POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC106

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

LDV 38/05

Master Tape Seal Number(s):

T100707A

PERSON INTERVIEWED: EUGENE FRANCIS FEE

ADDRESS: SPERRIN LAKELAND TRUST

DOB: [redacted]

PLACE OF INTERVIEW: PSNI, OMAGH

DATE OF INTERVIEW: 16/03/2005

TIME COMMENCED: 1538 HOURS

TIME TERMINATED: 1620 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, PSNI, ENNISKILLEN

2 D/CONSTABLE HALL, CARE UNIT, ENNISKILLEN

3

OTHER PERSON(S) PRESENT:

1 [redacted] SOLICITOR

2

3

MADE BY: D/SERGEANT CROSS

Tape Number and Tape Times:

Interview recommenced and caution given and explained.

D/Sgt Cross: I did have a discussion with your solicitor briefly during the interval in relation to the questions and answers about Doctor Quinn. If you just want to clarify that issue now for the purposes of the tape?

Mr Fee: There was an issue raised earlier in respect of whether or not Doctor Quinn advised me and Doctor Kelly to take further actions beyond his review and report, including for example to meet with the mother. I have absolutely no recollection of that suggestion made me to me either verbally and certainly it is not contained in his report that was provided to me.

D/Sgt Cross: ...Staff Nurse McManus...informed me that the system on the ward... didn't involve the use of a named nurse, at least on night shift. It was a task allocation system. So instead of...them coming on the ward and being detailed by the senior person that you are in charge of patients A, B and C, the system was - you will do the medications, you will do the suppers, you will do the observations, that type of a system...I feel

it's partly responsible for the fact that there are... few observations taken of Lucy. There are some temperatures, but... there is not a full range of what... should have been done. Do you agree with Staff Nurse McManus that that was the common system on the wards at that stage?

Mr Fee: Yes.

D/Sgt Cross: Is it still the system?

Mr Fee: Yes.

D/Sgt Cross: Do you feel does it allow the opportunity... because it's everybody's responsibility to look after this patient that in fact nobody does?

Mr Fee: Well it might be useful just to explain the sort of the background to the named nurse concept. This came out of the Patient's Charter basically during Mrs Thatcher's... the intention as I understand it... was that... the patient had somebody you could relate directly to.

D/Sgt Cross: Yeah.

Mr Fee: And secondly the nurse had some direct responsibility.

D/Sgt Cross: Yes.

Mr Fee: ...However, there are some practical difficulties to actually implementing such systems in some settings.

Mr Fee proceeded to describe difficulties with the named nurse system.

D/Sgt Cross: Right, well specifically Mr Fee in your experience was the system in place at that time of task allocations as opposed to naming a nurse..., eh I mean there were failures in relation to Lucy, but in your experience did that system allow for proper observations to be taken for 99.9% of the children who were there on an ongoing basis?

Mr Fee: Yes. The normal staffing in the Children's Ward at night duty at that time would have been two nurses and one auxiliary. Now because of the number of patients in the ward at the time there was actually a schedule of three nurses.

D/Sgt Cross: That's right and one extra.

Mr Fee: And one auxiliary to be on duty.

D/Sgt Cross: If I can jump back to where we were before the last tape ran out, I am anxious to try to determine the role of the medics in reporting to the Coroner because there is this potential that the Coroner wasn't told what he ought to have been told eh and you were describing, I had asked you about in your experience of patients who were treated in the Erne but move elsewhere and die in another hospital. Now somebody has to be responsible for giving the Coroner all the information that the Coroner is going to need to come to a proper decision. In your experience and in your opinion, Mr Fee, whose responsibility is that or where does that responsibility lie, is it in Belfast, is it in the Erne?

Mr Fee: I would expect that information be shared with the Coroner by the Belfast clinician.

D/Sgt Cross: And in your experience is that what has happened in other cases?

Mr Fee: Yes.

D/Sgt Cross: Ok right, would in your experience eh ... would the Belfast clinicians routinely consult with the clinicians in the Erne ... and advise them of what actual outcome there has been in relation to the Coroner?

Mr Fee: No.

D/Sgt Cross: No, and is that a proper practice or is that just a glitch in the system?

Mr Fee: I think it is an area where there could be stronger links than there are currently.

D/Sgt Cross: Right is that one of the issues that were raised at the... review about... difficulties in the regional hospital communication?

Mr Fee: Yes.

D/Sgt Cross: ...Right and so that I'm clear, you're telling me that in other instances... there has been a decision to have an Inquest or not to have an Inquest without the local hospital being informed?

Mr Fee: That would be quite usual.

D/Sgt Cross: That's usual as opposed to occasional?

Mr Fee: Yes.

D/Sgt Cross: Right and Mr Fee you did say that you eh ... I'm just repeating you here, but I want to make sure I'm clear in my own mind, you have said that you and your colleagues expected that an Inquest was going to happen and you only learned it wouldn't be happening in the later stages of the civil proceedings?

Mr Fee: That's correct.

D/Sgt Cross: Right, right eh ... could I ask were there any discussions about why an Inquest might be expected, I mean was it actually discussed as a likelihood or is it just taken for granted?

Mr Fee: Well to be quite honest with you I would have taken it for granted in such circumstances there would have been an Inquest.

D/Sgt Cross: Right. There is a note in one of Mr Mills' files that it was said that you know there is the potential for a criminal investigation if this goes to Inquest, do you recall that discussion?

Mr Fee: No.

D/Sgt Cross: Right... that's to a degree corroborating what you say, that there was an expectation that this is going to an Inquest?

Mr Fee: Well normally I would have expected... Such a case to be decided at an Inquest.

Solicitor: Have you seen that note?

Mr Fee: I can't say that I have no.

D/Sgt Cross: ...Was there any discussion between you and any of your colleagues or any of the medical personnel in relation to the Inquest to the effect that it would be wise not to press for this?

Mr Fee: No.

D/Sgt Cross: Right and were there any discussions to the effect that we'll not tell the Coroner this and there will not be an Inquest?

Mr Fee: No.

WRC26 pages 69 and 70 were shown to Mr Fee and discussion ensued on the record. Mr Fee did not recall the meeting.

D/Sgt Cross: Well if you don't have a recollection perhaps of that specific meeting do you have any recollection of discussions with your colleagues or the doctors, eh ... when I say colleagues I'm talking about the management basically as opposed to the like of Jarlath O'Donohoe eh ... who is classed as a medic. Do you recall any conversation with any of those people in relation to a criminal investigation?

Mr Fee: No I don't.

D/Sgt Cross: Right now I have some issues here, ... Mr Fee, along the lines of when it became apparent to yourselves that a electrolytes, fluids, hyponatraemia may have been an issue. Now I mean I can go through it pedantically and point out that on the 1st of June 01 which is a year later, you know there's a this is a record of a meeting with Moira Stewart I believe and she was highlighting hyponatraemia and fluid, but you have already confirmed to me that you were aware that was an issue in the very early stages anyway?

Mr Fee: Well it was one of the issues.

D/Sgt Cross: Yes.

Mr Fee: That struck myself and Doctor Anderson on the Wednesday after.

D/Sgt Cross: ... Yes, so and is it your position then that you didn't pursue that line to the end because Doctor Quinn and you know some months later Moira Stewart didn't really highlight that as a significant issue?

Mr Fee: Yes.

D/Sgt Cross: ...For the purpose of the tape this is WRC18 page 2 forwards. Now these just come out of the Trust notes and it is a meeting with Doctor Stewart 1st of 6th 01 and I suspect these are the cases that Doctor Asghar highlighted

Mr Fee: Yes.

D/Sgt Cross: They are anonymised obviously.

Mr Fee: They are, they are, they are the cases.

D/Sgt Cross: Do you recognise these notes and can you tell me who actually made them?

Mr Fee: I don't recognise them but I would suggest to you that they were notes made by Doctor Kelly.

D/Sgt Cross: Doctor Kelly...so I will ask him about that. For the purposes of your review...you interviewed...Doctor O'Donohoe and Doctor Malik and Sister Traynor and Mrs Martin and Teresa McCaffrey, Breige Swift and Sally McManus?

Mr Fee: Yes.

D/Sgt Cross: Sister Edmondson?

Mr Fee: Yes.

D/Sgt Cross: Is there anybody else?

Mr Fee: Nurse McNeill ... report from Doctor Auterson, Nurse Jones.

D/Sgt Cross: When we interviewed Doctor Auterson, he said at no time he had been asked for his opinion, now you have a report from him, was that report in relation to your review?

Mr Fee: Yes.

D/Sgt Cross: And was he asked for, for the purposes of your review?

Mr Fee: It doesn't say on the report, actually it's a handwritten report number 19, Appendix 19.

D/Sgt Cross: Is it dated Mr Fee?

Mr Fee: It's dated 20th of April.

D/Sgt Cross: ...And to your knowledge did Doctor Anderson interview him directly?

Mr Fee: I can't recall whatever he did or not.

D/Sgt Cross: Right, right Auterson didn't recall that?

D/Con Hall No, no.

D/Sgt Cross: Again I would put it to you, it appeared to us at the Inquest and since, that Doctor Auterson seemed to be fully aware that the fluids were a problem. Now having talked to Sumner about this, Sumner would take the view that...Anaesthetists are the experts in fluid management. Now it may be a bigger part of their jobs... And he wasn't surprised that Auterson would have seen that quicker than O'Donohoe or anybody else in the hospital. If that is the case you know and it would appear that Auterson recognised the difficulty there, I would put it to you that the failure to pursue him as part of the review was part of perhaps avoiding hard facts in relation to it.

Mr Fee: I would refute that suggestion. I was at the Inquest and I did hear Doctor Auterson...concur with the view as it was emerging at that stage that hyponatraemia due to dilutional use of solution 18 was the cause of death.

D/Sgt Cross: Yeah see it does appear to me that he saw the significance of the fluid and the electrolytes because the Royal notes record at nine o'clock in the morning of the 13th there was a telephone call from the Erne from the Anaesthetist, now I would be fairly certain that is Auterson, although while Auterson was on duty but he does not recall making the telephone call, but it simply records two electrolytes it records the sodium level 127 and the potassium I think the other one was. Now those are the two important electrolytes in determining the degree of dilution and the decrease in the sodium level. That would suggest to us that Auterson was aware that it's hyponatraemia and it is dilution of blood that is the problem here and he phoned the Royal to tell them that. That was the first record that the Royal had of that, so therefore I put it to you that he was a very suitable man to fully interview to attempt to determine why the child declined so rapidly.

Mr Fee: Well, personally didn't interview Doctor Auterson. We had his report at the time, I think people's position at the Inquest may vary from the position at the time as things were starting to unfold, I don't have the Royal medical notes immediately at hand, so I don't know the context of the phone call. I know there was an issue around the transfer of the notes at the time and there was some reference in some of the documentation about notes being requested or further information being requested from the Royal at a later date.

D/Sgt Cross: ...The context is that there's just a two-line entry to say Anaesthetist at Erne phones with the following two results. It doesn't give any other context.

Mr Fee: I would suggest, well you may need to clarify that with Doctor Auterson, but I don't know at this stage whether those was two results were available at the time of the child's transfer.

D/Sgt Cross: I don't think they were.

Mr Fee: So it may have just been just a follow up saying we have now got the results, here is the results.

D/Sgt Cross: You see what interests me too is that he didn't give the full results, he just gave those two, he was very selective and those are the important two... that highlight the problem and therefore it would appear to me that at nine o'clock in the morning at least, Auterson knew what had gone wrong and he may have been in the position, the person, to tell you what had gone wrong, he may have got further than Murray Quinn got.

Mr Fee: He may just have responded to the question as to what he was asked. I don't' know. I mean I can't speculate. There is no point in speculating. He may have been asked just for those two results, perhaps the doctor who was taking the call only wrote down those two results. I don't know what he was asked.

D/Sgt Cross: If I can ask now... I'm sure you're very familiar with the paperwork that Murray Quinn produced, there was an issue raised about his use of a seven and a half hour period, now I have addressed that with him. You have... used (it) again in your review. Did you not feel that was basically a highly inappropriate way of assessing fluid requirement? That minimised any mistake by the Trust because really the damage was done on a four-hour period but if you average the rate over seven and a half hours, it almost halves it?

Mr Fee: That wasn't apparent to me at the time. It is apparent to me now. However I would say to you that Doctor Stewart, who also looked at this case, did not raise that as an issue.

D/Sgt Cross: I accept that. We also started to discuss... the issue of restrictions placed on Doctor O'Donohoe, and ultimately suspension. Can you recall what were the grounds for that, why was that even discussed?

Mr Fee: Well there was two things happening... one was Lucy Crawford's death... then there was a letter of concern raised by Doctor Asghar in relation to his claim that Doctor O'Donohoe had mismanaged... a number of cases... The thinking at that stage clearly was that some consideration of competency had to be given. Ultimately the College was asked for help with that matter, but that was in advance of our meeting with Doctor Quinn and one of the cases that was within that, four cases, was Lucy Crawford. So Doctor Kelly clearly in terms of his professional responsibility for the medical profession and no doubt when you speak to him he will give you a greater insight...

D/Sgt Cross: ...If I could just point out here this is WRC10 page 2 and this is an extract from the files of Mr Mills... It is basically a time line and we were here on Thursday 20th of April, which is within a week of the death. Eh their discuss, well you're advising him what you have done now and you said you felt that you required advice from a Paediatrician you have already covered that and he agreed to arrange that. And Mr Mills enquired if Doctor Anderson and you had considered if Doctor O'Donohoe should continue to see and treat patients. So that was being discussed very early on here within a week. My understanding is that Doctor Asghar didn't submit his letter until June so it is ahead of Asghar that these concerns exist if and if it was the belief of all involved that Lucy died of natural causes, then this whole issue of restricting Doctor O'Donohoe wouldn't arise at all, because a doctor isn't to blame for a death caused by natural causes...so there is an acceptance here that his involvement may have had a bearing on her decline. Were there any other reasons for saying that - I mean had Doctor Auterson or had somebody else said this is what happened, and Jarlath O'Donohoe did something that killed the child?

Mr Fee: No.

D/Sgt Cross: There was no hard information?

Mr Fee: No.

D/Sgt Cross: These were general concerns?

Mr Fee: Yeah.

D/Sgt Cross: Right and just while we are on this page, because we will come to it in due course, at the start of the paragraph Mr Fee advised that the patient's note recorded a comment from Doctor O'Donohoe that he was uncertain about the instructions he gave staff about the rate of flow of IV fluids, fair enough that record is there. Did you discuss with O'Donohoe his uncertainty or are you going solely from notes?

Mr Fee: I am going solely from the notes.

D/Sgt Cross: Right was it discussed with Doctor O'Donohoe at any stage how...he says, I said to the nurses 100 mls for an hour and 30 thereafter. The nurses say, No you said 100 mls every hour until urine is past. So there is quite a difference there and he wrote it up retrospectively and he is being honest about that...But are you aware of discussions among your colleagues where...you were told or heard that O'Donohoe is not sure at all of what he did?

Mr Fee: I don't have any specific recollection of that.

D/Sgt Cross: Right. And also in your review it says that the nurses were of the view that such a fluid prescription was standard practice, you know 100 mls an hour per hour until urine was passed. Do you recall, Mr Fee, which nurses said that? I would...say that a fair number of them say to us, No, it wasn't standard practice. Do you recall who took which position?

Mr Fee: Well that's contained in a note of a meeting I had with Sister Traynor specifically, but I do understand that she may take a different position on that.

D/Sgt Cross: Now?

Mr Fee: Yes. Now I haven't said to you this is much more recently I have actually looked at arrangement notes to see what normal fluid regime patterns might be.

D/Sgt Cross: Could you put your hand on that note, do you have it handy, your note?

Mr Fee: It's number 11. It's appendix number 11.

D/Sgt Cross: Right if you just read out the relevant bit there?

Tape Number and Tape Times:

Mr Fee: I spoke with Sister Traynor, this is on the 27th, and Nurse Swift who commented that fluid replacement volume was not unusual in a child of this age given her condition. She also stated and I fully accept this is my note, this my note of the meeting, she also states that there didn't appear to be evidence of fluid overload. Reviewed the notes again, Sister confirmed that the rate to be administered normally recorded on the fluid balance, that's another issue. Normally would expect it to be recorded, rate and type of fluid. Spoke with Nurse Swift and confirmed that she and Doctor Malik were present when the fluid regime was commenced by Doctor O'Donohoe. She stated that they were advised to administer 100 mls per hour until Lucy passed urine. She was not involved in recording and then there was a discrepancy in the running total as well, but it was fairly clear I mean what had actually happened although there was a discrepancy and that's how.

D/Sgt Cross: Well broadly speaking...what she said to us was that there wasn't a standard prescription. It depended on the level of dehydration. Now Nurse Swift says exactly the opposite. She says that that level of prescription occurred frequently, but maybe I'm putting words into her mouth, but it was not unusual, it wasn't sufficiently unusual or abnormal for her to query it. And Sally McManus didn't disagree with that, although Sally did feel that she would have queried it personally, she thought it was high, but you know could well have happened - it wasn't altogether unusual on the ward.

Mr Fee: Well, Sally was in charge of the ward and she actually wrote up the notes, the nursing notes and didn't query it. Sally McManus is a nurse who worked in Great Ormond Street.

D/Sgt Cross: Again we will have to terminate it is 1620.