POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC107

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

LDV 38/05

Master Tape Seal Number(s):

T100708A

PERSON INTERVIEWED: EUGENE FRANCIS FEE

ADDRESS: SPERRIN LAKELAND TRUST

DOB: [redacted]

PLACE OF INTERVIEW: PSNI, OMAGH

DATE OF INTERVIEW: 16/03/2005

TIME COMMENCED: 1619 HOURS TIME TERMINATED: 1654 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN PSNI

2 A/D/SGT J CALDWELL

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 1619 and we are just going to continue with the interview. Just to confirm again Mr Fee that you are still under caution and I would ask you to confirm that we asked no further questions in relation to these matter while the tapes were being changed.

Mr Fee: That's correct.

D/Sgt Cross: Right, and also for the purpose of the tape D/C Hall has left and you give us your name John, please?

D/Sgt Caldwell: I am Detective Sergeant John Caldwell.

D/Sgt Cross: ...In the paperwork that we obtained from the Coroner there is a letter here from Doctor O'Hara who conducted the post-mortem to the Coroner dated...October 03 and what he says here, Mr Fee, is that this was a difficult case at the time...in which it was clear that there was a potential background of litigation. Were you aware of discussions of that nature?

Mr Fee: No.

D/Sgt Cross: ...That would suggest to me that at the time that Doctor O'Hara was doing the post-mortem he saw there is something unusual about this death that will go to law. Now whether that was a criminal investigation or civil proceedings I don't know, because he hasn't said. Unfortunately Mr O'Hara being dead, I can't ask him now.

Mr Fee: I don't know what he would refer to.

D/Sgt Cross: Right, because again if that were being discussed and people realised there was a difficulty then clearly the Coroner should have been told at the time. This is not natural causes. But you're telling me that there was no discussion along those lines at Board or Trust level?

Mr Fee: No.

D/Sgt Cross: Or with Doctor O'Donohoe or the Medical Personnel.

Mr Fee: None involved me, no.

D/Sgt Cross: Right, in your review you did highlight the difficulties between the regional centre and the local hospitals. You see a number of issues arose in respect with our link with the Regional Services in this case these included the arrangements to support the transfer, the need for greater communication between the local hospital and the regional hospital. Now you have already mentioned that and they have been in relation to the Coroner, are there any other failures in communication that concerned you at that time specifically?

Mr Fee: ...The main issue as is alluded to there, first of all we are an isolated hospital eighty miles from the regional centre, we have a one tier or had a one tier system in terms of on call arrangements. So you will have seen within some of the documentation to actually arrange the transfer of a child at night basically means having to put some other arrangement to cover the hospital and I don't know exactly the timing of these events, but there has been discussions ongoing at a regional level around the potential to develop a regional retrieval system as it is called. That has actually been established for adults. So for example if you come into our hospital with a significant head injury the required anaesthetic support, critical care support, but you needed to be treated at a regional centre in most circumstances, but not all, at this stage a team would come from the regional centre down and collect you and support your care back, now I'm saying on most occasions, because there is two issues to that. One is that it's not always available, secondly if they are already away on another retrieval, you know, your retrieval may be delayed and the third issue is that...on some occasions the clinicians involved particularly at the regional centre thinks it is so critical to get you to the Royal quickly that it would actually be wasteful of time of their journey here.

D/Sgt Cross: Yeah, yeah, take double the time.

Mr Fee: But the issues tend to be on the other way. Back then if things progress the link back to the local unit for example as a matter of course we don't get the PM report.

D/Sgt Cross: Just on that point because you did highlight that specifically in that paragraph, do you recall when you got a preliminary PM report and the final PM report?

Mr Fee: We got the summary report very early on eh, the.

D/Sgt Cross: Because you had that for Doctor Quinn's discussion.

Mr Fee: Yes, yes.

D/Sgt Cross: Right.

Mr Fee: Well we had that, I had that, eh, I think at the time I actually wrote to Doctor Quinn because, or certainly had knowledge of what was saying because I made specific reference to the cerebral oedema and the only way that I could have known there was cerebral oedema was from the pathology report. We had the version of the 13th of June, I think it was at the time we visited Doctor Quinn. Now there was another not substantially different, but another version which I saw at the Inquest. I just can't recall the date on it.

D/Sgt Cross: Well you see what happened, yes it is 2003 I think, because the Pathologist did a PM report for the hospital's information and that sat on file, but then whenever...the Coroner decided I'm going to have an Inquest, Doctor O'Hara was well enough to be back at work at that stage briefly and he obviously checked his notes again and did an addendum to it, to update it for the purposes of an Inquest and that became, it's very confusing...

Mr Fee: Well I didn't, I did, I didn't understand the context of the change.

D/Sgt Cross: Yeah, no, that is, that's the problem, it is confusing and as I say there are two provisional anatomical summaries, two different ones with the same title and then there is the final one, and, but I believe that is part of the trouble.

Mr Fee: Yeah.

D/Sgt Cross: And you have highlighted the long time delay in getting the final post-mortem report. You got the preliminary one early. I mean are we talking about a year here or more than that, or do you recall?

Mr Fee: No, no, the, I mean if this is in, I mean my report was

D/Sgt Cross: Yes, that's your review there.

Mr Fee: My review was the 31st July, was the report was written, so it was in advance of that so it was.

Tape Number and Tape Times:

D/Sgt Cross: You would have had by then. Right. Ok. Right. There was an issue raised by some parties in relation to the, the comment that all team members were traumatised basically by this and I suppose that is understandable. There was no team briefing held or any organised form of counselling or therapy. Is there any comment you want to make on that?

Mr Fee: Well I think that was a mistake. Such a death is a tragedy for the family and is a tragedy for the staff and I mean we have instances of multiple deaths; we have instances sometimes of individual deaths, which can be very traumatic for groups of staff. For example an RTA perhaps a young person comes in, brain dead, decision has to be taken...to switch off the machines. Often times we attracted discussion with the family around organ retrieval and so on so forth, it can be quite stressful for staff, either as individuals and I also accept that stresses you may not stress me, so within a team the stress levels may be different, but I do believe in this case it would have been beneficial to the team to actually have debriefing.

D/Sgt Cross: Right, was it, I would put it to you, that the decision not have a sit down team briefing was an attempt to cover this up so that there would be no further airing of all the concerns, just let it go away, be quiet, do nothing and people will forget. Was that why there was none?

Mr Fee: No I do not believe that's why there was none.

D/Sgt Cross: Right, whose job would it be, if such a thing were organised? Is it your job; is it the Clinical or the Medical Director's job?

Tape Number and Tape Times:

Mr Fee: Well I suppose the honest answer to that is that in different locations it may be different people who would stimulate as such, but the prime responsibility clearly for staff welfare in a department was with the front line managers. But you know if you take the Omagh bomb incident as an example you know the Chief Executive and others you know at a high level of the organisation would have been involved.

D/Sgt Cross: Yes, fair enough. On the last page of your review with Doctor Anderson, care of the family Mrs Doherty, Health Visitor and Doctor O'Donohoe were pro-active in offering support to the family. Could I ask specifically in relation to Doctor O'Donohoe pro-actively offering support to the family, who informed you of that? How did you know that?

Mr Fee: Well I was aware he had actually met with the family, I don't know the exact date, but it was May of that year. Now obviously we have more information today than we had then and indeed through the complaints system I'd became clear that the family didn't actually find that particularly helpful for example, Doctor O'Donohoe didn't have the notes available to him as I understand at the time. However, he did actually meet with the family.

D/Sgt Cross: Yeah, the point that I would make, is this suggests that Doctor O'Donohoe you know himself, instigated the meeting with the family, he was pro-active in offering help. Now having interviewed the family they would say the exact opposite. That Doctor O'Donohoe has never contacted them at any stage about anything. They contacted him to see would he meet them and he did agree to meet them, but they viewed the meeting as a disaster really in that they got no answers to anything and he didn't even have the notes, that did irritate them, maybe irritate is to trivial a word. It annoyed them intensely and there may be reasons for that, if you know what I mean. Maybe a meeting at a different time, in a weeks time may have been better, but again

I would put it to you that this... puts a gloss on Jarlath O'Donohoe's behaviour. It indicates that he is pro-active in helping the family when in fact he did nothing to help them. He only did what they asked and to put it bluntly, you know, made a horlicks of that.

Mr Fee: Right, well, I would say to you there was no attempt on my behalf to gloss over, I mean my understanding was that Doctor O'Donohoe was the one to actually see the family.

D/Sgt Cross: Right, yeah.

Solicitor: Sorry, your note of the 5th of July might help on that, that's your own note Eugene?

Mr Fee: Yeah well we were suggesting, I was suggesting to Doctor Anderson, but Caroline is referring to here is a suggestion that there be a further meeting with the family, that did not actually happen.

D/Sgt Cross: Yeah, yes well could I specifically ask you do you know, I'm not accusing you, of specifically glossing, did Doctor O'Donohoe lead you to believe that he was pro-actively supporting this family when in fact he wasn't but you were being mislaid by him. Did he tell you that?

Mr Fee: No, no he did not.

D/Sgt Cross: Right, I will accept that the Health Visitor had taken steps of her own volition and then I think at your request to pro-actively support the family, I will accept that that is entirely accurate in her, in regard to her.

Mr Fee: She is referring to a letter that again would refer to the meeting to Nurse McManus in response to a letter that she had sent to me.

D/Sgt Cross: Right, again I'm at, again at your report Mr Fee page 125 in my numbering. The main issues identified here are the need for clearly documented prescriptions for IV fluids. The fluid administration, the need for documentations and parents descriptions of unusual events. If, if this was identified as an issue could I ask you to tell me what was done by the Trust to address that in practice?

Mr Fee: Well there was a range of changes made to the documentation for fluid prescription within paediatrics; I can actually get you copies of that if you so wish. I don't have copies here with me, but I can actually get you copies of that. In terms of identifying, not alone the prescription, but also an aide-memoire for the prescribing clinician as how to calculate the fluid regimes. Obviously there was a range of other things that happened beyond that. There was a BMJ article in June 2001, which became to Doctor Kelly's attention, which started to raise the issue about solution 18, which was shared with clinicians, Doctor Campbell then following as I understand it from the Raychel Ferguson issue, issued for the guidance of management of hyponatraemia, which again was provided to clinicians. We ensured that it was displayed in relevant areas, that people were actually familiar with it in using it and so on.

D/Sgt Cross: And is what killed the child at the end of the day; it was the fluid and the amount of it, that's why she died. Now it appears to me that while all that you have described is certainly useful in a hospital context. The real need was to take O'Donohoe aside and say you made a prescription and look at the hole in the page, there is no rate written down there, the nurse wasn't told how much to give. And the nurse should have been taken aside and said you set up a drip, you ran it at a certain rate and you had no idea from the record as to what you should have done. Do you know what I mean? And neither of you should ever do this again and equally Doctor Malik if he had still been in your employment at the time should have been taken aside and told the exact same, because I think it was actually his job to write it at O'Donohoe's dictation broadly speaking. So I think those are the three key players in this... but am I right in saying that those three people were not specifically taken aside and told this was a fearful mistake and don't do it again?

Mr Fee: Not by me.

D/Sgt Cross: Right, and to your knowledge it wasn't done by anyone?

Mr Fee: No.

D/Sgt Cross: Right. I mean what do you think of that Mr Fee? Do you take my point? Do you think was that a mistake?

Mr Fee: I accept, I accept your point absolutely.

D/Sgt Cross: Right, there was a comment here that I wanted to ask you about. It said the "unexpected outcome of Lucy's condition"... Now having spoken to the family and I'm not aware that they have actually seen this, this document, but I know what their view would be on that. I mean is it accepted now that it wasn't her condition that produced the unexpected outcome; it was the treatment that produced the unexpected outcome?

Mr Fee: I mean that, that was the conclusion of the Inquest. We have no argument with that.

Discussion ensued on the procedures for investigating adverse incidents.

D/Sgt Cross: Could I ask you why the Trust didn't pursue it to get an absolute explanation...?

Mr Fee: ...Well, I think that, I mean, that I suppose was part of our debate and I suppose in human life and in medicine there is not always absolute explanations to every outcome or response to treatment.

D/Sgt Cross: Can you recall who took the decision to call a halt to the review? You'd done what you had done and you wouldn't go elsewhere?

Mr Fee: Well, I suppose the concluding discussions really rested between three parties, myself, Doctor Kelly and Doctor Anderson, although not necessary all at the one time.

D/Sgt Cross: Yeah, right, and did none of them think there was value in, in pursuing this to see if somebody else could come up with an answer. Bearing in mind and I know there are difficulties but Asghar seems to have come up with the answer from reading the notes?

Mr Fee: Well, I don't actually recall seeing the word hyponatraemia in Doctor Asghar's response now but I'm working from memory. I don't actually remember seeing that.

D/Sgt Cross: That might be true although my comment on that would be hyponatraemia is what caused the cerebral oedema, but the real issue wasn't hyponatraemia to me, the real issue was fluid management. If normal procedures for fluid management had been followed hyponatraemia would never have resulted. So it was a failure to manage the fluids and that failure then led to hyponatraemia, which wasn't recognised in time and the damage was done. But whether Asghar mentioned it or not, but he highlighted fluid, that it was too much of the wrong fluid. Did you not feel, any of the three of you, that we need to pursue this to rule fluids categorically in or out?

Mr Fee: No, not at, not at the time.

D/Sgt Cross: Right.

Mr Fee: But clearly the Inquest, there was two themes coming through all the time, wrong fluid, wrong dose.

D/Sgt Cross: Wrong amount. Did you find that Doctor Quinn's report was satisfactory and adequate to meet your needs?

Mr Fee: I think it addressed our needs as far as he could go. You will see within Doctor Anderson's response to me, you know, he raised the issue that it doesn't give us necessarily a conclusion as to what happened to Lucy.

D/Sgt Cross: ...Did you discuss your review with...colleagues in Belfast? Medical personnel or management up there?

Mr Fee: No.

D/Sgt Cross: Right, what about discussions with Asghar, Malik, O'Donohoe?

Mr Fee: I didn't personally...

D/Sgt Cross: Right, right. In one of these papers, Mr Fee, that...we looked at in relation to whether Doctor O'Donohoe should continue with, with or without restrictions. You have said that. Mr Mills this is from his file, Mr Mills says that I enquired if Doctor Anderson and Mr Fee had considered if Doctor O'Donohoe should continue to see and treat patients. He confirmed it was their opinion he should continue. Now I'm not sure who the "he" is, because he asked you and Trevor Anderson, but one of you has confirmed that in their opinion that he should continue. Do you recall which of you it was?

Mr Fee: Eh, well, that's Hugh Mills' note, I think it was a note of a discussion he had with me personally asking me what conclusion Trevor and I had come to in respect of.

D/Sgt Cross: Right, ok, right and

Mr Fee: So it was not my personal opinion but it was the opinion of the two of us.

D/Sgt Cross: Ok and right that he should continue, was that opinion based on consultation with anybody else?

Mr Fee: Not at that stage.

D/Sgt Cross: Not at that stage. There were consultations more widely later on then?

Mr Fee: Yes.

D/Sgt Cross: Ok, that's basically all I have to ask Mr Fee. I appreciate that this has gone on for a long time, but I think it is complicated and it is fairly detailed, is there anything else you want to say?

Mr Fee: There is nothing else I want to say other than two issues really, one is that this type of incident is a tragedy for the family, it is a tragedy for the staff as it was the, the events that's happened beyond that, including this event and the next event that we are facing, there is a further stress to all. I do hope however it brings a conclusion that draws some line under the incident for both family and for staff and that we can have a system in place that is perhaps safer than went before.

D/Sgt Cross: What I would say Mr Fee, I mean we have done a lot of reading and done a lot of preparation for this interview and the other ones we have still do. This interview didn't go entirely the way I expected it to and the way I was sort of perhaps led to believe that it might go, in that you have been quite forthcoming in admitting shortcomings and failures at the time, particularly in relation to the family. And having spoken to the family it appears to me you know if, if you had conveyed those sentiments to the family at the time, this would have taken an entirely different course, entirely different, what I would say to you is if you are the sort of a person who acknowledges shortcomings and failures, why did you not address that with the family?

Mr Fee: Well I suppose there's a range of issues around that, first of all get into a complaints system, the family at that stage had engaged with the advocate in terms of the Western Health and Social Service Board, whom we would had a good relationship with and I suppose whom we would have hoped would have been fit to facilitate some dialogue between ourselves and the Erne and in fact there was a range of opportunities offered to the family. I perfectly respect their right to decline those. Then we get into to a medical legal case and clearly in such circumstances organisations consult their lawyers and you're into a very different environment then.

D/Sgt Cross: Well I'll, I'll accept once a lawyer tells you not to contact I accept that, that's legal advice and they are entitled to say that. Could I ask you did Hugh Mills tell you on no account will you meet that family and tell them that?

Mr Fee; Absolutely not.

D/Sgt Cross: Are you sure?

Mr Fee: Absolutely not.

D/Sgt Cross: Did Jim Kelly at any stage tell you on no account will you acknowledge shortcomings?

Mr Fee: Absolutely not.

D/Sgt Cross: Right, or Trevor Anderson?

Mr Fee: Absolutely not.

D/Sgt Cross: Right, right, so that's your personal view and you were not, you were not prevented from expressing that?

Mr Fee: Absolutely not. Nor would I be prevented to be quite honest here.

D/Sgt Cross: Yeah, fair enough. Caroline is there anything you want to say?

Solicitor: No, it's fine, I'm happy enough.

Mr Fee: I did actually I don't know if it's any help to you, it's probably isn't relevant, but I did actually write to a range of personal reflections after the inquest which identify some of the issues.

D/Sgt Cross: Yes, I think I have read that in the notes. Cause you have raised, there were issues for the local hospital, there were issues regionally as well. Now I'd have to say I don't recall the detail of it, but I have read it.

Mr Fee: But if it is of any help to you.

PACE 21 served and interview terminated at 1654 hours.