POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark RH111

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

DHV 81/05

Master Tape Seal Number(s):

T115864A

PERSON INTERVIEWED: HUGH SPROULE MILLS

ADDRESS: STRATHDENE HOUSE, TYRONE/FERMANAGH HOSPITAL

DOB: [redacted]

PLACE OF INTERVIEW: ANTRIM PSNI

DATE OF INTERVIEW: 07/04/2005

TIME COMMENCED: 1234 HOURS

TIME TERMINATED: 1316 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN

2 D/CONSTABLE 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:

Interview commenced and introductions made.

D/Sgt Cross: ...It's my opinion as the investigator that Lucy died as a result of being given too much of the wrong fluid on the night in question and the people involved there are O'Donohoe, and Malik and Breige Swift. It's also my opinion that the review that was conducted by the Trust was insufficient bearing in mind the seriousness of the incident and it's my opinion that certainly they should have been an inquest...In relation to those issues have you any opinions in addition to what you've already given that you want to express?

Mr Mills: It certainly was a serious adverse incident, which resulted in the death of a young child. Now there were immediate concerns that the actions that were taken by staff had potentially caused harm to the child and as circumstances were followed up and the investigation as it took place, this became perhaps less obvious and less clear cut, but the information that was compiled in the review I mean I would argue would have been thorough in terms of its content for a review of that nature at the time. And then there was further information from the review and indeed subsequently obtained by Doctor Kelly which presented other aspects and conveyed reasons to ease our concern as we progressed. You asked me earlier in relation to whether we considered if Doctor O'Donohoe was going to be subject to disciplinary processes.

D/Sgt Cross: Yes.

Mr Mills: I would be happy enough to convey the actions that I would have been directly involved in at that time and would refer you to the diary note that I made on the 20th of April a week after the incident where I enquired from Mr Fee if Doctor Anderson and he had considered if Doctor O'Donohoe should continue to see and treat patients. He confirmed that it was there opinion that he should continue. Now I'm not saying that that would have led to disciplinary action, but for example, Mr Fee and Doctor Anderson said no he should be advised not to see patients then we would have been involved in a different set of circumstances which could have involved discussion about sick leave or if he refused to go absent then disciplinary matters. That was a direct question that I was asking at that time and subsequent to that not included there was a further page of my diary note, which is not type written but it's not included in the papers that you sent me. There is a handwritten page, which is this page here, I suppose to some extent this is how my notes, this is how the diary notes are compiled, they are compiled from these sort of notes and this is dated 15th of June.

D/Sgt Cross: We may have that Mr Mills, I'm not sure and if we have you see I may not have identified it as being associated to this document as just being the next page in the ... right if you want to read that to us?

Mr Mills: The 15th of June, this is a meeting or conversation I would have had with Doctor Kelly.

D/Sgt Cross: Is that in the year 2000?

Mr Mills: 2000 yes, he had given me feedback as a result of his enquiries for example that's an enquiry he was making in relation to [redacted] the ENT consultant, [redacted] who is the consultant for Child and Adolescent Psychiatry who were identifying no problems with Doctor O'Donohoe. So we are now checking out with other... Consultant colleagues' position regarding Doctor O'Donohoe. There is, I accept it didn't fulfil, the prescription in relation to that sort of thing... Then this third point he was advising me about the case, the case of competency is building, in other words whilst we had those doubts initially as time progressed there was this case of competency in relation to Doctor O'Donohoe which was building. It got the verbal feedback at that stage from Murray Quinn and we were planning to meet him on the 21st of June. Interestingly enough there is this comment, which is attributed to a source in Belfast, which again Doctor Kelly would have given to me where Belfast were saying fluid near miss, but not direct cause. Now whether that was out of the post-mortem report or some other view from Belfast but that was a note that I took in terms of what Doctor Kelly had given to me.

D/Sgt Cross: So your note is saying that Doctor Kelly is reporting that he has heard from Belfast that this was a near miss with fluids, but fluids were not the direct cause.

Mr Mills: Yes.

D/Sgt Cross: Doctor Kelly didn't ...

Mr Mills: He mightn't recall saying that to me.

D/Sgt Cross: And again you see, I believe I have read this, but there is nothing on that to make me think that is a relevant question for Doctor Kelly, would that be fair to say?

Mr Mills: It doesn't relate to the fact that it is a conversation with Doctor Kelly.

D/Sgt Cross: No.

Mr Mills: Then there is obviously a conversation with Doctor Kelly which is in and around disciplinary, sort of saying we need to identify major reason for bringing, presumably a case, the fact that we had already engaged the Regional Advisor, Doctor H is Doctor Halahakoon, who is Doctor O'Donohoe's colleague. She wasn't identifying issues of professional competency. And then we discussed possible health problems, if it's not a competency issue is there a health issue in relation to Doctor O'Donohoe and there is even a note here from myself that if he was absent on suspension and then go sick, it could be a major delay in actually concluding our investigations in our report and at that stage Doctor Kelly was discussing it with Bill McConnell so he was taking advice from Bill McConnell in relation to the issue and he agreed to ring the GMC Help line.

D/Sgt Cross: Doctor Kelly did?

Mr Mills: Yes. He would anonymously discuss the circumstances with the GMC in terms of their help line to get advice from them.

D/Sgt Cross: Are you aware Mr Mills that he actually did that?

Mr Mills: Yes.

D/Sgt Cross: He did. Right. Ok.

Mr Mills: Now the other occasion that I was involved in actually asking the direct question was whenever the second report was received from the Royal College of Paediatricians and Doctor Boon and Doctor Stewart were giving us, presenting the report to Doctor Kelly and myself, both Doctor Kelly and myself asked them the direct question is Doctor O'Donohoe competent, should he be suspended and they said, No. So disciplinary was there in the back of my mind even from the start, but at no stage did we from the advice we were given, because in essence if there was disciplinary hearing or suspension it was going to be Doctor Kelly who was going to be presenting the case and he had to have the evidence from others in order to do that. So those are the examples that I can point to you and I'm aware of that would identify that we did consider it at the time, but we didn't go down that route.

A document that Mr Mills had been referring to was taken by Police and marked RH39.

D/Sgt Cross: ...You're saying now on the basis of this diary note, which is WRC10, at the bottom of the first page, it says I enquired if Doctor Anderson and Mr Fee had considered if Doctor O'Donohoe should continue to treat and see patients, I mean is that tantamount to saying should Doctor O'Donohoe be suspended, have you considered this, is that another way of asking that question?

Mr Mills: It is, although in essence there might be a health issue, so it might not be a suspension.

D/Sgt Cross: Fair enough.

Mr Mills: In essence there is a process that you would go down the road, if they said, no he shouldn't see patients, then there is a process that we would have to consider, which would take you to either down a health route or down a disciplinary route.

D/Sgt Cross: ...The Coroner was not informed of the concerns, is there anything you want to say further on the relationship between the doctors at the Trust, the Royal and the Coroner?

Mr Mills: ... The actual death took place in Belfast and the Coroner for the Belfast area is obviously the Belfast Coroner John Leckey... In essence because the death didn't occur in our area, obviously it wouldn't have been part of our jurisdiction, so my view is that it was quite rightly reported by the Belfast staff to the Belfast Coroner. They contacted the Coroner's Office and reported the death to the Belfast Coroner, so that seemed to me to be appropriate.

D/Sgt Cross: And I think you mentioned early was it in 2001 that your legal people heard there wasn't going to be an Inquest?

Mr Mills: So the scrutiny committee (considers litigation issues) were checking on the 25th of June 2001... when the Inquest would be. It was still our assumption in June 2001 that there was going to be an Inquest. And the information came back through that mechanism in that the CSA advised us on the 12th of October 2001 that there was no Inquest... and as I say I can't actually recall anybody ever telling me there wasn't going to be an Inquest, I always assumed there was going to be an Inquest.

D/Sgt Cross: If I could just ask you on your diary note, I think at the very first point, Doctor Kelly, says that Doctor O'Donohoe had been asked to obtain a copy of the patient's notes. Now I've asked Doctor Kelly about that, do you recall why Doctor Kelly suggested that to Doctor O'Donohoe?

Mr Mills: I don't recall why at the time, but Doctor Kelly would always have identified and conveyed to staff the importance of any notes going out of the Trust to make sure you keep a copy, because we've had situations in the past where basically we don't get them back, we don't get the notes back again or it takes a long time to get them back again. So I don't remember him saying that to me at the time or why but he would have been, it would be something he was reinforcing, emphasising on a number of occasions.

D/Sgt Cross: Doctor Kelly... expected the notes would go to the Coroner and he therefore expected you would be losing them? ...Do you recall him mentioning that the Coroner will be taking notes?

Mr Mills: No. It wouldn't have been a specific recollection I would have.

D/Sgt Cross: Right. Well you see the law seems to indicate that there is a very wide responsibility on everybody involved in health care to keep the Coroner informed and that that responsibility isn't time limited either, it goes on forever and a day apparently. But am I right in assuming that it's your position that all liaison with the Coroner was the responsibility of Belfast?

Mr Mills: Certainly yeah, in essence in advising the Coroner of the deaths and the circumstances of the deaths would be the location where the death occurred and that would be done to the Coroner who has jurisdiction for that area.

D/Sgt Cross: And you've experience obviously for 31 years in the Health Service and I take it that 15/20 of those are going to be at a reasonably senior level. Do you recall situations where the Trust in which you were working reported matters to a Coroner when another Trust actually hadn't? In other words you see a defect in what another Trust has done.

Mr Mills: No I don't recall any situations. The only time that I would have been involved in discussions with John Leckey is the Belfast Coroner was actually when Angela Colhoun asked him to be involved in the Inquest in terms of the Omagh deaths.

D/Sgt Cross: That's the Omagh bomb?

Mr Mills: In terms of the Omagh bomb... This issue you have identified... about... facts were concealed is obviously a matter of some concern to us and to me in particular. It's an allegation that was obviously conveyed in the Insight Programme and I suppose in that respect I would want to refute that and say there was no cover up... There were quite a number of people that were involved and organisations that were notified and participated in terms of what we were doing. You just listed them, apart from anything else there is the nursing and medical staff at the Erne Hospital itself who were involved, there is the staff at the Royal Belfast Hospital for Sick Children and the Paediatrician who was specifically involved in the death and then obviously the Pathologist as well who would have carried out the post-mortem, the Coroner's Office, was notified at the time, there was the internal review carried out by Mr Fee and Doctor Anderson, the external review which is as I said at the outset was conducted by a Doctor from another Trust which was relatively unusual at that time in the absence of a complaint or litigation. We also reported the incident and the issues to a number of senior officers in the Western Health and Social Services Board. Reports were requested from the Royal College of Paediatrics and there was two of those and I suppose in essence again come back to the issue of cover up, ask serious questions of the integrity of not only myself but other senior directors in terms of Mr Fee and Doctor Kelly and to think I suppose all three of us would be compromising ourselves would be quite unacceptable from my perspective so I just felt that I want to

convey that opinion. (In this answer Mr Mills read from a list of 8 points.)

D/Sgt Cross: Yes. Doctor Quinn's report, Mr Mills, are you aware that when that became available was it discussed with any Doctor at the Royal or at Pathology?

Mr Mills: Other than Doctor Moira Stewart?

D/Sgt Cross: Yes.

Mr Mills: That would be the only one that I would know. I can't be certain about this, but I think that Doctor Kelly would have shared it with Doctor McConnell in the Western Board, but I can't be certain about that.

D/Sgt Cross: But as far as the Paediatricians and the Pathologists in the Royal at the time you don't recall any discussion of it?

Mr Mills: No.

D/Sgt Cross: Doctor Quinn, or the review says that he can't be satisfied of absolute explanation on the basis of the post-mortem and Doctor Quinn's review and yet all the experts at the Inquest were satisfied of what we may call an absolute explanation, [if] such a thing is possible. I mean why again was it not pursued until you had an absolute explanation?

Mr Mills: ... Again I go back to the fact that there was a sort roll over of sequences. ...I wouldn't have considered it that it would have been left hanging... Before we had Doctor Quinn's report we were already commissioning another report from the Royal College of Paediatrics, and then we were always anticipating that the Coroner's work would obviously be done... It would never have been an issue I would have felt was concluded and we would have said, right there is no explanation for this therefore you close the file, cause in essence it was always, there was always a roll over in terms of how the issues were progressing, it wasn't as if it was as clear cut as saying that's it you know. And then when you sort of got the first Royal College report

then there was the second Royal College report and I suppose by that stage we were already aware of the second death in Derry, I'm sure Doctor Quinn has explained that to you.

D/Sgt Cross: Yes. The next point is largely answered, it relates to what procedures then existed to investigate an issue like this and you've explained that this is before clinical governance come in and, could I ask you before clinical governance if a patient died unexpectedly was there any sort of informal perhaps, but expected response by the Trust to an adverse incident?

Mr Mills: ...It is interesting to note for example, that there are procedures in relation to mental health or childcare but there wasn't actually a procedure in Northern Ireland in relation to adverse incidents in terms of the Acute Services. It's only last year that the Department published that so in the Autumn of 2004 we have only now got that procedure and it is still very much up to the individual Trusts as to how they progress for example an investigation or an independent review or an assessment we, in terms of identifying whether you go to Doctor Quinn or not, I mean that is still very much a matter for Trusts. Nobody has said to the Trusts you can't go to the hospital next to you or who you should go to. No guidance has been issued in relation to that yet.

D/Sgt Cross: ...There is a line in [the Review –WRC3] that says there was the unexpected outcome of Lucy's condition...I would say that's a fairly significant spin...what happened to Lucy was not the outcome of her condition, it was the outcome of her treatment. It was what the doctors and the nurses did that led to the unexpected outcome, is that why it was worded like that to try to deflect from the fact of a failing within the ward and say it was her condition that led to this?

Mr Mills: I mean I didn't word it, I think the evidence that they had at the time wouldn't have been actually been conclusive in relation to whether it was her condition or whether it was the treatment.

D/Sgt Cross: Well do you recall a discussion about what words to use and a decision to?

Mr Mills: Absolutely not, I wouldn't have been involved in writing the report and I was not involved in any discussion about the use of words there.

D/Sgt Cross: Do you recall, Mr Mills, being informed prior to the report that the nurses had a clear view of fluid treatment which was different to Doctor O'Donohoe's.

Mr Mills: Yes, I was informed of that at the outset.

D/Sgt Cross: Do you recall being informed that the nurses believed a 100 mls an hour of number 18 solution until urine is passed was a standard practice.

Mr Mills: Yes. I was aware of that opinion being expressed by the nurses.

D/Sgt Cross: Do you recall a discussion that the nurses' opinion wasn't shared by Doctor O'Donohoe and it was his recollection that he... had prescribed much less than that?

Mr mills: Yes, I would have been aware of that, yes.

D/Sgt Cross: And are you aware of what steps were taken to clarify then exactly what should have been given?

Mr Mills: ...Other than what through the review and the recommendations of the review in terms of one of the recommendations was that documentation should have been completed and the fluid balance charts should have been provided.

D/Sgt Cross: Are you aware if any steps were taken to confirm if the nurses were right in their opinion that this fluid prescription was standard practice?

Mr Mills: No. I don't know if, again that is the matter for the detail of the review and it is something Mr Fee and Doctor Anderson would have been progressing, I don't have a specific recollection if they took any steps on that particular issue.

Tape Number and
Tape Times:

D/Sgt Cross: I'm still, I suppose, uncertain as to actually what went on in the ward generally, because some of the nurses, I think two, are saying yes that type of prescription did happen. I have not interviewed Doctor O'Donohoe but I will expect I know his answer, but Doctor Asghar who undoubtedly has an axe to grind against Doctor O'Donohoe in some respect, he is quite adamant that there was no standard practice, that Doctor O'Donohoe never just automatically said that for every child do this, that he did work out a prescription to meet the needs of the individual child, which you see is very much in O'Donohoe's favour from an enemy of O'Donohoe if I use that word, and yet the nurses are saying, two of them anyway, are telling us the exact opposite. You don't have anything to contribute to that?

Mr Mills: I have no contribution to that.

D/Sgt Cross: ...Was there training given to nurses and to doctors to tell the doctors you must write your prescription into the nurses you must be careful to record the fluid accurately on the chart?

Mr Mills: The new guidelines that were issued as I said on hyponatraemia were obviously developed regionally and we would have introduced the guidelines...there would have been training provided associated with the introduction of those guidelines, but in terms of the detail ...it probably would have been dealt with by Mr Fee's staff as opposed to involving myself.

D/Sgt Cross: It's 1316 we will take a break.