POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark RH106

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

BDV 71/05

Master Tape Seal Number(s):

T88906A

PERSON INTERVIEWED: JAMES FRANCIS KELLY

ADDRESS: C/0 ERNE HOSPITAL, ENNISKILLEN

DOB: [redacted]

PLACE OF INTERVIEW: GROSVENOR ROAD PSNI

DATE OF INTERVIEW: 06/04/2005

TIME COMMENCED: 1456 HOURS TIME TERMINATED: 1537 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN

2 D/CONSTABLE R HALL, CARE UNIT, ENNISKILLEN

3

OTHER PERSON(S) PRESENT:

1 [redacted] SOLICITOR

2

3

MADE BY: D/CONSTABLE HALL

Tape Number and Tape Times:

PACE 10 completed, rights as a voluntary attender explained, reasons for the interview as explained in pre-interview letter, introductions made, caution given and explained. Dr Kelly had a statement prepared for the interview, which was marked by police as RH 33. He was invited to read it.

Mr Kelly: I, Doctor James Kelly, say as follows: Qualifications and experience. I qualified from Queen's University, Belfast in 1981 with the qualifications MB BCH, BAO. I gained membership of the Royal College of Physicians in 1984; I was awarded a Medical Doctorate by Thesis from Queen's University in Belfast in 1998, 1988 sorry and was made a Fellow of the Royal College of Physicians of both Edinburgh and London in 1977. Post qualification, I worked as a House Officer in the Mater Memorial Hospital for one year between August 1981 and August 1982. I was employed as a Senior House Officer at the Royal Victoria Hospital between August 1982 and August 1985. I worked as a Registrar in Geriatric medicine out of Belfast City Hospital between August 1985 and August 1986. I then

took up a year's research fellowship at the Belfast City Hospital; I was employed thereafter as a Senior Registrar in Geriatric Medicine at the Belfast City Hospital between August 1987 and August 1988. I worked as a Senior Registrar in Respiratory Medicine at Belfast City Hospital from August 1988 until 30th of November 1988. I took up my current post as Consultant Geriatrician at the Erne Hospital, Enniskillen on 1st of December 1988. Between January 1996 and September 1999 I was the Clinical Co-ordinator for the Medical Directorate at the Sperrin Lakeland Trust. I was Medical Director of Sperrin Lakeland Health and Social Care Trust from 1st of December 1999 until 1st of December 2003. There would be roles and responsibilities aside from my responsibilities as a Consultant Geriatrician within the Trust, my post as Medical Director included the responsibilities detailed within the Medical Director's job description attached to this statement. Would you prefer that I read that out or?

D/Sgt Cross: This is it at the back.

Mr Kelly: Yes.

D/Sgt Cross: No I think we'll let that sit eh I'll probably ask you later then what your duties may have been specifically in relation to an incident such as Lucy's, but the rest is there for anybody that wants to see it.

Mr Kelly: Ok. Continuing on then. Area C Doctor O'Donohoe's report April 2000. Doctor O'Donohoe contacted me by telephone on either Thursday 13th of April before I attended a Management Network Meeting on Accident and Emergency Services at the American Ulster Folk Park or on the morning of Friday 14th of April 2000. Doctor O'Donohoe explained he wanted to apprise me of the events surrounding a child who had been admitted to the Paediatric Ward of the Erne Hospital on 12th of April. Doctor O'Donohoe outlined that he was raising this under Clinical Incident Reporting. Doctor O'Donohoe informed me that the child had been admitted with

diarrhoea and vomiting and had subsequently suffered an unexplained collapse requiring resuscitation and incubation. He explained that he had transferred the child to the Paediatric Intensive Care Unit at the Royal Belfast Hospital for Sick Children RVHSC. Doctor O'Donohoe advised me that the child was on a ventilator at the RVHSC, but that her prognosis appeared very poor. He explained that brain stem tests were planned. Doctor O'Donohoe said he was not sure what happened stating that there may have been a misdiagnosis, the wrong drug had been prescribed or the child had an adverse drug reaction. Doctor O'Donohoe explained that there had been some confusion over fluids. In response to Doctor O'Donohoe reporting this incident I informed him that there would need to be a full review of the case and this would be established in the coming days. I asked him to ensure a copy of the relevant clinical notes was obtained as I thought it likely based on previous experience that Lucy Crawford's records would be sent to the Coroner. I contacted Mr Mills the Trust Chief Executive at the first opportunity on the morning of Friday 14th of April and advised him of the case and my concerns regarding the possibility of an misdiagnosis, adverse drug reaction, confusion over fluids or Incorrect drug administration. I suggested that we needed a comprehensive review and during our discussion Mr Mills and I agreed that there were possible serious nursing and medical issues in this case and that a senior experienced officer, such as Mr Eugene Fee, Acute Services Director of the Trust, should lead such a review, assisted by Doctor Trevor Anderson, Consultation Obstetrician and Clinical Director for Woman and Child Health Directorate within the

Trust. I additionally asked Mr Mills to make sure our commissioners in particular Doctor Bill McConnell, Director of Public Health at the Western Health and Social Services Board, WHSSB, were aware of the case and the Trust's plan for review. I viewed this case more seriously than any other that I've dealt with as Medical Director, as this was the first occasion that I felt the need for the Trust to make such a report to the Western Health and Social Services Board. Thereafter I phoned Mr Eugene Fee and advised him f the phone call from Doctor O'Donohoe and that Mr Mills and myself were requesting that he lead a review of the case supported by Doctor Trevor Anderson. I was on annual leave for the following two weeks. Area D – Lucy Crawford review. The review was established to investigate the events surrounding the death of Lucy Crawford and in particular to establish if there had been failings in the Trust's treatment or care of Lucy Crawford and whether there were areas of practice requiring improvement within the Paediatric Department. I was not involved in any of the interviews with staff members and other than the meeting with Doctor Murray Quinn, Consultant Paediatrician at Altnagelvin Hospital Health and Social Services Trust on the request of the Chief Executive and Mr Fee at Altnagelvin Hospital on 21st of June 2000, I had no direct role in undertaking the review, which was being dealt with Mr Fee and Doctor Anderson. Mr Fee would have provided as Medical Director with occasional updates on progress with the review. Area E – Doctor Murray Quinn. I understand that whilst I Was on Annual Leave Mr Fee in the course of undertaking his review indicated to the Chief Executive that an external paediatric opinion was required. I believe that the Chief Executive suggested and subsequently contacted Doctor Murray Quinn to request and provide such a review. The Chief Executive suggested at our monthly meeting between Chief Executive and Medical Director on the 4th of

May 2000 that Mr Fee, Doctor Anderson and myself should meet with Doctor Quinn when his report was prepared and discuss any issues or actions required. I spoke with Mr Fee at our regular meeting between the Acute Services Director and the Medical Director on the8th of May 2000 when I believed he provided me with an update as to Doctor Quinn's progress in preparing his report. I do not recall specific details after our discussion. I believe that Mr Fee advised me that he had received initial comments from Doctor Quinn by telephone. I had o contact with Doctor Quinn prior to the meeting of the 21st of June. The meeting was arranged by Mr Fee who had specifically requested my presence as Doctor Anderson was on annual leave and unable to attend the meeting. I attended the meeting to satisfy myself in light of the death of Lucy Crawford and given Doctor Asghar's letter of the 6th of June there were no issues of medical incompetence that warranted the precautionary suspension of Doctor O'Donohoe or other immediate measures. At the meeting on the 21st of June Doctor Quinn had an opportunity to review the more detailed post-mortem report, which I understand had just arrived at the Trust. He then provided us with a step-by-step analysis of the case, his opinion on the treatment given and in particular the fluids administered. I specifically asked Doctor Quinn about any evidence of incompetence on the part of Doctor O'Donohoe and if I needed to be considering a precautionary suspension. Doctor Quinn advised that he saw no reason for such action. I went to the meeting on the 21st of June in anticipation of receiving Doctor Quinn's report, although it was soon clear at the meeting that he had not yet written his report. Doctor Quinn advised that he did not to be involved in complex complaints or litigation processes. Mr Fee and myself explained to Doctor Quinn that A if this case proceeded litigation the

Trust would seek an alternate medical legal opinion through the Trust's legal representatives and B his report needed to be in writing so that it could be included in Mr Fee and Doctor Anderson's review. Doctor Quinn then agreed to provide a written report. Area F – Doctor Asghar – I understand that Doctor Asghar met with Mr Mills on Monday 5th of June 2000 and presented him with a letter copied to myself and five others within the Trust, outlining allegations that he was being bullied and harassed by Doctor O'Donohoe and that in his opinion, Doctor O'Donohoe was incompetent. Doctor Asghar sited some cases including the Lucy Crawford as evidence of this. Mr Fee and myself met with Doctor Asghar that afternoon between 4.00 and 5.30 pm in my office to discuss his letter and his concerns. Doctor Asghar was provided with the opportunity to outline the incidents of harassment and bullying, Doctor Asghar was advised that this issue would be formally investigated in line with the Trust's policy on harassment at work. Doctor Asghar then outlined the issue of Doctor O'Donohoe's competency. The cases sited by him were discussed I detail. Doctor Asghar was advised that the Lucy Crawford case was currently under formal review involving external paediatric advice. From the examples sited it was not immediately obvious that there was an incompetence case to answer, however Doctor Asghar was advised that I would look at the cases highlighted and ascertain if there was a case to be addressed. I advised Doctor Asghar that this process may also require external paediatric assistance. Doctor Asghar was advised that the allegations would be shared with Doctor O'Donohoe at the earliest opportunity. Potential interim changes to The work schedules within the paediatric department that would minimise direct contact between the two parties, Doctor O'Donohoe and Doctor Asghar, while investigations proceeded were also discussed with Doctor Asghar. I recall thanking Doctor Asghar for

bringing his concerns to our attention. Doctor Asghar was also offered formal support by the Occupational Health Department. Mr Fee and myself met with Doctor O'Donohoe at 9.00 am on the 12th of June 2000 to advise him of the complaints from Doctor Asghar and seek his response to the allegations. I met with Doctor Halahakoon, lead Paediatrician at the Trust on the 23rd of June 2000 to discuss 1. the issues raised by the Lucy Crawford case, and 2. [redacted] I also met with Sister Traynor, Sister in charge of the Paediatric Ward at the Erne Hospital on the 23rd of June 2000. I discussed the same issues with Sister Traynor that I discussed with Doctor Halahakoon. [redacted] Following these discussions there did not appear to be any immediate issue of patient's safety or a case for suspension of Doctor O'Donohoe and following consideration of the totality of the issues raised, I advised the Chief Executive, that external paediatric advice was required and this would be best done through the Royal College of Paediatricians and Child Health RCPCH. It was agreed that this would be done by contacting the Royal College of Paediatrics Regional Advisor, Doctor Moira Stewart; Doctor Halahakoon the lead Paediatrician supported this decision. I subsequently met with Doctor Malik, Paediatric Senior House Officer on the 7th of November 2000, in response to comments made within Doctor Asghar's letter of the 5th of June 2000 and discussed with him his involvement in the Lucy Crawford case. I also sought assurances from Doctor Malik that he had not been harassed, intimidated or encouraged to alter notes. Doctor Malik provided reassurance,

reassurance as regards these issues and indicated that he had a good working relationship with Doctor O'Donohoe. Area G – RCPCH reviews – RCPCH first review. Following the number of telephone conversations with myself, Doctor Stewart agreed to explore with the RCPCH if they could be of assistance. This led me to making an informal written request in September 2000 to the Secretary of the College, Mrs Pat Hamilton. Follow up telephone conversation to clarify my requests led to correspondence from the college dated the 9th of November 2000 agreeing to assist but only on the issue of professional competency. The college nominated Doctor Moira Stewart to provide the college opinion. Doctor Stewart was provided with copies of relevant case notes, including those of Lucy Crawford, all the correspondence from Doctor Asghar, notes of interviews held between April and December 2000 and complaints analysis for all Clinicians in the Paediatric Department to assist in her deliberations.

[redacted] Doctor Stewart provided her report at the end of April 2001. Upon receipt I shared Doctor Stewart's report with the Chief Executive, Doctor Fee and Doctor Anderson. I subsequently contacted Doctor Stewart to arrange a meeting to clarify aspects of her report. This meeting took place on the 1st of June 2001. Doctor Stewart's report and the notes of the meeting on the 1st of June 2001 were sent to Doctor McConnell at the Western Board, WHSB on the 27th of June 2001, with a request that he provide his comments. RCPCH second review. Doctor Asghar raised concerns relating to a further three cases during the Autumn of 2001 and in addition Doctor Halahakoon had also raised one case of concern. I met with Doctor Anderson and

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Doctor Halahakoon on the 28th of September 2001 to discuss the issues raised by Doctor Asghar. A decision was reached that the Directorate would review the cases under the Incident Reporting Process and that external advice may be considered. Following the Directorate's review of these cases the reports were provided on November 2001 and advice from Doctor McConnell at the Western Health and Social Services Board I felt that the issue of Doctor O'Donohoe's performance and safety needed to be again addressed by the RCPCH. In February 2002 I requested that a long side a review of the case notes this review should include a detailed site visit with direct interviews of all parties involved. The college nominated Doctor Andrew Boon, Consultant Paediatrician at the Royal Berkshire Hospital and Doctor Moira Stewart to be the external Clinical Advisory Team to perform this review. During February and March 2002 I worked with Directorate to produce a new strategic review of paediatrics within the Trust to provide additional paediatrician, clarify roles and responsibilities and enhance the overall service. The College visit on the 23rd, 24th and 25th of June 2002 included a full day of interviews of medical staff, including Doctor Asghar, Nursing Staff and managers. Mr Mills and myself met with the college team at the end of their visit on the 25th of June and they advised that no immediate action such as suspension was required. The college's formal report was provided in August 2002. This report was shared with Doctor O'Donohoe at the end of September 2002 and Doctor Asghar in October 2002. That completes the statement.

D/Sgt Cross: You at the relevant time...were the Medical Director of Sperrin Lakeland Trust and Doctor Anderson is the Clinical Director...what is the distinction in your role and his role?

Mr Kelly: The Clinical Director looks after operational aspects within the remit that they had, Doctor Anderson that would include maternity, gynaecology and paediatrics... and as a Clinical Director he would be responsible for budgets, he would be responsible for the service. The medical Director's role is much more strategic to the Trust. And is in relation to long term planning providing advice overall. Additionally in terms of incident reviews they, they would be normally done by the Directorate, the Medical Director would get advised of the more serious ones.

D/Sgt Cross: Yes. Yeah when you say again, you know, this isn't my field at all, when you say critical incidents etc would be resolved by the Directorate, who comprises the Directorate?

Mr Kelly: ...The Directorate is all of the clinicians, medical, all of the nursing, all of the staff within that belongs within the Directorate. It is led in most cases in Sperrin Lakeland Trust... by a Clinical Director, Doctor Anderson, supported by a Clinical Services Manager who from the Directorate was Esther Millar.

D/Sgt Cross: Esther Millar. Right ok...At paragraph 20, Doctor, you say, I specifically asked Doctor Quinn about any evidence of incompetence on the part of Doctor O'Donohoe and if I needed to be considering a cautionary suspension, Doctor Quinn advised that he saw no reason for such action. I think you know to be fair to you...Mr Fee that's exactly what he would say too. But Doctor Quinn told us differently, he said when he was asked that question he in a sense side stepped and he didn't want to deal with that issue at all. Are you clear in your mind?

Mr Kelly: Absolutely clear and took notes at the time.

D/Sgt Cross: Yeah, yeah.

Mr Kelly: Typed them up and then the computer record will, it would want to be checked and it would demonstrate that those notes were taken at the time.

D/Sgt Cross: We have a copy of that, but that is what Doctor Quinn says. He was quite clear to us that he did not go down that.

Mr Kelly: I am absolutely clear that as we finished the discussions on being the case that was an area, is there anything here that warrants such action.

D/Sgt Cross: No.

Mr Kelly: That's why it is at the end of the thing.

D/Sgt Cross: Yes.

D/Sgt Cross: Also, Doctor, at paragraph 34 in relation to the first review by the Royal College, eh you said that, paragraph 34, slightly above half way down, the college agreed to assist but only on the issue of professional competency. What were they excluding themselves from, were there other issues?

Mr Kelly: The issues for example in Doctor Asghar's letter, which was a key feature in moving this forward were [redacted] The College were advising me that they were comfortable in getting involved in competency... [redacted]

D/Sgt Cross: That's grand. A document that I have marked WRC10 and this comes from the notes of Mr Mills... it's entitled Confidential Lucy Crawford, 18 month old child admitted to Erne Hospital with suspected gastroenteritis, and it's basically a chronology doctor of Mr Mills' dealings. It is a report made by Doctor Kelly to Hugh Mills that you've already covered; I just want to ask you in more detail. It does say here on the first page that you have raised the issue of wrong, a wrong drug having been given or a wrong dose, now you've already mentioned that... Doctor O'Donohoe had raised that with you.

Mr Kelly: Yes.

D/Sgt Cross: Could I just ask you more on, along that lines, did, was Doctor O'Donohoe in anyway specific about which wrong drug may have been given, which wrong dose?

Mr Kelly: I cannot recall.

D/Sgt Cross: And you have said Doctor in your statement there was an issue, there was some confusion over the fluids, do you recall any more detail about what Doctor O'Donohoe may have said as to the nature of the confusion?

Mr Kelly: He was basically outlining to me that he had prescribed a fluid regime and there was confusion of over what was administered.

D/Sgt Cross: Right.

Mr Kelly: That was it. I did not get into any detail at that stage...

D/Sgt Cross: Right. From your experience now if, to me you know a fluid is a fluid and a drug is a drug, but as I have... investigated this other doctors are saying no, a fluid regime is a prescription, it is a prescribed drug, even though it's basically dilute, it's a solution of salt with dextrose. If a doctor said to you that there may have been a wrong drug, could that to you mean a wrong fluid?

Mr Kelly: No, no that was not.

D/Sgt Cross: No.

Mr Kelly: That was no my interpretation of that of that conversation, it was relating a medication type drug.

D/Sgt Cross: Right.

Mr Kelly: And I would also mention to you that what you have just described would not universally be a held view amongst all doctors.

D/Sgt Cross: Right. Right.

Mr Kelly: i.e. Doctors in Paediatrics would probably hold your view very tightly.

D/Sgt Cross: Yes, that's where we've got it from, Doctor Sumner.

Mr Kelly: Doctors across the medical field would not necessarily see fluids as a specific drug, it is a drug that has to be written up and signed for. But the practice in paediatrics, and I discovered this as well, from my appointment to this, is different in practice to adult medicine.

D/Sgt Cross: Right. Ok. This again is a question that I've asked all your colleagues who have been interviewed. Doctor O'Hara who was the Pathologist at the time, now deceased, he wrote to the Coroner and said at the time it appeared to him there was a difficulty about this death that may lead to litigation. Now unfortunately now I can't ask him what he meant by at the time, but it appears to me...he means at the time of the post-mortem at the time of her death as opposed to you know any period thereafter. This letter was written in 2003, but do you recall any discussion along those lines doctor among yourselves that there is a problem here, it will go to law?

Mr Kelly: Well I don't think I've ever seen what you're referring to, Doctor O'Hara.

Solicitor: It's difficult for us to comment on this.

D/Sgt Cross: I appreciate that.

Mr Kelly: So there is always, I just wouldn't say there was a nervousness about commenting on something being taken out of context, but I would say to you that the area of litigation, I'm trying to think for clarity, this is best recall of five years ago was probably first discussed when Murray Quinn raised it.

D/Sgt Cross: Right.

Mr Kelly: And said, Murray Quinn's direct words, his exact words were I know how some of these cases go, get involved in complex complaints and complex litigation, I don't want to be involved in those and that's why.

D/Sgt Cross: Right, he was drawing the line. Right. Also Doctor in the review conducted by your colleague Doctor Anderson and Eugene Fee, it does say that all the staff were shocked and traumatised by this incident. Would you have had any duty in respect of staff who have been shocked and traumatised by an incident like this?

Mr Kelly: It would normally lie with the Directorate who managed those doctors and nurses.

D/Sgt Cross: Right.

Mr Kelly: But I would have certainly expressed to others and including the Chief Executive, would have been concerned by Doctor O'Donohoe as he was clearly traumatised by this. And at a later stage I clarified support for him with Occupational Health.

D/Sgt Cross: Yes, but are you saying then the issue of how the nurses felt and perhaps the like of Malik etc. that is a matter for Doctor Anderson and he's the head of that Directorate.

Mr Kelly: Doctor Anderson and Esther Millar would deal with those particular issues.

D/Sgt Cross: Yes.

Mr Kelly: Obviously if somebody came to my office. I would know the pathways and would refer them on for appropriate support and would give them support. Other managers in different settings might visit the ward and provide support and things if it was a major event or something.

D/Sgt Cross: Yes. And, Doctor, are you aware of any changes that the Trust brought out or any training that was implemented by the Trust as a response to this. I'm thinking in particular in relation to the issues say that were raised in the review with regard to the recording of fluid prescriptions, the quality of the documentation, recording maybe the experience of the parents etc.

Mr Kelly: Well again I'm not the best person to answer on operational issues.

D/Sgt Cross: Who would be?

Mr Kelly: Doctor Anderson, Esther Millar, but I stressed to Doctor Halahakoon, which I have said in my statement and I stressed to Sister Traynor the lead Paediatrician and the lead nurse to address these issues and I know that we had these issues addressed well in advance of the CREST work to produce new guidelines on the management of fluids.

D/Sgt Cross: If you would just explain to me, what is the CREST work?

Mr Kelly: Sorry, the CREST, following this being highlighted at a regional level with the Chief Medical Officer the issue of hyponatraemia in children, the CREST which is a group Clinical Resource Efficiency Strategy Team, that's what it stands for. They were appointed by the Chief Medical Officer to look at this issue and come up with recommendations and guidelines for the whole region. They produced very sophisticated and highest quality guidelines that are posters and booklets that are on every ward and every outpatient and I made sure that they were put in every clinical area.

D/Sgt Cross: Is that Doctor John Jenkins' works, was he involved in that?

Mr Kelly: John Jenkins was one of the leaders in that. Correct. So there was that. Additionally I put a warning of the system when I heard about Raychel Ferguson's death in Altnagelvin. I put a letter in to our Trust system in June advising Doctors that this became an issue and to let all the Paediatricians clarifying that we must be very careful with the use of fluids and to not to use Solution 18, to change to and I'm sure if you haven't got it you can have a copy of that letter.

D/Sgt Cross: Fair enough.

Mr Kelly: I included with that a recent publication at that time in March 2001, in the British Medical Journal on the issue. So I just hadn't put the warning out but I actually cited... and provided a copy of it for all the Paediatricians. So they're the type of changes that are an ongoing result of all this.

D/Sgt Cross: Fair enough. Then, Doctor, in the review conducted by Mr Fee and Doctor Anderson, it is recorded that the fluid prescription as understood particularly by Nurse Swift, she is the person that set the drip up and who has dialled in 100 mls, and it was her understanding that Doctor O'Donohoe had prescribed a 100 mls an hour for every hour until urine is passed. I know he has a different opinion in what he actually said, and that's for them to resolve, but some of the nurses are saying 100 mls an hour for every hour until urine is passed was a standard practice on the ward. Now others dispute that. Have you any comment on that?

Solicitor: That's a decision for paediatric.

Mr Kelly: I make no comment on that at all. As I said I didn't know any of these people and it would have been improper for me to have interviewed any of these people.

D/Sgt Cross: You would have interviewed Sister Traynor, who wasn't on in the night in question but would be very familiar with what happened and I'm sort of asking you ...

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Mr Kelly: I would want to clarify that I didn't interview sister Traynor in direct relationship with that.

D/Sgt Cross: I appreciate that.

Mr Kelly: I was coming back from Doctor Quinn's meeting, I had Doctor Asghar's letter, so I had two areas that I had to satisfy myself in and one was that I wanted to share the information that Doctor Quinn had provided to us in the previous two days and clarify with her that there was a need to address proper prescribing and recording etc in such issues. The second area was and more importantly I know it mightn't sound right, but more importantly for me was the issue of Doctor O'Donohoe's competency. Were children at an ongoing basis being put at risk? Sister Traynor was satisfying myself, I didn't have any interview or discussions about going back to this - Nurse Swift says this and Doctor O'Donohoe says that...

D/Sgt Cross: But what I'm asking you for is, you in all likelihood are not in the position to help me, but what I'm asking is this. I am being told by one set of people, this was standard practice and being told by another set of people no it wasn't... Have you any information that came to you that would indicate, it was or wasn't standard practice?

Mr Kelly: No I have no information on that at all sorry.

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D/Sgt Cross: That's grand. I would have to say looking at it from my point of view: the investigation that the Trust carried out into why Lucy died, number 1 - it didn't get an answer and number 2 - an Inquest years later did get an answer and number 3 - in between times Asghar seems to have produced an answer. Now whether that's because he is very clever or he's lucky, I don't know. It would appear to me looking at it from an outsider, it was possible to get an answer but the Trust didn't get an answer and therefore I would have to say it was an ineffective investigation. Now Mr Fee would say that may be or it may not be, but there was no procedure in place officially to tell management how to investigate such issues. Have you any comment on that? In fact he went on to say that while you're near one now there still isn't actually a written protocol or set of procedures for you to follow.

Solicitor: I would like to have a bit of ...

Mr Kelly: Right there's kind of there's almost three or four issues in that, that's too much for me in one go. Can you break it down a bit.

D/Sgt Cross: What I would like to know is: when an incident arises in a hospital whereby someone dies, that's a serious issue. What is your understanding, where do you go for advice, what are the procedures for properly dealing with an incident like that?

Mr Kelly: The dealing with that in its totality and I'm trying to understand what you are saying in the question. I would say to you that in the years 1999/2000 there was absolutely no agreed system.

Tape ended at 1537 hours.