POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC105

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

LDV 85/05

Master Tape Seal Number(s):

T100706A

PERSON INTERVIEWED: EUGENE FRANCIS FEE

ADDRESS: SPERRIN LAKELAND TRUST

DOB: [redacted]

PLACE OF INTERVIEW: PSNI, OMAGH

DATE OF INTERVIEW: 16/03/2005

TIME COMMENCED: 1403 HOURS

TIME TERMINATED: 1515 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN

2 D/CONSTABLE R HALL, CARE UNIT, PSNI, ENNISKILLEN

3

OTHER PERSON(S) PRESENT:

1 [redacted] SOLICITOR

2

3

MADE BY: D/SERGEANT CROSS

Tape Number and Tape Times:

D/Sgt Cross: ...It is 1433 and we are continuing the interview. There are the same four people in the room and if I could just remind you Mr Fee that we are still under caution and if I could ask you to confirm that we ask no questions further to the interview while the tape was off?

Mr Fee: That's correct.

D/Sgt Cross: Right, ok, if you want to continue Mr Fee then?

Mr Fee: I think I was at the stage of explaining that Doctor Quinn had given us some verbal feedback on telephone and Doctor Kelly and myself had arranged to meet with Doctor Quinn to first of all talk through those issues, also to share with him the post-mortem report, which was in its longer version at that stage. So we went, we travelled together to his office in Derry; there was a further issue, which you probably have in Doctor Kelly's notes when you come to explore that with him. But I mean I have seen his notes and I am aware of it. This further issue we raised with them was around whether or not there should be any restriction considered in respect of Doctor O'Donohoe's practice - in

Doctor Quinn's opinion that is, so those were the sorts of the three main issues that we talked to him about. The meeting happened, I can't remember the date now, it was June 21st I think it was, of June in Doctor Quinn's office and Doctor Kelly took some notes of the discussions and Doctor Quinn agreed to do a written report. There was an issue in the programme.

D/Sgt Cross: About the sweet-talking?

Mr Fee: Yes.

D/Sgt Cross: What's your view on that?

Mr Fee: Well I don't understand the comment to be honest, although he did ring me in somewhat of a panic the following Monday after he had been door stepped at his door... I didn't get into any long dialogue with him about what he meant. I mean my attitude is if you say anything to the press you have said it - there is no control there afterwards... We hadn't asked him for a medical legal opinion and that wasn't the purpose of our intentions, if we were looking for a medical legal opinion we would go to a solicitor and asked them to identify a doctor to give us one. I don't know if that concurs with his thinking on the matter or not.

D/Sgt Cross: Yes, he's, he would take that position most emphatically, it is not a medical legal opinion and that he had specifically said that he wouldn't go down that route at all - at best he was giving you a fairly quick opinion on the basis of very limited information, he was only going to look at the notes. He didn't want to interview anyone or go broader than the actual notes. If I could just stick with the sweet talking issue because clearly we would have to cover that before we finish. Is it the case that he was encouraged to put opinions in or leave opinions out that were advantageous to the Trust as far as his written report that he was going to forward to you? Did you or Doctor Kelly take that line with him?

Mr Fee: Absolutely not.

D/Sgt Cross: I mean clearly that's what I would say 90 per cent of the people who heard that programme would assume - that whoever was involved had persuaded him to bias his report in favour of whoever was discussing it with him.

Mr Fee: No, there was no intention to actually persuade him to bias it in any way or the other, nor did we make any attempt to do so.

D/Sgt Cross: Right... I'll tell you what he says he meant now, this is what he tells us about sweet-talking. He said that he agreed to do a review for yourselves, it was going to be a very limited review; it would never approach a medical legal opinion; he was refusing to interview anyone; he would just look at the notes and give you a verbal report, but he said to us he was then sweet-talked into writing a report. He didn't want to do that, but that's how he explains the use of this word sweet-talk.

Mr Fee: I do recall his view that this wasn't a medical legal report. I do also recall was that we asked him for a written report.

D/Sgt Cross: Yeah, yeah, and do you recall that he was reluctant to provide a written report but agreed in the end?

Mr Fee: I don't have a particular recollection of any significant reluctance, I mean I don't recall it so.

D/Sgt Cross: I would have to say, you know, in our line of work normally we deal with child abuse and sexual offences, so we would be in contact with Paediatricians on a very regular basis and quite frequently on the wards in your hospitals and the paperwork that Doctor Quinn produced doesn't really come up to the standard you know or layout of any other report ever we obtained from a doctor, I would have to say, and it does strike me as something that he ran off very quickly. Do you think is that the case?

Mr Fee: I don't know. He did do the report fairly shortly after our meeting with him.

D/Sgt Cross: Right, right, and, Mr Fee, are you sure that you discussed the post-mortem report with him?

Mr Fee: ...I'm nearly certain. Well his exact words here. I have been subsequently made aware of the Pathologist's report and the child has pneumonia and cerebral oedema. That is his actual wording.

D/Sgt Cross: Is that in his report or is that in your review?

Mr Fee: No, no, that's in his, that's in his report.

D/Sgt Cross: ...It does seem very unusual to me that a doctor would review the issues surrounding the death of a child and never look for the post-mortem report, you know, to me that's a fairly important document if you are reviewing. The questions that you specifically asked I thought he would be informed by a post-mortem report. Why would you do a review of the notes and not get the post-mortem report?

Mr Fee: Well I mean one of the questions I asked directly was about the cerebral oedema, which was only established in post-mortem.

D/Sgt Cross: ...The post-mortem also established the bronchial pneumonia, which wouldn't have been mentioned anywhere else in the notes...

Mr Fee: ...Murray Quinn was saying based on his assessment...the fluid load... between the admission and event was within the normal range...and perhaps close on a year later, Moira Stewart, who was a Regional Paediatric Advisor said in her report... that the fluid volume would have been within the normal range.

D/Sgt Cross: I'm not sure if she does, but some of them mention the fact that it, it had been used for maintenance but wasn't maybe the best for replacement.

Mr Fee: There was a technical debate around that at the inquest.

Mr Fee proceeded to describe his difficulty in locating a BMJ article in 1991, which had been reported as easily found.

Mr Fee: ...I met with the Clinical Chemist and asked him about, you know, the significance and relevance of the sodium, now it wasn't at the time of my review it was subsequent to that. He made the point to me that it wasn't necessarily the low sodium in itself; it was the rate of drop that was significant. The BMJ article which was a review of 30 something cases in the States, some of whom died, some of whom recovered, showed that quite a number of them had sodiums much lower than

D/Sgt Cross: Yeah, yeah, I think that's, that's accepted and 127.

Mr Fee: Yeah, and 127 in fact lower than 120.

Some discussion ensued on the possibility of the sodium level being even lower than 127.

D/Sgt Cross: ...Could I ask then Mr Fee, you go to Murray Quinn and he reviews the notes...did that meet your needs? What you wanted him to do at the start, has he done that for you?

Mr Fee: I think it depends on the point in time you're asking, but the benefit of hindsight, you know, maybe the information wasn't as full as could have been, but I suppose the key deciding factors for us at that stage was the PM report and Murray Quinn's opinion.

D/Sgt Cross: ...In what way were they key? What did you settle on as the cause of her sudden decline?

Mr Fee: Well I mean our view, you will see that in Doctor Anderson's report, was that there was no definitive explanation.

D/Sgt Cross: Well then I would ask...if, because the child unexpectedly dies, gastroenteritis is relatively trivial in the western world...the review that you conducted and that Murray Quinn assisted you with didn't produce an answer...Why did you not go elsewhere to get that definitive answer?

Mr Fee: Well at that stage we were anticipating that there would an Inquest. Now we, well we didn't know there wasn't going to be an Inquest... if I was doing it again, I would do it very differently... in many respects. The first thing I would have done differently is, I would have went directly to the family.

D/Sgt Cross: Right, right, from a PR point of view?

Mr Fee: No. Not from a PR point of view, but I mean I think one of the hurts to the family is around their level of involvement. It was a fairly fundamental mistake on our behalf at the early part, but also the family I think could have contributed the review with more information, for example, what happened exactly in the room when that event happened.

D/Sgt Cross: Right, right, you see Murray Quinn did make the point and you have already referred to it, that he said... if you want more than I'm going to do, go and get your independent expert. Go elsewhere, and he has guided you partially by looking at the notes, but and I'm quoting what he tells us, what he wouldn't do was interview the nurses, he wouldn't interview the doctors and crucially to him he wouldn't interview the family and maybe he has discussed this with you, that he did feel just as you have said there, that the mother had important information, because he says the type of incident that occurred at ten to three or three o'clock in the morning is very important. If it's a febrile convulsion it means one thing, if it's coning it means another and he said the only person who had the information there was the mother, because if she would describe exactly what, how the child behaved in the seizure, Murray Quinn says he would have known immediately whether it was coning because it's very distinctive or whether it was some other form of a seizure and therefore your review is hampered significantly by the fact that the mother isn't interviewed and the doctors aren't interviewed and the, well maybe that's not true, but not by Murray Quinn anyway.

Mr Fee: Yes, I would accept that.

D/Sgt Cross: Right, ok, could I ask then as well as going to Murray Quinn as part of your review with Doctor Anderson who else did you go to for information?

Mr Fee: ...I had a discussion with Sister Traynor, who was the sister on the ward, at the time, I had some information from Marion Martin as I alluded to earlier, I had a range of discussions with Doctor Anderson, Mrs Millar, Doctor Kelly, much like what we are doing now, we were trying to talk through the things, trying to think through...the issues for us. In terms of... additional external help we did not seek.

D/Sgt Cross: Right and did you interview O'Donohoe himself in relation to this.

Mr Fee: Doctor Anderson from recollection.

D/Sgt Cross: And what about Doctor Malik?

Mr Fee: Doctor Malik as well.

D/Sgt Cross: Right, and what about Doctor Asghar?

Mr Fee: Doctor Asghar wasn't interviewed.

D/Sgt Cross: No, he wasn't on the ward.

Mr Fee: He wasn't on the ward; he wasn't involved in the case.

D/Sgt Cross: You see what appears to me Mr Fee is that, now this might be a cynical view and it may be based on very little information, but it appears that Doctor Asghar the next morning (now I appreciate there is a long history of difficulties between the two personalities here), but Asghar would allege anyway that he looked at the medical notes and knew what killed the child and the Inquest broadly speaking came to a similar conclusion. And I am aware that other doctors and medical people were raising the issue about hyponatraemia and the fluid regime and I would suggest for the purposes of your review it was possible to get a definitive answer, if there had been a determination to get it and I would put it to you that the reason you didn't get a definitive answer was that you didn't want that answer?

Mr Fee: I would absolutely refute that.

D/Sgt Cross: Right, because a definitive answer would have pointed the finger directly at Doctor O'Donohoe and there was an attempt made to protect him.

Mr Fee: Again I would absolutely refute that.

D/Sgt Cross: Right, well Mr Fee there was, there was a discussion ...

Mr Fee: I would accept though in the benefit of hindsight that there are flaws in our review.

D/Sgt Cross: Yeah, right, right. You did discuss with Murray Quinn the issue of taking restrictive action, which is maybe a nice way of saying suspending him. Would that be right?

Mr Fee: Well I mean there is a range of possibilities from, you know, supervising arrangements and restricting care to certain types of patients to ultimately suspending you.

D/Sgt Cross: Right, ok, what was Doctor Quinn's comment in relation to that?

Mr Fee: I just can't remember the exact comment and I am sure Doctor Kelly will be fit to give you, as I say I don't know whether you have Doctor Kelly's notes of that.

D/Sgt Cross: We do have, yes.

Mr Fee: But it was raised and broadly speaking his view was he didn't see any reason for such action. That might not be the exact words but that's basically what it meant.

D/Sgt Cross: Yes, Doctor Quinn would be very adamant that he avoided that question, that he said that's not for him - go elsewhere for that advice, what would your response to that be?

Mr Fee: I don't recall that.

D/Sgt Cross: Right, right, and...Mr Fee what would you have done with your review then whenever that was completed to whom would that have been circulated?

Mr Fee: It went to the Chief Executive.

D/Sgt Cross: Right, alone?

Mr Fee: And well Doctor Kelly had a copy of it as well.

D/Sgt Cross: Doctor Kelly, right. Was there any feedback of any significance as to whether it was adequate or inadequate or whether there should be further action or no action?

Mr Fee: No, I did not get any steer to take further action beyond that in terms of my understanding, but again you will no doubt explore this with, with other people you want to speak to, my understanding is that Mr [Mills] briefed the Western Health and Social Services Board on progress and I know Doctor Kelly for example wrote to Doctor Bill McConnell around that time, Doctor Bill McConnell is a Director of Public Health with the Western Board and he actually wrote to him in relation to what we were actually doing here. I understand he also shared with Doctor McConnell our intention to use Doctor Quinn.

D/Sgt Cross: Right, eh, after the review was complete were there any discussions directly with Doctor O'Donohoe in relation to his part in the events that contributed to the problems with Lucy?

Mr Fee: I didn't have any direct discussion with him. I know Doctor Kelly met with Doctor Halahakoon to give her feedback. Doctor Halahakoon was the lead Clinician with Paediatrics. And he has a note of that meeting and he also met with Sister Traynor and has a note of that meeting as well.

D/Sgt Cross: Yeah, would you accept Mr Fee that part of the concerns discovered in your review were in relation to record keeping and in particularly in relation to this fluid prescription, which is partially recorded but there is a very important element missing. That's a significant finding in the review?

Mr Fee: Yes.

D/Sgt Cross: And to your knowledge was that issue addressed with the person responsible for it, who professionally is going to be - the Consultant?

Mr Fee: I don't know whether it was or was not.

D/Sgt Cross: Right, whose job would it be to address that issue in the Health Service?

Mr Fee: Well I suppose you could point the finger at one of a number of people. I wrote to Doctor Anderson who was the Clinical Director ultimately responsible for the area and in terms of bringing that forward within his sphere of authority you could say that Doctor Kelly who is the Medical Director potentially was responsible...

D/Sgt Cross: Right just for our information maybe what is the difference in the Clinical Director and the Medical Director as far as responsibilities go?

Mr Fee: The Clinical Director is the person responsible for managing the area. They are the person managing, responsible for managing the area. The Medical Director is an Executive Director of the Trust Board and is responsible for advising the Trust Board in respect of medical issues. He would also have a responsibility in terms of I suppose guiding the profession.

D/Sgt Cross: Ok, right, so you personally didn't address it with O'Donohoe and to your knowledge you are not aware if any other person directly addressed that issue?

Mr Fee: I didn't personally and I'm not aware of anyone else having done so. But there were a range of changes happened beyond that, including the change of the documentation to support inclinations, eh, setting out process for calculating levels of fluid regime.

D/Sgt Cross: Yes, it's, I'm aware of that. I mean that concerns me to a degree in the sense that one of the reasons you set out to review the whole matter... was to see if there were any lessons that could be learnt to prevent recurrence... Now it would appear... there is a clear lesson that fluid prescription should be written down fully before any nurse ever attaches a drip and that is a job for the doctor and the doctor failed in that regard. In my view they are probably both liable, but professionally

Doctor O'Donohoe is perhaps expected to see that is done right. If however nobody from the Trust actually went to him and said look this was prescribed but it was never written down and the nurse didn't know what to do, and you say one thing and she says another and the reason there is confusion is you didn't write it down. If nobody went and told him that, again it adds to the suspicion that he is being protected here and the real issue is not being addressed.

Mr Fee: Yes well, I would say to you in respect of that, one is that there was feedback given in terms of what the findings were and the issue of the absence of some vital pieces of the prescription was identified within that.

D/Sgt Cross: Feedback to whom though?

Mr Fee: Well, the feedback given back into the Directorate...but I accept the point that you make in terms of making sure that the relevant people,... I accept the point.

D/Sgt Cross: Yeah, because equally I'm not sure that Breige Swift, the nurse who set it up, I am not sure that anybody took her aside and said for whatever reason, maybe with the best intentions in the world, you know, you set that drip up, but the prescription wasn't written, you shouldn't have done it and on no account do it again and we will be advising all your colleagues the same. I am not sure that anybody told her that and again that would strengthen the suspicion that the issue was being fudged?

Mr Fee: Right, well I would wish to say to you there was no intention to fudge it. I accept that some of the feedback, some of the follow through, perhaps wasn't as thorough as maybe it should have been.

D/Sgt Cross: Right, right, could I just go back Mr Fee to look again at the issue of the Coroner. Section 7 of the Coroner's Act does require broadly speaking anybody and it's for all of time, it's open ended, anybody who comes

into possession of information that is relevant to the death of a person, particularly as touching whether there ought to be an inquest or not, they have an obligation to inform the Coroner. Now that would extend, in the Coroner's opinion, now to the parents themselves, it extends to the parents' Solicitors themselves, so it's not a case where we can say you're to blame or you're responsible or Jarlath O'Donohoe is. It's very open ended, but you did mention that you expected a Coroner's Inquest, if you want to, if you don't mind expanding on that, why you expected it and why you think it didn't happen?

Mr Fee: ...I mean one would normally expect an Inquest in such circumstances, but again based on experience we wouldn't normally expect that to happen quickly, you know, and time lag can often be two years or more.

D/Sgt Cross: Yes, I accept that, yeah.

Mr Fee: And we have experience of participating in Inquests, you know, over the years, and that normally happens some considerable time later. I suppose it didn't occur to us to actually find out from the Coroner to make sure that was actually happening, you know, we didn't know it wasn't happening, we anticipated it would. In discussions with Doctor Kelly in more recent times, I was trying to clarify when was it, when it, when did it become apparent to us that there wasn't going to be an inquest and from what he has told me it was fairly late on in the stage of the medical negligence case.

D/Sgt Cross: Right, that was 03, that was quite late?

Mr Fee: Naw, it might have been, I'm not quite sure of the timing on that, you might want to talk to Jim about that. My understanding was that it was quite late on in the medical negligence debate; it became clear that there wasn't going to be an Inquest. Now you are probably aware of what actually stimulated the Inquest then.

D/Sgt Cross: Yes, Raychel's

Mr Fee: Yeah, Raychel. The outcome of that case, Mr Millar who was the... Chief Officer of the case who had been acting as an advocate for the family and who... attended the meeting with the Pathologist.

D/Sgt Cross: That's right.

Mr Fee: Then said well I think there is some similarities here. Mr Leckey then explained in some length at the beginning of the Inquest that he had to go through a certain process as to actually having an Inquest given that there was already a Death Certificate signed. Which again wouldn't be, we wouldn't have been aware of.

D/Sgt Cross: Right, well could I ask Mr Fee, I mean, it is, it's a concern obviously from public interest, and I'm not saying that this happened in this situation, but I have to be aware if children die or if people die and there ought to be Inquest, I mean there are good reasons for Inquests from the public interest. If there ought to be an Inquest and there's not, then we have to be sure that it wasn't a deliberate attempt to prevent an Inquest to cover up a mistake or worse and clearly with Shipman that onus is more on the police than ever it was, however it all pans out in the longer term, but in your experience can you think of other instances where patients were transferred from the Erne to a Belfast Hospital or to a hospital elsewhere in the Province and died there and there was or there wasn't an Inquest?

Mr Fee: Well my experience would be that the clinician treating the patient at the end of their life... if it is an unexpected death, those that fall within the descriptions and the arrangements for the Coroner, would contact the Coroner's Office. In most circumstances my experience would be that the Coroner and the clinician would have a discussion... he may direct that... there's a post-mortem. If there is a post-mortem... the Coroner then would consider the outcome of the post-mortem and make a decision to either issue a death certificate... or decide to have an Inquest. Now we were aware that there was a post-mortem carried out at the time... I assumed that the Inquest or the post-mortem was carried out at the direction of the Coroner... as it transpires I was incorrect in that.

D/Sgt Cross: Yes it was a hospital post-mortem in effect.

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

D/Sgt Cross: I'm afraid we will have to break again. It is 1515 and terminate the interview.