Young, Christine

From: Carson, Ian
Sent: 26 October 2004 19:14
To: Hamilton, Andrew
Cc: Sullivan, Dean; Neagle, Heather; McCann, Noel; Bill, Jonathan; Campbell, Dr Henrietta; Gowdy, Clive
Subject: FW: [redacted] Coroner/
Importance: High

Andrew,
Please find attached comment from the RHT concerning the Lucy Crawford case.
In light of recent events and other comments below, I would like to discuss how we take forward the development of guidance concerning investigation of serious incidents in the HPSS as a matter of urgency.
Yours, Ian.

-----Original Message-----
From: Michael McBride [mailto:Michael.McBride[redacted]
Sent: 21 October 2004 09:38
To: Ian Carson Work
Cc: henrietta campbell
Subject: FW: [redacted] Coroner/

Ian,

[redacted]

Can I also alert you to to Ulster Television programme this evening on the Sperrin & Lakeland Case. I've attached a copy of our latest correspondence with Ulster Television. The "investigative" reporting of this has been unprecedented, Donncha Hanrahan has been extremely distressed by this, he has been "door stepped" and at one time moved his young children out of the family home. I am concerned for his well-being and will be meeting with him at 11.00 am this morning. CMO is aware of the programme and like us has refused to give an interview to Trevor McBurney. It is our understanding that it will be alleged that Donncha attempted to cover up the cause of death despite the fact that he reported the case to the Coroner's office. You will be aware that the Coroner's office determined that this was not appropriate for a coroner's post-mortem and D[redacted]s O'Hara then carried out a post-mortem examination at Dr Hanrahans request.

In relation to the ongoing inquest and my email of the, I remain increasingly concerned regarding the for a number of reasons although I would not expect to respond at this time;

- continued used and reference to the RCA process which I regard as inappropriate. This is a process that seeks to determine preventability, statements are not taken under oath, there is no cross-examination and the process itself cannot withstand the rigours of a legal benchmark. The organisational and regional consequences in my mind may be far ranging, despite your and our own subsequent meeting with HRM coroner, PSNI on the 28th April to and our subsequent development of our internal RCA process which we shared and consulted fully with HRM Coroner and the PSNI to avoid such difficulties.
- the aggressive cross-examination of witnesses
- changes in the agreed standards of media reporting of coroner's cases
- the demoralising and demotivating effect that this is having on staff involved which concerns me greatly

I advise you that at the conclusion of this case I will be formally writing to CMO and yourself and request that William writes to Clive, advising him that we feel that in advance of the recommendation of the NI Review of the Coroner's Service that interim agreed guidance between DHSSPS -on behalf of Trusts, PSNI, HSE, and

the Coroner's office is urgently required. Whilst fully aware of the context as I mentioned at our meeting on the 5th March, these changes in practice have occurred in the absence of a guiding framework and in the absence of a MOU which I feel is urgently required.

Ian, it is my assessment at service level that we risk loosing the "open and fair culture" we have been striving successfully to establish in this organisation and the ultimate casualty will be patient safety not just here within the Royal, but elswhere. This is surely not what any of us wish.

Yours respectfully

Michael

-----Original Message-----
From: Susan McCombe
Sent: 20 October 2004 12:06
To: Michael McBride
Cc: Patricia Donnelly; Bernie Owens; Dympna Curley
Subject: RE: [redacted] Coroner

Dear Dr McBride

(nmary of case attached. (Copy was sent to Ms Jo McGinley in PR yesterday for Dymphna, but I've sent another copy direct.)

Mrs Donnelly, Ms Owens, Ms Curley:-
If any additional information is needed, please do not hesitate to contact myself of Miss Amanda Lennon.
Susan

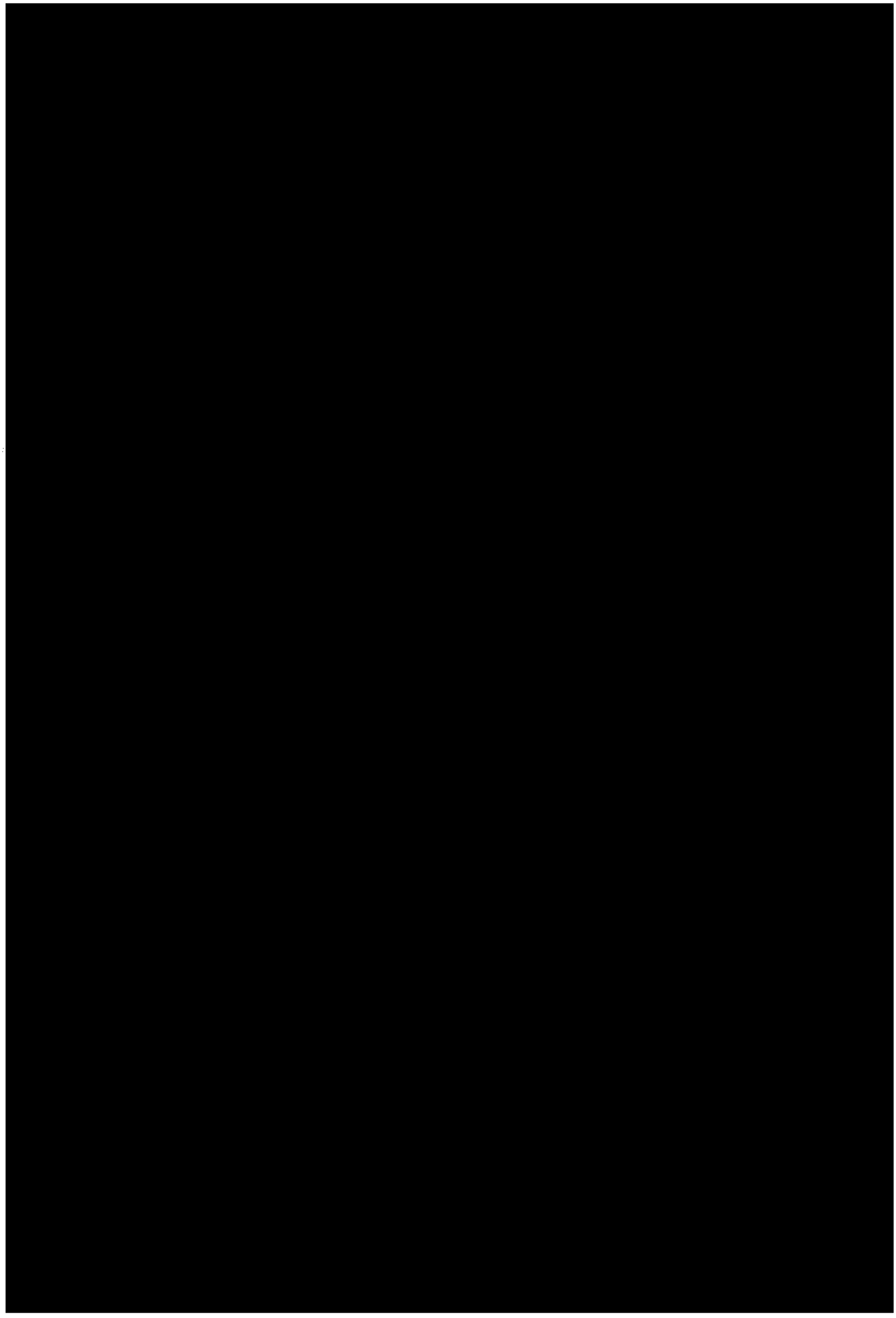
RVH ext [redacted]

-----Original Message-----
From: Michael McBride
Sent: Wednesday, October 20, 2004 11:34 AM
To: Susan McCombe
Cc: Bernie Owens; Dympna Curley
Subject: [redacted] Coroner

Susan,

Following discussions with Peter, would you please forward a briefing on the reopening of the [redacted] in the coroners court today to Patricia, Bernie and Dympna for information.

Michael



[redacted]

DHSSPS-C Gowdy

001-087-299

Young, Christine

From: Jo.McGinley [redacted]
Sent: 20 October 2004 16:15
To: Dympna Curley
Cc: Michael McBride; Peter Crean; Bob Taylor; Donncha Hanrahan; Heather Steen
Subject: FW: Ulster Television v Royal Hospitals
Importance: High
Sensitivity: Confidential

Please find attached the latest correspondence between the Trust and UTV. The programme is due to go out tomorrow night at 9.00pm. Please do not hesitate to contact me should you require any additional information.

Jo McGinley
Media and PR manager
Corporate Communication
Ground Floor, East Wing
The Royal Hospitals
Grosvenor Road
Belfast
BT12 6BA

Tel: [redacted]
Fax:
E-mail:

RGH/O/291/GB

20 October 2004

Ms Jo McGinley
Media & PR Manager
Corporate Communication
Ground Floor, East Wing
The Royal Hospitals
Grosvenor Road
BELFAST
BT12 6BA

BY E-MAIL & FIRST CLASS POST

Dear Ms McGinley

ULSTER TELEVISION PLC -v- ROYAL GROUP OF HOSPITALS

I refer to our previous telephone conversation.

Please find attached a copy of the letter sent to the Solicitors acting on behalf of Ulster Television PLC.

Should you wish to discuss this matter further, please do not hesitate to contact me.

Yours sincerely

Gary Daly
for Brangam Bagnall & Co
g.daly[redacted]

Enc

GD-TT-20-10-04

DHSSPS-C Gowdy

001-087-301

RGH/O/291/GB

JRR/IC/238

20 October 2004

Messrs Maclaine & Co
Solicitors
Lombard Chambers
13 Lombard Street
BELFAST
BT1 1RH
DX 411 NR BELFAST

BY FAX & DX

Dear Sirs

ULSTER TELEVISION PLC -v- ROYAL GROUP OF HOSPITALS

We acknowledge receipt of your letter of 12 October 2004.

Unfortunately, by the time Lucy arrived at the Royal Belfast Hospital for Sick Children, there was little that could have been done to help her. The staff at the RBHSC did their very best to treat Lucy at that time and subsequently assisted the Coroner by providing detail of the events leading up to her death.

There is no question of anyone in the Royal Hospitals having mislead the Coroner as to the cause of Lucy's death. The post-mortem examination was, in fact, carried out at the request of the doctors and with the consent of Lucy's parents.

The diagnoses that our doctors made did not contradict one another. Both of the doctors concerned were evaluating Lucy from different perspectives of her illness.

We require an unqualified retraction of the allegation that you have made and an undertaking that you will not publish it in the forthcoming programme or elsewhere. We can indicate that if you do not retract the allegation, the Trust reserves its right to take legal action against you and/or your Servant or Agent. In addition, the Trust's employees who gave evidence may also seek any remedy or redress which may be available.

Yours faithfully

Gary Daly
for Brangam Bagnall & Co
g.daly[redacted]

GD-TT-20-10-04

Young, Christine

From: Carson, Ian
Sent: 25 February 2004 14:59
To: Michael McBride
Cc: Neagle, Heather
Subject: RE: Letter HM Coroner re Hospital Deaths

Michael,
Further to our discussion at the fringe of the contract meeting with BMA, you will be aware that we have now confirmed the meeting with John Leckey and the PSNI for Friday 5th March at 3.00pm. The status of the MOU is still a draft document in England, I am happy that we touch on the key elements proposed, but I need to emphasise that everything within the context of HM Coroners Service relating to death and its certification/verification/investigation will be subject to discussion at the Interdepartmental Working Group that will be considering the recommendations of the Luce Review and the Shipman Inquiry.
The purpose of the meeting on the 5th will be principally to allow the Coroner to express his concerns (assuming that he has some) and also allowing Trust Medical to share theirs also, in the context of his draft proposal document.
Yours, Ian.

-----Original Message-----
From: Michael McBride [mailto:Michael.McBride[redacted]
Sent: 10 February 2004 19:29
To: ian carson
Cc: henrietta campbell
Subject: Letter HM Coroner re Hospital Deaths

Dear Ian,

Further to Mr Leckey's letter of the 30th January, I write to seek clarification of the Departments position and further advice.

Mr Leckey has suggested a significant change to current practice in relation to the investigation of Hospital deaths bringing our arrangements in line with those outlined in a "Health care joint agency memorandum of understanding for the investigation of serious untoward incidents" of which I have only seen a draft dated 16th June 2003. My understanding is that this is a memorandum to be agreed between the Dr Liam Donaldson, CMO England and John Broughton, assistant chief constable Essex.

While it is would be difficult to sustain a position in N.Ireland that differs from agreed best practice elsewhere, there obvious needs to be consultation with a variety of parties, communication, dissemination of information and training prior to moving to implementation.

While it may be an isolated incident, it has been brought to my attention that an SPR within the Trust has been advised this week to attend with legal representation a police station to provide a statement under caution in respect to a patient in [redacted] I am concerned that Mr Leckey's constructive and helpful suggestions of further initial dialogue may already been interpreted by other as implementation.

Issues that immediately arise professionally and organisationally are significant and include;

1. the impact of Route Cause Analysis within Trusts if notes are seized and statements taken under caution-as you realise this is a process we are working hard to implement at Trust level and there are real and significant opportunity costs here which need to be balance in the wider patient safety debate. Trusts may no longer be in a position to investigate internally such deaths prior to Coroners inquests and potential the issue of ongoing risk, systems and process failures may go unaddressed. This issue is addressed in the memorandum and clear accountability and responsibilities are outlined.

2. the position of other coroners in the province on this issue and might there be differing approaches

in some jurisdictions

3. I'm unclear if the BMA has been involved in any of discussions which I understand are still preliminary and I am certain they would wish to be consulted

4. there will obvious service implications

Mr Leckey has suggested a meeting. Does there need to be pre-meeting with yourself and a number of MDs or would a joint meeting with Mr Leckey and representatives of PSNI be best?

I'm confident we can work through this to whatever is agreed between the Department, PSNI, NIO and HM coroner. It is as always a question of balance and working through it together as Mr Leckey has suggested.

I await you thoughts and comments

Michael

02/11/2004

DHSSPS-C Gowdy

001-087-304