POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark RH110

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:	PERSON INTERVIEWED:	HUGH SPROULE MILLS
DHV 81/05	ADDRESS:	STRATHDENE HOUSE, TYRONE/FERMANAGH HOSPITAL
Master Tape Seal Number(s):	DOB:	[redacted]
T115863A	PLACE OF INTERVIEW:	PSNI, GROSVENOR ROAD
	DATE OF INTERVIEW:	07/04/2005
	TIME COMMENCED: 1131 HOURS	TIME TERMINATED: 1213 HOURS

INTERVIEWING OFFICERS:	OTHER PERSON(S) PRESENT:
1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN	1 [redacted] SOLICITOR, [redacted]
2 D/CONSTABLE R HALL, CARE UNIT, ENNISKILLEN	2
3	3

MADE BY: D/CONSTABLE HALL

Tape Number and Tape Times:

D/Sgt Cross: It's 1131 and we will continue the interview. We are still in the same location and it is the same four people in the room and if I could remind you Mr Mills that the caution still applies and I would like to say while the tapes were being changed there was some discussion about these documents, there were no questions asked in relation to it other than an agreement that we would clarify this when the tape commences. Are you happy that's a fair summary Mr Mills?

Mr Mills: Yes.

Mr Mills clarified the document marked by Police as WRC3 was an abbreviated report given to Lucy's family but that the full Trust review was a larger document. The family did not receive the Appendices to the Trust Review, but the content was substantially the same.

Tape Number and Tape Times:

D/Sgt Cross: ...I am interested in why certain people weren't interviewed in the process, but can I ask you who is responsible for establishing this process, was that your direction or was that left in Mr Fee and Doctor Anderson?

Mr Mills: The process would have been left to Mr Fee and Doctor Anderson... established with them by Doctor Kelly.

D/Sgt Cross: And you had reasons to distance yourself from that because of the possible disciplinary consequences?

Mr Mills: Yes.

D/Sgt Cross: ...Are you aware of a decision having been taken not to ask Doctor Auterson for an opinion?

Mr Mills: No.

D/Sgt Cross: Doctor Auterson...did have an opinion as to the cause of the child's death, but he said he wasn't asked for that at any stage and obviously if there was a decision made not to ask him, that would be of concern, but what you're saying is you didn't take that decision and you're not aware that anybody else did?

Mr Mills: Well it would concern me because I think there are professional obligations on Doctor Auterson, that if he did have an opinion and again he claims he wasn't being asked for. There are professional obligations for doctors to convey that.

D/Sgt Cross: And what is that obligation?

Mr Mills: Basically if they feel that some damage or harm has come to a patient or client then they do have to report it to the Medical Director.

D/Sgt Cross: Right, would that apply to nurses as well?

Mr Mills: Yes, I think that's in their code of practice and code of conduct. Now again I don't know what conversation you've had with Doctor Auterson, I know he was asked for an opinion at the time of the Inquest, but whether he had formed an opinion in the light of the information that was applied that was presented at the Inquest or whether he had formed his opinion in the light of the information, because he wouldn't have had all the information in terms at an earlier stage.

D/Sgt Cross: It would appear to us anyway that he may have formed an opinion as to the significance of the fluids administered at the time, but your position would be that if a medical professional had a relevant opinion it's not necessarily the Trust's job to find that out, they are professionally obliged to volunteer it themselves to approach the reviewers and say this is what I think happened, is that what you're saying?

Mr Mills: Yes, in that we get plenty of opinions from doctors and obviously it would be, even if you didn't, even if you hadn't have asked for a statement, now obviously Doctor Auterson was involved the review group would have obtained a statement, but if for example they hadn't asked him for a statement and he had an opinion, my view would be that they have a professional obligation to convey that opinion to the Trust and that's their responsibility in terms of the Medical Director.

D/Sgt Cross: Right fair enough, further to the process of the review are you aware of any discussion and outcomes in relation to the role of Doctor Malik in the review process?

Mr Mills: I know that Doctor Kelly met with Doctor Malik after the, at a later stage, particularly in the light of the allegations that Doctor Asghar was conveying and I know that took place, but I'm not aware of anything specific in terms of the review at the time of the review. Again he would have been a doctor from whom a statement would have been requested.

D/Sgt Cross: And would you expect Mr Mills in this process that Doctor O'Donohoe would be interviewed?

Mr Mills: I would have expected Doctor O'Donohoe to provide a statement and to be interviewed.

D/Sgt Cross: Right. And do you know did he as part of the review, I know I'm springing that on you with the detail?

Mr Mills: I don't know.

D/Sgt Cross: ...I'm not sure if he did, but that would be a matter of record anyway, so that can be clarified. You see it does appear to me that the review focused to a large degree on the nurses, there seems to have been no reluctance to interview nurses... but I'm not aware really there was a full interview of O'Donohoe... Doctor Kelly is saying that he interviewed Malik in November of that year, because he had felt Malik hadn't been interviewed as part of the review and perhaps ought to have been so he wanted to... pursue that and make sure, although you're right in saying that Doctor Asghar had raised other issues anyway that brought Malik into the picture. Do you recall any discussions in relation to what we will do with O'Donohoe and Malik in this review will we or will we not interview them?

Mr Mills: No. There is a list of the appendices here so, there's Doctor Malik's report... and Doctor Auterson.

D/Sgt Cross: ...Yes. If I were in a situation in where I fired a baton round and somebody is injured... that will be reviewed. There will be an investigation and... I will be asked for [a statement], if I refuse, which I can do, I would be ordered to write a report, which I can't refuse, but then somebody will come down and sit me down and I'll be interviewed, because there are always questions that are relevant for me and I feel were relevant to be asked to O'Donohoe and relevant to be asked of Malik, that they may not volunteer in reports and it would appear to be that this was not a full-blooded attempt to get to the facts when O'Donohoe wasn't interviewed.

Mr Mills: Well my view at the time was that it certainly seemed to be a comprehensive report...t wasn't something that was sort of done in a matter of a few days, they had taken a lot of evidence from the various people that were involved in terms of their statements, they as I said obtained an external opinion in relation to Doctor Quinn...it involved looking at the post-mortem reports...the work load on the ward and other issues, so it seems to me to be fairly comprehensive in terms of the review...Now it may not stand up or compare in relation to your type of reports in relation to the police service, but in terms of a health service type of report of this nature at this time, I would have thought it would have stood up fairly well.

D/Sgt Cross: ...Doctor Asghar submitted his letter before this report was finished?

Mr Mills: He did.

D/Sgt Cross: And would it in your opinion have been relevant to have interviewed Asghar?

Mr Mills: He wasn't directly involved in the care of Lucy Crawford and I think in terms of sticking to the facts the staff who were directly involved in the care of Lucy at the time would have been the main focus.

D/Sgt Cross: You see it appears looking at it as an outsider it appears to me the main difficulty for this review for the Trust and where allegations of cover ups will, I think will always emanate, a child dies and a review is conducted here and there is no Inquest, so you don't, we don't get a verdict from an Inquest...But the Trust conducts a review that doesn't produce an answer really...Murray Quinn is inconclusive and I think the Royal College is inconclusive...but Asghar appears to be conclusive, who didn't see what happened but he just read the notes so he's in the same situation as Murray Quinn, he's in the same situation as Moira Stewart and Doctor

D/Sgt Cross: Boon or whatever, looking at the notes, but Asghar says it was the fluid that killed her, and it was the fluid that killed her and therefore... it appears to be the case... that an answer was obtainable if somebody had looked for it... Asghar could see it, the Inquest could see it, Sumner could see it, Evans could see it, Jenkins could see it to a limited view... Does that not suggest that this review wasn't thorough, it didn't get to the answer, not because her death is inexplicable... there is an explanation but it didn't find it and it didn't find it because it wasn't thorough.

Mr Mills: Asghar never identified hyponatraemia.

D/Sgt Cross: No I accept that.

Mr Mills: In relation to his representations of the case and indeed he was identifying Lucy's case along with a number of other cases so it wasn't specifically Lucy's case he was identifying. And Doctor Asghar would have been raising issues on, apart from the professional competence... he would have been raising issues about his treatment.

D/Sgt Cross: Yes I'm aware of that, bullying etc.

Mr Mills: Harassment, bullying and in essence any opinion that doctor Asghar would have conveyed may well have been influenced by potentially how he was being treated, however we had got, in the process we hadn't got it at that time, but we were in the process of obtaining an external opinion which wouldn't be contaminated from a more senior person in the sense that Doctor Quinn's opinion, which was provided on the 21st of June, Asghar would have come in and conveyed his views on the 5th of June.

D/Sgt Cross: Yes.

Mr Mills: So that's superseded it and you could see the review would obviously have taken much more recognizance of Doctor Quinn's opinion than they would necessarily in relation to Doctor Asghar, but Doctor Asghar, you are quite right, Doctor Asghar wasn't asked for a statement, but Mr Fee would have been aware of Doctor Asghar's letter, because Doctor Asghar went and met with Mr Fee at the same time he came and saw me. I mean Doctor Asghar, contrary to the Insight Programme, Doctor Asghar actually came and provided the letter by hand.

D/Sgt Cross: Yes that's what he told us.

Mr Mills: And asked to speak to me and as opposed to putting it in the post.

D/Sgt Cross: Yes that's what he did tell us.

Mr Mills And we would have treated Doctor Ashgar's letter as significant in terms of the issues that he was raising in terms of Doctor O'Donohoe and immediately would have taken steps to establish under our Harassment Policy and investigation where we would set up a team and also that's where we commissioned the Royal College of Paediatricians to look at the issues of professional competence. So in actual essence we were identifying as a Trust that we were going to get a further opinion beyond Doctor Quinn's opinion before we even had got Doctor Quinn's opinion. In other words we were identifying on the 8th of June my letter to Asghar basically says we are going to review these issues of clinical competence to the Royal College of Paediatricians. Now we had got a verbal report from Doctor Quinn at that stage, but we didn't get his final report until the 22nd of June, so again it demonstrates our preparedness and willingness to be open and investigate issues that were provided to us.

D/Sgt Cross: It certainly demonstrates your... intention to get a review of the notes... with Doctor Quinn and I accept that he at that stage may properly be considered an independent expert...Where I'm still not happy with how that proceeded, Mr Mills, is rightly or wrongly Doctor Quinn didn't produce an answer for you. You need a review that explains, clarifies why the child died and... prevent... recurrences. Now he didn't do that, because he's not sure why the child died. Now he tells us and it's in the records, ... he says that he didn't really want to be involved...I'll not be involved in litigation; I am not doing a full medical report. He also says he didn't even want to put his findings in writing, but he was persuaded to do that and his account of the rather startling comment, you will recall on Insight, that he was sweet-talked into... providing a written report when he didn't want to...I accept that it's appropriate to try to leverage him into producing a written report, but he says that he is quite clear that he is not going to interview any of the staff involved, he would do no interviews. Very importantly he said he was not going to interview the parents and he highlighted the mother as a very relevant witness, particularly because she was the woman... who would give evidence that would demonstrate whether this was a febrile convulsion or coning, and to him that was vital... now he says all that needed to be asked was for that woman to describe what her child did and he would know if it was coning, he would know if it was a febrile convulsion - so would anybody else, but he says he's not going there, because he doesn't want to get involved. And he advised the Trust to go and get themselves somebody else to do this and I suppose gather further information that would give them a better chance of identifying why the child died. And the Trust didn't do that. Now do you know why not?

Mr Mills: Well my involvement with Doctor Quinn was to request, make the initial approach to request his participation and I did that at the time and he didn't raise an issue with me in terms of how he would do it or what way he would do it, subsequent to that then Mr Fee then put in writing the letter that basically identified the terms of reference. Now Doctor Quinn wouldn't have spoken to me after that and wouldn't have said to me at the time that he wasn't doing it as it were in relation to a complaint or litigation, so I have no direct knowledge of what Doctor Quinn claims he told the Trust. I did speak to Doctor Quinn after the Insight Programme because I was significantly concerned about the claim he was making and I want to find the background to that and what he told you confirms what he told me, in other words he basically said he was persuaded obviously by Doctor Kelly and Mr Fee to provide a written report. Now he obviously makes a protest in that respect. Having said that, the meeting... took place on the 21st of June, the report was written on the 22nd of June, so I don't see much reluctance there in relation to providing the written report.

D/Sgt Cross: Right Mr Mills do you recall...any of your colleagues then telling you that Murray Quinn's advice to them was to go and get somebody else who will interview O'Donohoe, who will interview the mother and the nurses? For instance Murray Quinn is not happy...the fluid notes were not properly written up on the night and Murray Quinn is not sure actually how much fluid was given and his advice was somebody needs to go and talk to the nurses and have them clarify this fluid chart to see actually what was given and since fluid is in the ball park here, and he's saying I'm not sure how much she got, I think it was then incumbent on somebody to go and attempt to actually clarify exactly how much from what time to what time and of which fluid was given to Lucy? But...that wasn't done...I'm fairly certain it's not. Did anybody raise those issues with you?

Mr Mills: No I've no recollection of that.

D/Sgt Cross: Do you recall a decision being taken that you've got Doctor Quinn's report, that's sufficient we are not going for anyone further other than the Royal College? ...

Mr Mills: No. I want to come back to a point you made earlier about there not being an Inquest. It certainly would have been the view of the Trust that there was going to be an Inquest. In fact, I never remember anybody telling me that there wasn't going to be an Inquest. In relation to that now I went back and enquired when did we know there wasn't going to be an Inquest and it wasn't until October 2001 that our legal people were advised that there were no plans for an Inquest and so prior to that we were always viewing the fact that this had been reported to the Coroner and the coroner would be having an Inquest. We would have always acknowledged that, but by the sequence of the events they tended to overlap. In other words we hadn't got the first review completed whenever the Royal College of Paediatricians, the response then in terms of the complaint hadn't been completed in terms of the review, the first review of the Royal College of Paediatricians and then we were into litigation and then we were into the Inquest so there was a sequence of events that tended to overlap one on the other...

D/Sgt Cross: Can I put it to you...that there was a mistake by 1, 2 or 3 individuals on the night in question that led to Lucy's decline and sudden death. Now the only people responsible for that are the staff who made those decisions, I accept that and that's being investigated separately, but the response to that, that perhaps should have led to a criminal investigation, it certainly should have led to an Inquest, but neither of those things happened and neither of those things happened because the information...as to actually what happened didn't come to the Coroner and didn't come to the Police and the reason that it didn't get to either of those two places was that the Trust's actions frustrated it. The review did not produce an easily obtained answer that Doctor O'Donohoe/Malik/Staff Nurse Breige Swift gave far too much of the wrong fluid because one

D/Sgt Cross: didn't know what the other had said and the nurse wasn't, she says the doctor said this, the doctor said no I didn't, nobody wrote it down and the doctor has no idea what she has given, so the child dies as a result. The review didn't actually say that anywhere and if it had...recorded that it would have been clearly a matter for the Coroner and therefore it would have come to the Police. I would ask you to respond to that?

Mr Mills: Well I mean the review did look at the fluid and they got the report from Doctor Quinn and Doctor Quinn it actually states in writing in his report that the fluids were not excessive. I mean it would appear to be difficult for us to have, the Trust to have identified anything contrary to that.

D/Sgt Cross: You see the response to that would have to be that Doctor Quinn has either made a mistake, a genuine mistake, or is being misleading because to other doctors they are very excessive and even to Doctor O'Donohoe they are excessive, because he says my prescription there was a third of what she was given, broadly speaking. So he thought that what she was given was excessive and therefore Quinn is covering up for O'Donohoe.

Mr Mills: Well I'm not medically qualified as I say.

D/Sgt Cross: Nor am I.

Mr Mills: In terms of that, I wouldn't have been in a position to question Doctor Quinn's medical opinion in terms of the report. Now subsequently other Doctors have. The first person that we had that looked at Doctor Quinn's report after we had used it and after it was in fact another Paediatrician who is basically appointed by the Royal College of Paediatricians, that's Doctor Moira Stewart and her report would have again been inconclusive in the sense of identifying a number of reasons why Lucy may have died, but agreeing with Doctor Quinn. So the information that the Trust was receiving at that time was all pointing to the fact that fluids may not have been an issue and that was the professional opinion that the Trust was receiving from the initially the external Paediatrician that we had appointed and then the Paediatrician that the Royal College of Paediatricians had appointed.

Mr Mills:

D/Sgt Cross: ...Were there any steps taken by the Trust...to actually address failures...such as documentation and...regional issues in communication with the Royal etc.

Mr Mills: Yes, The recommendations...had been taken forward by Mr Fee and Doctor Anderson...and would have involved Doctor Kelly. I think I would place on record that it has been regrettable that the meeting...with the family was not held...Subsequently then we were informed that...the family were liaising with Stanley Millar, Chief Officer of the Health Council. That in fact give me some comfort because in essence I knew that Stanley had quite a considerable experience in relation Health Care Services, would know his way round the system and could advise the family in terms of progressing the complaint in terms of how to get information.

Tape Number and
Tape Times:

D/Sgt Cross: The difficulty there, Mr Mills, is of course the family are I suppose disappointed by their contact there because they are aware now that his wife is actually heavily involved in the Trust end of things, it was actually his wife who would be a colleague of Doctor Anderson's and I think put in the first clinical incident report so they feel now there is no independence there either. Stanley Millar is helping us with our complaint but his wife is actually helping the nurses write their depositions for the Inquest...I know Fermanagh is Fermanagh and everybody is related to everybody, that's a fact of life there, but you can see how they perceive that.

Mr Mills: I'm not sure about this information, but in addition to that I understand that there is a family relationship between the Crawfords and Mrs Millar as well.

D/Sgt Cross: Yes somebody's a cousin, she is a cousin of Mrs Crawford's mother or there is, you're right there is a family connection. I think none of them were aware of that until the Inquest actually...

Mr Mills: Having said that I would certainly view Mrs Millar as being acting in a professional capacity at all times. She wasn't involved in the review, she is the manager admittedly for the nurses...involved... Again I would say it's a matter of personal regret that the Crawford family did not feel that they could meet with me, despite the offers, which we made...

Mr Mills listed the letters he had sent to Lucy's family.

Mr Mills: ...They did meet with Doctor O'Donohoe. I gather that meeting wasn't satisfactory from the family's perspective, because Doctor O'Donohoe didn't have the answers.

D/Sgt Cross: And I think they then formulated the view that they were being asked in basically to be offered a cup of tea and given more time for platitudes. That's what they felt Doctor O'Donohoe had given them and they were upset that he hadn't the notes with him at the time

Mr Mills: No it wasn't very satisfactory.

D/Sgt Cross: Would you feel however if the Trust had nothing to hide in this Mr Mills, would it not have been you know worth considering that somebody went out and rapped the Crawford's door and said, I'm Mr Mills, I'm Eugene Fee, I'm Doctor Kelly, I'm sorry about your daughter, can I come in and we'll talk about it. Is that never considered by the Trust?

Mr Mills: No, I don't think that approach would be very professional either in the sense that you do, you would certainly in my opinion, certainly feel that you would want to make sure that the family would be prepared for something like that, in others words it wouldn't be something you would descend upon them and sort of say here we're here to arrive, it wouldn't be very professional and could actually cause other health problems in relation to that. I'm not sure we would have even considered that type of approach. It's an approach we use in many cases and basically in all the cases that I'm not aware of any other family refusing an invitation of that nature.

D/Sgt Cross: Right ok... So the procedure that you were using in relation to the Crawford's you are saying it had worked in virtually every other case.

D/Sgt Cross: Right. Could I ask to go back to one point that I wanted to clarify. Doctor O'Donohoe wasn't interviewed as part of the review, although he did submit a written document, would the potential for disciplinary proceedings have created any procedural difficulty in having an interview with him?

Mr Mills: No.

D/Sgt Cross: I think we'll just break there it's 1213 and we will terminate this tape.