whether or not there is any feature of our contribution to care in this case, which may need to change in our approach to the care of other patients in the paediatric department...

D/Sgt Cross: What was Murray Quinn's role then going to be...if I could just ask you to clarify that, what were you expecting of him?

Mr Fee: Well I, I suppose wrote to Murray Quinn... the issues for us when we done the case note review was around was there an issue around the fluid, why did the sodium level drop from 137, what was the issue about the cerebral oedema. Those were the sort of issues that struck us from the information we had at that stage eh, following our telephone conversation enclosing a copy of the notes and the specific questions that I was asking him was the significance of the type and volume of fluid administered...The second issue I was asking for an opinion was the likely cause of cerebral oedema saying the indication coming out of the PM was that there was cerebral oedema and the third issue I was asking about really was what was the likely cause of the change of the electrolyte balance, that is the sodium and the various different chemicals in the blood, i.e. was it likely they would be caused by the type of fluid, the volume of fluid used, the diarrhoea or other factors. There was again in the notes the child had very significant diarrhoea during the night and from a person who works in the service but not being specifically knowledgeable about paediatrics I would have sufficient knowledge to know that diarrhoea can change the electrolyte balance. So I was trying to get his help in eliciting what might have been the factors that changed, changed these. I then invited him to make any other observations...which he might feel relevant.

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D/Sgt Cross: What was his response to that? I mean we have spoken to him and I would have to say his view would be that he wasn't dying about doing this at all for the Trust, did he, did he have to be persuaded to do it, is that your recollection?

Mr Fee: When I spoke... to him initially he had agreed to do the review, I wasn't party to any conversation between him and Mr Mills. He had agreed to do it... He initially came back to me with a verbal report again on the telephone... I think you have access to that. We followed that up with then a visit to Doctor Quinn and myself and Doctor Kelly. Doctor Kelly was the Medical Director at this stage in our Trust. We followed that up with a visit to him to explore the detail of what he was saying

D/Sgt Cross: Sorry we will have to change tapes. It is 1430 and we will terminate this part of the interview.