Bill, Jonathan

From: McCann, Noel
Sent: 03 June 2004 13:39
To: Bill, Jonathan
Subject: RE: Impartial reporter story 030604 - CMO interview w. Denzil McDaniel

Jonathan

These are fine. I would tweak as follows:

- I believe the action that Sperrin Lakeland are taking to look critically at the way this situatio was dealt with is very positive. We need to learn from events such as this.

- It is important that the Trust and its staff understand what happened in this tragic case; why it happened; what can be learnt; and what action can be taken to prevent similar events. The root cause analysis to be undertaken will identify areas for improvement and development.

- The steering group will include a senior representative of the Western Health and Social Services Board and will receive totally independent advice from the HPSS Clinical and Social Care Governance Support Team.

- The Support Team was recently established by my Department to lead the development and implementation of clinical and social care governance in the HPSS. It will work to sustain longer-term cultural change and organisational development so as to ensure continuous improvement in health and social care services.

- I will be taking a close interest in the outcome of the work and will want to be made aware of any lessons that can be learnt not only for the Sperrin Lakeland Trust but also any implications for the wider Health and Social Services in Northern Ireland.

I would leave it at that.

NOEL

-----Original Message-----
From: Bill, Jonathan
Sent: 03 June 2004 13:34
To: McCann, Noel
Subject: FW: Impartial reporter story 030604 - CMO interview w. Denzil McDaniel

Noel

Mentioned to you about the need for revised bullet points in response to the accusation that Sperrin Lakeland will be "investigating themselves". My suggested lines to take are as follows:

- I regard the announcement of this action [Sperrin Lakeland Trust undertaking an analysis of aspects of its handling of the Lucy Crawford case] as a positive one.

- It is important that the Trust and its staff understand what happened in this tragic case; why it happened; what can be learnt; and what action can be taken to prevent similar events. The root cause analysis to be undertaken will identify areas for improvement and development.

- I understand that the steering group is to include a representative of the Western Health and Social Services Board and will receive independent advice from the HPSS Clinical and Social Care Governance Support Team.

- The Support Team was recently established by my Department to lead the development and implementation of clinical and social care governance in the HPSS. It will work to sustain longer-term cultural change and organisational development so as to ensure continuous improvement in health and social care services.

- I will be taking a close interest in the outcome of the work and will wish to be made aware of any lessons that can be learnt not only for the Sperrin Lakeland Trust but also any implications for the wider Health and Social Services in Northern Ireland.

DHSSPS

Does it need a line about Trust staff feeling more comfortable about dealing with internal consideration of the events rather than the imposition of a neutral investigation?

What do you think?

Jonathan

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

From: Shannon, Colm
Sent: 03 June 2004 10:28
To: McCarthy, Miriam; Sullivan, Dean; Bill, Jonathan
Cc: Gowdy, Clive; Lindsay, Sharon; Mulhern, Kevin
Subject: FW: Impartial reporter story 030604 - CMO interview w. Denzil McDaniel

There are a number of additional points raised by this morning's Impartial Reporter article for which we would need answers ahead of the Minister's interview this afternoon:

How can the Trust investigate itself? -Jonathan can you provide a line on this? The involvement of Anne O'Brien and the WHSSSB should help to deal with this point.

The CMO has not allayed public health fears? This is a very sweeping statement and it is unfortunate that the paper chose to report a 45 minute interview in about 10lines. I think the existing Q&A can deal with this given the introduction of the new guidelines and the new reporting arrangements which are being developed. However, I think we need to have an answer for the statement that "the Royal didn't fully realise the implications of how Lucy died". I don't believe CMO said this. Miriam can you get an answer on this?

The quote that the CMO is wrong in her claim that the GMC will not look at how the investigation will be carried out. Miriam can you look at this.

Colm

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

From: Moore, Martin
Sent: 03 June 2004 09:28
To: Mulhern, Kevin; Shannon, Colm; Gardner, Jeremy; Lindsay, Sharon
Subject: Impartial reporter story 030604 - CMO interview w. Denzil McDaniel

Trust to review Lucy case, again

010-013A-046

The Sperrin Lakeland Trust says it has set up a steering group to review how it handled the case of Lucy Crawford, the 17-month-old baby who died as a result of mistakes at the Erne Hospital in April 2000. Immediately after Lucy's death, the Trust held an internal review which has largely been discredited as nothing more than a whitewash. As news of the latest review was released, the Impartial Reporter has learned that the General Medical Council has received a complaint alleging serious professional misconduct against the doctor in charge of Lucy's case, Dr. Jarleth O'Donaghue. The pressure is clearly on the Sperrin Lakeland Trust to come up with answers; but there must already be serious doubts about how they can be trusted to investigate themselves again - having failed so clearly to do so in 2000. And in a further twist, the Chief Medical Officer in Northern Ireland has confirmed that she was NOT informed about Lucy Crawford's death until 2003, the year AFTER she issued new guidelines on the dangers of hyponatraemia. Lucy, the 17-month-old daughter of Neville and Mae Crawford, died in April 2000 as a result of "fundamental errors" at the Erne Hospital. An inquest this year found that Lucy died from hyponatraemia, brought on by the hospital's disastrous management of her drip. Since the inquest revealed this in February, debate has raged not only about how this could have happened, but how Lucy's death was swept under the carpet in the Trust's investigation. The whole issue of accountability within the health service is under intense scrutiny. The chairman of the Trust, Mr Harry Mullan, this week confirmed plans to undertake an analysis of aspects of the Trust's handling of the Lucy Crawford case. Mr Mullan said "Immediately following the inquest into Lucy's death, we stated we would be reflecting on the Coroner's conclusions. In the course of this reflection on how we, as an organisation, handled this tragic case, we recognised some flaws and areas where improvement was needed." The Trust's move will be viewed as something of an admission that their original internal review failed to get at the truth, among other "flaws". The terms of reference for the steering group have not been worked out yet; but questions will remain. Inevitably, how can the Trust investigate itself this time? Setting out the draft terms of reference of the "root cause analysis", Mr Mullan emphasised the commitment of the Trust and its officers to reflect on how improvements could be made. "Our primary goal is to learn lessons and improve our practice. Additionally, where we identify process issues which have wider implications, we will want to inform the appropriate authorities," said Mr Mullan. Mrs Jenny Irvine, non-executive director for the Trust, will be chairing the steering group. She will be joined by Dr Diana Cody, the Trust's medical director and there will be representation on the group from the Western Health and Social Services Board. The first task for the steering group will be to agree the terms of reference for the work to be undertaken. The steering group will be supported by a representative of the NHS Modernisation Agency Clinical Governance Support Team. A specialist independent consultancy firm will manage the use of the "root cause analysis" approach, and develop a report to the steering group on findings and recommendations. The steering group may also commission external opinion and advice. It is anticipated that the exercise will take 4-6 months to complete, culminating in a report and recommendations from the steering group to the Trust's Clinical and Social Care Governance Committee for approval. The Chief Medical Officer, Dr. Henrietta Campbell, is responsible for ensuring lessons are learned for the benefit of the population here, but in an interview with the Impartial Reporter, Dr. Campbell fails to allay fears on that score. Among the points which emerge from Dr. Campbell's interview are: The Royal Victoria Hospital in Belfast didn't fully realise the implications of how Lucy died. New guidelines introduced in 2002 did not take into account the circumstances of her death. Dr. Campbell fails to withdraw her belief that there could have been something "idiosyncratic" about Lucy which led to her death; this despite expert evidence to the contrary given at the inquest. The CMO says it is "not her job" to investigate untoward deaths, and she has not "looked at" how the Sperrin Lakeland Trust investigated Lucy's death. She

believes the General Medical Council will consider the investigation. In fact, she is wrong; the GMC will only consider the allegations against individual doctors and NOT how the subsequent investigation was carried out. In fact, the GMC does not have the powers to look at systems employed by a hospital trust or the quality of its investigation into an incident. They hold doctors' registrations, as in order to practice in the UK doctors have to be on the register, and the GMC examines allegations of serious professional misconduct. The Impartial Reporter understands such a charge has been levelled against Dr. Jarlath O'Donaghue, rather than the quality of the investigation into the incident carried out by the Trust."

010-013A-048

DHSSPS