

Trevor Birney

From: Marie Dunne - Commun. Mgr [REDACTED]
Sent: 27 September 2004 15:33
To: Trevor Birney
Subject: RE: Raychel Ferguson

Attachments: Raychel Ferguson - Dr. Nesbitt's statement - Sept 04.doc



Raychel Ferguson -
Dr. Nesbitt...

Trevor - Find attached Dr. Nesbitt's response to the queries in your email below. Apologies for the delay but as you know I was on leave until 20th September.

Marie

-----Original Message-----

From: Trevor Birney [REDACTED]
Date: 14 September 2004 10:19
To: Marie Dunne - Commun. Mgr
Subject: RE: Raychel Ferguson

Marie,

As you know, we're still working on a programme examining the deaths of Lucy Crawford and Raychel Ferguson.

In terms of the death of Raychel, in a meeting I had with Geoff Nesbitt last year he spoke of his concern at the RVHSC not disseminating information relating to the death of Adam Strain in 1996.

Can you ask Geoff when exactly did he find out about the death of Adam?

When did he first speak to the CMO about his concerns?

When did Geoff discover that another healthy child, Lucy Crawford, had died at the Erne Hospital 14-months previous to the death of Raychel?

How many deaths did the Working Group, set up by the CMO, examine?

Best wishes,
Trevor.

Trevor Birney
Editor, Current Affairs
Ulster Television

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-----Original Message-----

From: Marie Dunne - Commun. Mgr [mailto:[REDACTED]]
Sent: 15 June 2004 12:12
To: Trevor Birney (E-mail)
Subject: Altnagelvin statement

Hi Trevor - Statement as promised.

Regards.

Marie

<<Raychel - Insight 3 - June 04.doc>>

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**Response from Dr. G. Nesbitt, Medical Director, Altnagelvin HSS Trust to
email from Trevor Birney dated 14th September 2004**

27th September 2004

The meeting to which Trevor Birney refers was, as agreed by him, off the record.

I am not aware of the death of a child named Adam Strain. I spoke to colleagues in the Royal Belfast Hospital for Sick Children after Raychel Ferguson's death in relation to their use of No. 18 solution. I was informed that there had been a death in the Children's Hospital in 1997. I contacted the CMO on 1st May 2002 seeking clarification as to any guidelines that may have been issued following that death.

My recollection of the first time I heard of Lucy Crawford, although I do not think her name was mentioned then, was when Trevor Birney referred to a death in Sperrin Lakeland Trust at our off the record meeting.

The CMO's working group was established to prepare guidance on the prevention of hyponatraemia and not to consider the case of any specific child or children.

ENDS