POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC109

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

BDV 94/05

Master Tape Seal Number(s):

T18007A

PERSON INTERVIEWED: TREVOR ANDERSON

ADDRESS: C/O ERNE HOSPITAL

DOB: [redacted]

PLACE OF INTERVIEW: GROSVENOR ROAD PSNI

DATE OF INTERVIEW: 04/05/2004

TIME COMMENCED: 1113 HOURS

TIME TERMINATED: 1121 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, PSNI, ENNISKILLEN CARE UNIT

2 D/CONSTABLE 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's 1113 and we continue the interview. Just to confirm that the same four people are in the room and if I could remind you Doctor that the caution still applies and could I ask you to confirm that we asked no questions in relation to these matters between tapes?

Dr Anderson: Correct.

D/Sgt Cross: Right. Doctor could I ask you to comment at the time what is your understanding of a proper procedure for investigating an unexpected death like Lucy's? At the time now, I know we're five years on, but at that time?

Dr Anderson: Yes. My understanding was that we were looking into the notes that were available to us, the reports that were available to us, to see if there had been any obvious mismanagement on the part of our professional staff, medical nursing and to see if there were any lessons that could be learned for the future. That was my understanding and that was what I saw myself as assisting in doing.

D/Sgt Cross: And have you any comment on say the use of an outside expert like Doctor Quinn. I know you were only two years in the Erne at that

Stage but was that the expected thing, was it an unusual thing, have you any comment on that?

Dr Anderson: The only comment I can make was...as I said earlier, felt that weren't in a position to comment on the medicine the drugs, the fluids used and the dosages, we felt that it would be inappropriate to ask for one of our Paediatricians in house, it could have been perceived then as being a cover up and so we asked for an outside someone outside of the Trust. We were informed that Doctor Quinn who was from the Altnagelvin Hospital and to me that seemed an appropriately independent. I was unaware that Doctor Quinn had had dealings with the Erne Hospital beforehand. In fact I only discovered that a couple of days ago.

D/Sgt Cross: Right. From our point of view it seems to be that Lucy died and an investigation commenced. And the investigation didn't actually say she died because of A, B and C.

Dr Anderson: Hm hm.

D/Sgt Cross: And yet Doctor Asghar, who worked on the ward, I appreciate that there were difficulties between O'Donohoe and Asghar, but Asghar could look at the notes the next morning or very soon after and say straight off that it was the fluids that caused this. Looking back on it do you think was the failure to come to that conclusion an honest failure or was it the case that there was no real intent to actually get the answer?

Dr Anderson: I can honestly say that we were honestly trying to find the answer and Asghar never made his allegations to me personally and on questioning the management informally with Doctor Halahakoon, who was Senior to Asghar and Doctor Quinn and subsequently investigated on two occasions by the Royal College of Paediatrics and Child Health. They didn't immediately turn round and say, Oh it was obviously the fluids.

D/Sgt Cross: And has anybody from the Trust had any conversations with you in an attempt to influence the content of the review?

Dr Anderson: Not that I'm aware of, are you asking me was anyone, am I conscious of anyone trying to influence me the answer was no. Very definitely no.

D/Sgt Cross: Right. Are you aware Doctor that if your review is sort of laid down anywhere in a Code of Practice as a thing to do when you have an adverse incident or was it a sort of a process that was largely ad hoc and.

Dr Anderson: Clinical governance, you are probably familiar with the term is now widely practiced in the NHS, it was not in place at the time, so there was no recognised way of going about things, so we were in a sense working off the seat of our pants. Doing what we thought was correct.

D/Sgt Cross: Right.

Dr Anderson: As a result of the recommendations that we made, changes have been made in the ward. Documentation is always an ongoing problem. I think every medical director will tell you that they are constantly reminding people of documentation. There are now protocols clearly up on the walls of the unit.

D/Sgt Cross: Right and was there any training to your recollection offered the nurses. It is accepted I think that the documentation by the nurses was sub-standard too, are you aware if that was addressed directly with them?

Dr Anderson: Yes, I have in discussion with Mrs Millar who I mentioned earlier, who was the Clinical Services Manager, who was essentially, would have been in charge of the nursing aspect of the department. She has had training sessions with the nursing staff, not only the ones involved I think, but all of the nursing staff on the ward, so that has been addressed.

D/Sgt Cross: Is there anything Rosemary you want to say?

D/Con Hall: No.

D/Sgt Cross: Miss Gilbert?

Solicitor: No I think the points were covered.

Tape Number and
Tape Times:

D/Sgt Cross: Are you happy enough Doctor, I've no further questions, is there anything you want to say?

Dr Anderson: No. Just I felt the whole thing is very sad very tragic and you will see that the last two recommendations that I made was A. the staff were very traumatised by this all of them from Doctor O'Donohoe, through the junior Doctor through all of the nursing and one of the recommendations that I made that they should have time to be counselled and looked after and my last recommendation that the family should be apprised of all the information we had, so as far as I was concerned there was no attempt to cover anything up. My recommendation was the very opposite.

D/Sgt Cross: Right it's 1120. I will just give you that it's a notice to person whose interview has been tape-recorded and if you could just sign that you have got that. I acknowledge receipt of notice to person whose interview has been tape-recorded.

Dr Anderson: Thanks.

D/Sgt Cross: It's 1121 and we'll terminate the interview.