POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark RH109

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

DHV 81/05

Master Tape Seal Number(s):

T115862A

PERSON INTERVIEWED: HUGH SPROULE MILLS

ADDRESS: STRATHDENE HOUSE, TYRONE AND FERMANAGH HOSPITAL

DOB: [redacted]

PLACE OF INTERVIEW: PSNI, GROSVENOR ROAD

DATE OF INTERVIEW: 07/04/2005

TIME COMMENCED: 1047 HOURS

TIME TERMINATED: 1125 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, [redacted]

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MADE BY: D/CONSTABLE HALL

Tape Number and Tape Times:

D/Sgt Cross: PACE 10 completed, reasons for interview explained as set out in pre-interview disclosure, rights as voluntary attender stated, caution given and explained.

Mr Mills asked to state his qualifications and experience.

Mr Mills: Ok. I have a BSC in Economics 1973 from Queens University, Belfast, an MSC in Policy Analysis 1987 from the University of Ulster in Jordanstown, I have been a member of the Institute of Health Care Management for approximately 18 years, at the time I was a member of the National Council of the NHS Confederation, which is a UK wide organisation, which would be an organisation that would be a representative of employers across the UK and I was the representative of all the Northern Ireland Trust Chief Executives on that. I was appointed to the Health Service in 1973 as a Graduate Trainee and that was the Northern Ireland Health

and Social Services, so approximately 31½ years experience in Health Service management. Currently my employment since 1996for the past 9 years has been as Chief Executive of Sperrin Lakeland Health and Social Care Trust. Sperrin Lakeland Trust is a combined Hospital and Community Trust providing Health and Social Services to the West Tyrone and Fermanagh area. Approximate population is about 120,000 it covers a thousand square miles; we employ over 4000 staff and have an expenditure in excess of 130 million per annum. Prior to 1996, from 1990-1996, I was employed as the Unit General Manager for the Omagh and Fermanagh Hospital and Community Services, basically the same responsibilities as what Sperrin Lakeland Trust have in terms of the range of services we provide, except for mental health. Mental Health were amalgamated in 1995 with the services that the former Tyrone and Fermanagh Unit Management had and at that time we were directly managed by the Western Health and Social Services Board and prior to 1990 I worked in Derry in a series of administrative posts, concluding with 3 years as what was called the Deputy Group Administrator for the Londonderry, Limavady and Strabane area where I was the administrator based in Altnagelvin Hospital.

D/Sgt Cross: Mr Mills at the relevant time say in April 2000 you were the Chief Executive then for the Erne Hospital and further afield. Am I right in saying that ultimately you would be the person that everybody else involved in this investigation would report to as far as the Erne Hospital is concerned?

Mr Mills: Yes. Sperrin Lakeland Trust provides Acute hospital services from two facilities, Tyrone County Hospital in Omagh and the Erne Hospital in Enniskillen. The Trust is managed by a Trust Board, which consists of eleven executive and non-executive directors. There are as far as the team who report to me, I'm the Chief Executive, the team that report to me consist of the Director of Acute Hospital Services.

D/Sgt Cross: Which is Eugene Fee?

Mr Mills: Which is Eugene Fee. He is also the Executive Director for the Nursing Profession. In terms of all advice that the Trust Board would receive regarding nursing the nursing profession, Eugene would provide that. Then there is the Medical Director who at that time was Doctor Jim Kelly and he again has the professional responsibility for providing professional advice in relation to medical staff.

Mr Mills proceeded to explain the role of others in the Trust who were not part of this investigation.

D/Sgt Cross: Then Mr Mills if we can move on and ask you to describe how you became aware of the concerns regarding Lucy?

Mr Mills: Doctor Kelly advised me within 24 hours of the adverse incidents to Lucy and this was done by telephone, some uncertainty if this was on either the 13th of April or 14th of April and I don't recall my location when I received the information.

D/Sgt Cross: Did you want to go on and describe what your actions would have been, having received the information. Could I ask maybe before you did that could you tell us actually what you were told in relation to Lucy as far as you can recollect?

Mr Mills: I made a note of it at the time and you I actually; I shared with my diary note. ...Primarily the recollection is contained in that diary note. Doctor Kelly advised me of an adverse incident regarding the illness of Lucy Crawford: he advised me that there could be a situation where the wrong drug or the incorrect dose/levels of fluids may have been prescribed, although blood tests were not confirming this. Child had been transferred to the Royal Belfast Hospital for Sick Children, however was reported as brain dead. Doctor O'Donohoe had been asked to obtain a copy of the patient's notes. I agreed that I would advise Doctor McConnell, Doctor Bill McConnell would be the Director of Public Health in the Western Health and Social Services Board. Advised Ms O'Rawe through Janet Hall, Janet would be a member of her staff, given the adverse incident and the potential for press interest. Provided information to Doctor McConnell who stated that he would advise Martin Bradley. Martin Bradley would be the Director of Health Care and the Chief Nurse within the Western Health and Social Services Board, so both the Chief Nurse and the Chief Doctor in the Western Health and Social Services Board were being advised.

D/Sgt Cross: Right, Mr Mills, just for the purpose of the tape can I ask you to confirm that what you've just read from this document here, which I have marked WRC10 as far as we are concerned, and this is your personal record.

Mr Mills: That's what I describe as my diary note.

D/Sgt Cross: Can I ask you, Mr Mills, you say that Doctor Kelly advised you that there could be a situation where the wrong drug etc may have been prescribed? Did he tell you on what basis he had that information, how did he know that?

Mr Mills: Yes he told me that Doctor O'Donohoe had contacted him.

D/Sgt Cross: Right and do you have any recollection, it doesn't say so in the notes, but do you recall was there a discussion as to what the wrong dose may have been, what the wrong drug may have been, what the mistake was?

Mr Mills: No.

D/Sgt Cross: Do you recall anything further being said about the level of fluids, because that is what it came down to after, at the Inquest I suppose, it's more fluids than the diazepam or whatever, do you recall was there any detail in your briefing?

Mr Mills: No.

D/Sgt Cross: Can I say is it a case that you can't recall that, or are you saying that there was no detail?

Mr Mills: There wouldn't have been any detail at that time.

D/Sgt Cross: Right.

Mr Mills: You will find that that detail was provided by Mr Fee on the Thursday of the 20th, that would have been whenever I was being advised.

D/Sgt Cross: If we just go down then to Thursday the 20th and ask a few questions in relation to that. Mr Fee you have recorded that Mr Fee told you that the patient's notes 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, now clearly that is significant in our investigation because the nurses are clear, well some nurses are clearly saying this is what was prescribed. Let me be more specific. ...Breige Swift says I was told by Doctor O'Donohoe to give a 100 mls per hour until she passes urine. Doctor O'Donohoe says afterwards, not to me, but he has recorded that he didn't say that, it was a 100 mls an hour and then 30 mls an hour, so there is a dispute about the prescription and we are endeavouring to try and clarify what actually happened. ...Do you recall any more detail about this comment?

Mr Mills: Obviously Mr Fee at that stage had seen the patient notes and he was advising me on the issue that what was recorded in the note and that's my interpretation of what was recorded in then notes, because as I understand it, the note that Doctor O'Donohoe made was not contemporaneous.

D/Sgt Cross: That's right yes. And therefore when you made that note Mr Mills, it was at your opinion that Doctor O'Donohoe himself wasn't certain what he had prescribed?

Mr Mills: I didn't speak to Doctor O'Donohoe so it wouldn't be appropriate for me to say...

D/Sgt Cross: Fair enough, but what I am asking you, I think it is appropriate that you comment on this. What I'm asking you is, as Mr Fee briefs you, did you write this note with the impression in your mind that O'Donohoe is uncertain about what he said, that's what you're being told?

Mr Mills: I wouldn't put any emphasis on that.

D/Sgt Cross: Because there could of course be another slant on that - that the conversation is that there was uncertainty about the prescription if you know what I mean, and O'Donohoe was actually certain that he said a thing, but the nurse is certain of another thing, so there is uncertainty here and that would be different, but if Mr Fee had told you no O'Donohoe himself doesn't know what he said or isn't certain what he said that's what I'm trying to get to, but you're not in a position to be specific?

Mr Mills: No.

D/Sgt Cross: Could I ask you then, Mr Mills, ...what...actions did you set in motion to deal with this issue.

Mr Mills: ...There had already been a decision to establish the review, that was taken by Doctor Kelly and he basically agreed with me that Mr Fee and Doctor Anderson would be involved in...that review.

D/Sgt Cross: Could I ask...why was there a review set in motion? Was that the procedural thing to do or was that a decision that you took as a management team irrespective of other procedures?

Mr Mills: ...I received information and I took advice from various professional people within our organisation. I engaged support for the Trust, I will come on to that in relation to the appointment of Doctor Murray Quinn and I advised other people both internally and in terms of the Trust and externally outside the Trust...I suppose I should share with...you that if there was the potential for disciplinary proceedings and let's face it that was one of the things that would have been in our mind at the outset...if a case was being presented through disciplinary channels I shouldn't be too close to it in the sense that I would have probably been the person who would have been hearing the case. People who had to be close to it were obviously people like Doctor Kelly and Mr Fee who then subsequently would be presenting the case at a disciplinary panel...

Mr Mills continued to explain the disciplinary procedures and a copy of these was exhibited as RH37.

D/Sgt Cross: So what you are saying Mr Mills is because of this disciplinary procedure you set certain wheels in motion in relation to the review that was going to be conducted by other personnel and you basically stood back and left them to get on with it then?

Mr Mills: Yes, but they kept me informed on a regular basis and I would have had the opportunity to ask questions on a regular basis.

D/Sgt Cross: You did say that you sought external assistance in Doctor Quinn, could I ask why you selected him or whose decision that was?

Mr Mills: Yeah. I suppose I've sort of jotted down a list of the various actions that I would have taken and that's the summary of the information that is in the diary note and just for completeness I advised the Western Board of the adverse incident within the 24/48 hours and followed that up I informed Trust staff responsible for the quality complaints litigation and communications, I would be in contact with Mrs Hall. I informed the Trust chairman. I arranged for external paediatrician Doctor Quinn to examine the circumstances of the case. That came as a request for a paediatrician... from Mr Fee. In April 2000 the request for an external opinion were fairly unusual in the absence of a complaint or litigation... Clinical governance is a concept that was developing and has since been applied in Northern Ireland in 2003 as a statutory requirement, but because of my role as I said earlier on in relation to the NHS confederation, I would have been aware of developments in relation to clinical governance in England and because they were ahead of us in that respect and it was coming our way as it were. Now given the involvement of Belfast Children's Hospital in the care of Lucy I felt it was appropriate to seek an opinion from elsewhere. We obviously had been involved at our end, Belfast had been involved at the time of her death and I think that demonstrates good practice and demonstrates the Trust willingness to pursue openness in the examination of the issues. I was also conscious of the sensitivities of both medical and nursing staff in relation to the issues and the differences of opinion. I approached Doctor Murray Quinn as, he is well respected... I expected that both the nursing and medical staff at the Erne Hospital would also be confident in his professional approach.

D/Sgt Cross: You appreciate Mr Mills that there had been fairly strident criticism of his selection, because he is non-independent, I think in particular the Insight programme and could I ask would it not been more prudent to get somebody from Coleraine, if it's a different board, or Ballymena or Newry... Doctor Quinn is bound to know Doctor O'Donohoe, he does clinics once a week or once a fortnight in the Erne, he must take coffee with him, those sorts of allegations are there and therefore the Paediatric world is small in Northern Ireland, he is not likely to shaft a colleague, to put it bluntly.

Mr Mills: Doctor Quinn at this time did not do clinics in the Erne Hospital.

D/Sgt Cross: Did he not?

Mr Mills: No. The Paediatric Service was established in 1994, prior to 1994 the care of children in Omagh and Enniskillen was provided by consultant physicians and when the amalgamation of the Maternity Services was introduced in 1994 we established a Paediatric Service, the Paediatric Service prior to that as I say would have been provided by Consultant Physicians with visiting Paediatricians from Altnagelvin, one of which would have been Doctor Quinn, so he would have been involved in doing clinics at that time and indeed shortly after, I'm not quite sure when his clinics would have finished, but they would have finished before this. Doctor O'Donohoe wouldn't have been appointed until 98, maybe, I think It was 98, I'm not quite sure about his date of appointment. Doctor O'Donohoe would have come into the Service well after it was established within the Trust. And Doctor Quinn's role had already finished at that stage. So Doctor Quinn wouldn't have known Doctor O'Donohoe in advance in terms of regular visits to the hospital or, now there would have been referrals between Doctor O'Donohoe to Altnagelvin. In essence quite a lot of our referrals would have gone to Belfast rather than necessarily gone to Altnagelvin.

D/Sgt Cross: Could I ask did anyone else have any input into the selection of Doctor Quinn?

Mr Mills: No.

D/Sgt Cross: Specifically did Doctor O'Donohoe propose Doctor Quinn?

Mr Mills: No.

D/Sgt Cross: Could I ask had you used Doctor Quinn in this capacity before to your recollection?

Mr Mills: No.

D/Sgt Cross: And also do you recall was Doctor Quinn paid to write this review, to do this review?

Mr Mills: That came, that came up recently. I mean I would assume he would have been paid, but I understand he didn't submit an account.

D/Sgt Cross: That is what he has told us. Do you have any information available to you to suggest that's wrong?

Mr Mills: No, my understanding is that he didn't submit his account. The time I would have engaged them I wouldn't have talked to him about how much it would cost, I basically was seeking his agreement to do the review, but that was on the assumption that he wasn't doing it for his employer, he was doing it for us and therefore we would be paying, in much the same way we would pay for other external things.

D/Sgt Cross: John Jenkins or whatever?

Mr Mills: Yeah.

D/Sgt Cross: Mr Mills are there any other professional responsibilities that you had in relation to this situation... that you are required by a code or whatever to actually do?

Mr Mills: I suppose, I can't think of any others, but obviously when it came to the complaints process then there was a requirement to respond.

D/Sgt Cross: ...Could I ask then...with whom you discussed these matters and the contents of those discussions...?

Mr Mills: I suppose this is my note in the sense, there is nobody other than this note that I would be aware of and people that I would discuss it with. So Doctor McConnell, Martin Bradley in that respect, Mr Fee obviously would have been identified there, I spoke to Doctor Quinn in terms of his appointment, Doctor McConnell again another person I spoke to, I have spoken to the chairman of the trust, who at that time was a Mr Richard Scott. I spoke to Mr Frawley, who at that time would have been the General Manager of the Western Board, that's dated 3rd May. Basically Asghar would have been the next person who would have contacted me on the 5th June. Doctor Asghar visited my office and provided me with a letter and his concerns.

D/Sgt Cross: ...Did you discuss it with anyone in the Royal Belfast Hospital for Sick Children or any of the Pathologists; O'Hara was the Pathologist in question?

Mr Mills: No.

D/Sgt Cross: ...What were the reasons for implementing such a review, what did you hope to achieve?

Mr Mills: Clearly it was obvious that there was a serious adverse incident, I mean the child had died and we didn't know why. The concept of clinical governance was emerging as I said and the use of critical incidents and adverse incidents is actually part and parcel of clinical governance which is about examining these in such a fashion that if there are issues then you learn from those and make improvements in terms of your services, people have talked about the aircraft industry learning from things like near misses and this was a similar type of concept. The culture within Health Services

Mr Mills: generally was changing and more away from an adversarial, a confrontational which would have been in terms say for example blaming professionals or individuals professionals in identifying examining issues. Looking at systems and looking to see if there was any issues in relation to those systems and support of staff and to identify where those had failed. A lot of that as it were had come out of the work that is associated with clinical governance and thinking in health care professional services at that time.

D/Sgt Cross: Right so when you set up a review and asked Mr Fee and Anderson to do it, am I right in assuming that the remit or the purpose is to find out what went wrong with a view to making sure it didn't go wrong again?

Mr Mills: We wanted to clarify what went wrong and identify if there were any issues as a result of the review that we needed to take action on.

At 1126 hours the tapes were changed.