[redacted]

From: MacSherry Eavan on behalf of Mills Hugh
Sent: 28 May 2004 10:00
To: Fee Eugene; Cody Diana; Kelly Jim; O'Rawe Bridget
Cc: McPeake Phil; Kettyle Jenny; McGurk Marese
Subject: FW: CMO interview with Denzil McDaniel

TRANSCRIPT CMO.DOC

Please see attached/below for your information.

Kind regards

'an

-----Original Message-----
From: Mulhern, Kevin [redacted]
Sent: 27 May 2004 17:50
To: Mills Hugh
Subject: CMO interview with Denzil McDaniel

<<Transcript CMO.doc>>

Hugh

Sorry that this is very bitty but the tape quality was very poor. It should give you the gist of it though.

Regards

Kevin

Interview with CMO – Tuesday 25th May 2004

CMO

It sounds grand, but what it means is that I, am fortunate enough to be the boss of this small team of very expert and hard-working doctors in the civil service - doctors like Miriam here (Dr Miriam McCarthy), Miriam in central headquarters, providing advice, and doctors who are providing (unclear) medical referee services so I'm chief of those civil service staff, senior, principal, assistant, I am chief medical officer. It doesn't mean, contrary to what Fergal McKinney or anybody else thinks, it doesn't mean that I'm chief of doctors in the health service. I am not, there is a complete distinction between doctors in the civil service and all those doctors in the health service. I am not their chief, nor am I Northern Ireland's top doctor. (unclear). I am just here to give the best advice I can about public health, which is what I am, public health director, to the Minister on matters that will protect the public health, and more likely to help them about smallpox epidemic, or how we try to ensure, that people get MMR vaccination. I have a role within the health service, and that is about trying to promote standards and guidelines by which the service could be measured, but a very minimal role in trying to help those others whose role it is to be responsible for that and to make sure that people (unclear). So that's the context of my job and that should help you.

DMcD

About standards and guidelines, can we go through a few points in the article. Your mistake, the correction that was in on Saturday, perhaps you can clarify that? How did Lucy's case come to your attention, (unclear) in June 2001 and you corrected that to 2003. There was a note (unclear) that I took where you previously said you became aware of Lucy's death when Raychel died in 2001.

CMO

(Unclear)I didn't. It's not a mistake, it's not important in general issue about what we were trying to portray, but it is important where you're coming from

and I know that. It was sloppy in part in the article, it (unclear) was in brackets to check it and I didn't check it, and the brackets then got removed. I mean, it was inferred in the debate with UTV, but you're going to have to discount that, because in the setting that I was, I wasn't briefed in any dates, or anything about Lucy, but I can produce a letter that did alert me to Lucy's death and the issue about (unclear) and if, for any legal purposes, it is there. But Denzil, that was a mistake on my part. I don't know if you've ever made a mistake before, but it was a mistake.

DMcD: When you said in the UTV interview that (unclear)

CMO

But not at the time of Raychel's death. It was in putting those two together, when the coroner was referred about Lucy's death, it was when the two of those deaths were put together, and the coroner, and you know, it was referred (unclear). It was only when we put the two deaths together that it was realised that it was imperative about trying to get out good guidelines, to implement them and to monitor them (unclear) and, indeed to be fair to Altnagelvin Trust, it was they who rang me about Rachel's death almost immediately after and said that there is something here that we need to sort out as a region (?) and all credit goes to Altnagelvin for that because it meant that we could get moving on it quite quickly.

DMcD

(unclear) coroner (unclear) informed you that was the first time you hear of Lucy Crawford's death?

CMO

Yes that was the first I heard of Lucy's death.

DMcD

(unclear)

CMO

No they wouldn't have, Denzil, they wouldn't have informed me. There are, as we tried to explain, and as I tried to explain to Fergal McKinney after the interview, there are 15,000 deaths in NI every year, and most of those actually take place in hospital. Most people, whether they are old, very old, or young, actually die in hospitals, a huge percentage of people. So, (question to Dr McCarthy?) about how many of those deaths (unclear) About 3500 would be referred to the coroner – so the coroner has a full time in questioning and investigating some of those deaths. If even just the coroner's deaths were all reported to me for a further or different examination, I couldn't do the job of Chief Medical Officer. Now, what we're looking at, the coroner and I, throughout the whole of the UK, we are looking at the methodology of trying to report untoward deaths and I don't know if you know we had a review of the coroner's system following Harold Shipman, where we are looking at trying to establish maybe exactly we think of medical examiners who sit with the coroner and look at those deaths. But we (unclear) that would be a huge resource to put in place.

DMcD
(Unclear) Altnagelvin – Raychel Ferguson (?)

CMO
As far as I can understand, the difference there is that went Raychel died, she was referred to the Royal and the doctors in the Royal said to Altnagelvin there is a problem here, it does need to be sorted out, it is a regional issue so Altnagelvin immediately referred it to (unclear.)
Lucy was also referred to the Royal. I don't think there was that same sort of oh my goodness, there's something here that for the region we need to sort out. I don't think that sort of realisation was there and it would be interesting to look at why that was or wasn't.

DMcD
(Unclear)

CMO

Well I don't know, I don't know. It would be interesting to go back to the Royal – it was a long time ago

DMcD
If there is a pattern (unclear) 2001, a year after Raychel was referred to the Royal, why do you think it took them until 2003 before Raychel's case was referred to the coroner(unclear)

CMO
Lucy's case was not referred to the coroner, and that's all I know, you know. I haven't gone into any of the detail of that as to why or what took place but certainly Raychel's death was referred to the coroner.

DMcD
It's just that if there was a pattern here of two deaths(unclear)

CMO
Now the pattern emerged with Raychel and that was referred, not the pattern, Raychel's death was referred to me immediately and we began to take steps and then Lucy's death was referred to me by the coroner to say there's another case which I uncovered and the (unclear) makes it really important that guidelines properly in place implemented (unclear)

DMcD
So the guidelines (unclear)

CMO
That was the first spark of danger lets see if we need guidelines in place – you know

DMcD
But not in Lucy's death?

CMO

Not in Lucy's death

DMcD
Could you maybe just clarify another thing for me (unclear) when you say in some instances (unclear) may put some children at risk – could you clarify for me (unclear)

CMO
Nobody really knows Denzil, I mean this is, I don't know if you are keeping up to date with the debate that is raging in the paediatric world.

DMcD
Unclear

CMO
I don't know because I'm not an expert, I have to know a little bit about everything but there is still a debate about proper fluid replacement and there is still a search to find how people could recognise early those children that might be at risk of responding in this dangerous way, developing hyponatraemia, which may go on to be better than

DMcD
Sorry, could I just cut across you there (Unclear)

CMO
If you read all of the literature on it (unclear) I don't know him personally but have read all that he has said and have been reading avidly.

DMcD
Unclear

CMO
Well look at the data, what we know from the death of and the biggest study of response to fluid replacement is, Miriam can help cite it for me, was a study

in district general hospitals. And this was some time ago, when the fluids that we're talking about, that Lucy got, were in general use and, I'm trying to write down the figures, one in 300 of children who were getting those fluids, would develop hyponatraemia, one in 300. And 10% of those would go on to have a fatal reaction. Now that data was gathered across many district general hospitals and the issue for Erne is that I don't know (I could check) how many children are referred to them each year, it may not be as many as 300, but you'd expect ...

DMcD

This is a really crucial point for me, in that one of he things you said to Fergal and I understand what you're saying (unclear) about the interview (unclear) in these two events was (unclear) reaction (unclear) to Lucy (unclear) some children, and it's crucial to know, because Dr Sumner's report no room for doubt, there is nothing, and there was nothing (unclear). Do you accept that?

CMO

Yes, I was basing that statement on what we had (unclear) in a large study of children (Unclear) about the incidence of hyponatraemia (unclear) being one in 300 will go on to die. And saying that in using those fluids, that has been the waste, it's a very small waste, but any death of a child is one that e should make every effort to ensure that it doesn't happen. So it may be a rare event that we get hyponatraemia, but you cannot allow even one death, so we therefore need to change what we o in NI and that's why we went on to produce the guidelines. The fluids that had been used...

DMcD

Sorry I keep coming back to the (unclear) Dr Sumner's said it wasn't (unclear) he was very clear that it wasn't (unclear). The family have been through hell anyway, especially in the way that (unclear) it was something in Lucy's make-up that may have led to her death (unclear) it was the fluid, it as the management of fluid. Are you sticking to your position that there may have been something idiosyncratic about Lucy that led to her death?

CMO
The point that I was trying to make (unclear) is that hyponatraemia is reported as being a very rare incidence, that would be one in every 3000 children receiving those fluids were hyponatraemia has been reported as being fatal. In NI context, that is very rare and the problem for us is that there has been nothing in medical literature that would say who that one in 3000 would be and that was the point I was trying to make.

DMcD
The other point I would like to make is, in your article you referred to the fluid, you don't refer anywhere to the management of the fluid. Is this something (unclear) that you would have been happy about, the management of the fluid?

CMO
What we've done in our guidelines is to say that you have to be careful and you have to monitor the fluid levels and electrolyte (?) levels in the patient, in which the fluid is being (unclear). I think it's clear in what I'm reading in the coroner's report, I haven't got access to medical notes, but anybody reading those reports would say and agree with the coroner that the management of the fluids could have been much much better and that it was inadequate

DMcD
That's an understatement

CMO
It was disastrous for Lucy, there's no doubt of that but what it did mean is that we are adamant in our correspondence with the health service that we have to be extremely careful to monitor carefully, annotate and carefully register what's happening with (unclear)

DMcD

Can I come back to the point (unclear) you speak about the fluid but you haven't addressed the management of that fluid (unclear). Do you back that the Sperrin Lakeland Trust did (unclear)

CMO
What I back and absolutely without any exception is the coroner's report in what he said that

DMcD
You have not addressed the management of the fluid in this (unclear)

CMO
No I haven't (unclear) As I said, I haven't got the medical notes, the coroner has referred them to the GMC, the case to the GMC ,and all I have to go on is the coroner's report which was sent to me and I agree with his conclusion, absolutely, and let there be no mistake about that, you know, now it's not my job to go and investigate what happened.

DMcD
That's the difficulty that I have and what I referred to in my original article in the Irish News, on the one hand you say that you back the coroner one hundred per cent but you then talk about an idiosyncratic reaction, the possibility of it (unclear) you can't really talk about the management of the fluid and the coroner really says that there were fundamental errors in the management of the fluid. Where do you stand on this (unclear)

CMO
I am in absolute agreement with the coroner, I absolutely agree with what the coroner has done, which has been to refer back to the GMC for proper conclusion on the medical care, that's the job of the GMC. The coroner recognised it as not his job, I recognise it as not my job to do that, that does need to be done by the proper body, the GMC, and I will have to wait on what those conclusions are and that's a proper place for the coroner to refer back

to so that's where the proper interrogation of that lies and it doesn't lie with me, nor would I ever want to cut across what is properly the role of the GMC in doing that.

DMcD
The sooner we're absolutely certain (unclear) possibility of idiosyncratic reaction in Lucy's case and you're not commenting on the fluid management

CMO
Now don't misquote me and try not to get yourself confused. What I'm saying about hyponatraemia in general because I have to talk in general and not about Lucy, because my job to the public health and it is other people's job to interrogate Lucy's death as the coroner has done, and the GMC will do that. What I'm saying is that we now have in the past four years, two children who died of hyponatraemia, now it's written up and recorded in the medical journals that death from hyponatraemia is a rare occurrence One in 3,000 post operative children in a number of (unclear) develop it but we don't want one to happen again in Northern Ireland, they are rare. Idiosyncratic is the wrong word to use because it infers, as you said, that maybe it was because of some genetic makeup of Lucy's. We don't know that yet. We don't know what makes certain youngsters at risk. Ten children given the same fluid, same volumes, children (unclear) and one of them to develop hyponatraemia. What makes them do that? I don't know that yet. Now it may be that someone knows who that might be and together with the other international experts that I have called together to look at this then we can help to reduce the risk even further. That's proper risk management done across a population in Northern Ireland. Now, I mean you are interrogating Lucy's death and that's (unclear) your right to do that but my job is to say are there issues here that the whole of the childhood population in Northern Ireland that we need to be aware of? How can we prevent the next death from hyponatraemia at any cost where the wrong fluid, right fluid, not enough fluid, too much fluid or even fluids given orally, because we know that they can cause hyponatraemia. That's my job Denzil, now I know you're anxious to find answers and in a way we need to make sure who the right people are to

give you those answers and the Minister is going to meet with you and she'll answer the questions which are properly for her. But I'm to trying to prevaricate, I'm just trying to tell you what I feel in my heart has needed to be done coming out of those two deaths.

DMcD
I think the difficulty is though we have to learn lessons from (unclear) cases as well and I think because we don't know the full circumstances (unclear) Lucy's death, how can we possibly learn all the lessons? Again I don't want to put words in your mouth but I just want to clarify something. It is possible then if you have ten children (unclear)

CMO
I was setting a hypothetical case of ten children, it might be 300 children, in a DGH, what happens in a district general hospital, the same fluid is given over the past thirty years have been a hypotonic solution that Lucy and Raychel got. Now from the evidence the evidence that we have here, and you have to look at the population sizes to begin to infer therefore what is that meaning for our population because the one case tells you something but there is a danger in generalising all this from the one case. What I'm saying is that in a district general hospital with those same practices that we have, using the same fluid, it would appear looking at large numbers of patients that out of 300 children, one of them will go on to get hyponatraemia and we want to know why that is but more importantly, we want to put measures in place to prevent that happening.

DMcD
The fluid that you refer to (unclear) clear about it being in use for 30 years condition of hyponatraemia not widely recognised by health professionals across the UK at the time of Lucy's death but in fact it has been written about widely for a number of years.

CMO

It started to be written up in the journals going back many years, quoting one or two cases here and there, and because the evidence of the experts is what's important here, you do need to refer to what is recently written, which gathers together all of the evidence over the years and begins to put that in place and unravel a picture. Now the most recent and probably the most comprehensive essay on hyponatraemia was about 2/3 weeks ago in the archives, and I don't know if you have seen that one yet but that's the one that you could turn to which gives you a full expression of the debate around hyponatraemia. I'm not an expert you know, I have to know a little bit about everything but if you want to know more, and updates what was said by Dr Evans in a recent inquest, it is an up-to-date debate around hyponatraemia and you need a copy of that we can get it to you.

DMcD
So this supersedes (unclear)

CMO
It expands on the debate and says there is no black and white and we need more research. What it does is it sets out the case on one side and the case on the other and again I would say the conclusions are what we have put in our guidelines which are really about being careful, being watchful and monitoring what's happening to each child and if you don't know what you're doing or what's going wrong, call in the experts. Now as you are probably aware, the guidelines that we have put in place are ahead of many places in the UK and indeed have been commended by them but we will continue to updated those in the light of the new debate and in the light of what a number of international experts will be telling us in the next few weeks as we continue to review the guidelines.

DMcD
And do those experts include (unclear)

CMO

Well I would regard Dr (unclear) as very much an expert in paediatric intensive care and rightfully (unclear)

DMcD
Unclear

CMO
No, no. but I intend to because I think he will provide quite a valuable judgement on what our guidelines are and how we might begin to apply them (unclear).

DMcD
Well why do you think after three years (unclear). Three years on from Raychel Ferguson's death (unclear)

TAPE ENDS

Dr McCarthy
...(unclear). You would need to actually contact and speak Dr Sumner. Unfortunately you won't have the opportunity to meet him but I had a conversation with him and several correspondences by email so (unclear) very valuable (unclear) in doing so. Combined with our own paediatricians and intensive care specialists locally, I think they all contributed very valuably.

CMO
And is it right that you would have, Miriam spearheaded the work around the guidelines

Dr McC
I spoke to (unclear) about what he would like to see (unclear) His input among many others (unclear)

CMO

So the response Denzil, to make it mine, is I don't know Ted Sumner, I intend to meet him very soon and have never spoken to him but thankfully Dr McCarthy (unclear) did involve him (unclear)

DrMcC
Unclear

DMcD
I suppose overall, when you said previously, in a previous interview that my job as chief medical officer is to look at the issues of the population of Northern Ireland to make sure that we learn from untoward events.

CMO
Yes

DMcD
Well there don't seem to be too many lessons learned from Lucy's untoward event

CMO
We have produced guidelines Denzil which are commended by Ted Sumner

DMcD
Unclear

CMO
But they are (unclear) we now know, aren't they?

DMcD
(unclear) issues of fluid management haven't been addressed.

CMO
Well, we'll give you a copy of the guidelines, I don't know if you've ever seen them. So have a look at that and it is quite clear about insuring close

management of fluid replacement, so it is relevant to Lucy's death. It is also relevant to the death in the UK, some months ago, in a major paediatric unit, headed by a very highly esteemed international expert. A death the same as Lucy's and the one or two deaths that do happen each year which are hyponatraemia throughout the UK. It is relevant to all of those deaths. It is relevant, those guidelines, and I've said that, had they been in place in early 2000 (unclear) Raychel Ferguson's death (unclear) both very emotional and very emotive stories and I do mix up the two, but had those guidelines been in place, then it might have been that Lucy and Raychel might not have died.

DMcD
But the real point that I'm making though is to learn lessons from and untoward death, then that untoward death has to be properly investigated and this hasn't been properly investigated (unclear) didn't even inform you about it.

CMO
I don't know if you're aware of all the work that has gone on in the last 2/3 years throughout the UK (unclear) out of Shipman, out of the...

DMcD
Sorry, specifically, to learn from an untoward death, it has to be investigated properly. Do you feel (unclear)

CMO
Okay I expect that to be looked at by the GMC because they are responsible not only for investigating how Lucy died and what went wrong, but also, the papers were reported to them about how it was investigated by the processes that the Trust put in place. The GMC, I expect to tell us, or inform us, whether or not the medical examination of Lucy's death, whether or not that was appropriate and up to standard.

DMcD

But quite apart from the medical aspect, the investigation (unclear) should have been done properly (unclear)

CMO
I can't answer that because for me to answer

DMcD
But it is crucial for you to learn from untoward events, you have to be able to say to a health trust, was that investigated properly and four years on we haven't had any answers

CMO
And what I'm saying is that there has been no proper formalised process in place to date for the investigation of untoward deaths. We now recognise that, throughout the UK, not just me but throughout the UK, we know that we have to begin to have a process in place which will allow us early warning on issues such as this. There are bits and pieces...

DMcD
So there is no investigation procedure (unclear)

CMO
Each Trust would be responsible for the investigation and

DMcD
So there's no formal procedure so they wouldn't have to report it to you which I find quite strange but if there's no procedure fine (unclear)

CMO
Well each death will have a different method of investigation and interrogation, that's a question that I have not looked at because it is not my job to look at

DMcD

Sorry, I keep coming back to this, if you're going to learn from an untoward death, which is an issue for the whole population of Northern Ireland and not just the Crawford family, there must be a proper investigation (unclear) in the Sperrin Lakeland Trust it doesn't seem that there was (unclear)

CMO
Well it's quite clear that there was no process for the reporting Lucy's death to me, nor indeed the outcome of any investigation. Now, whether or not the CMO is the right person to refer that to, but even throughout the Uk in England, Scotland or Wales, we have not yet proper processes in place for doing it, we are striving to do that and I think we have learnt the lesson from Lucy's death, that if such a process were in place, and could properly be put in place, then we could hopefully take early action that would prevent deaths.

Colm Shannon
Maybe just one last (unclear)

DMcD
In my opinion, Lucy's death wasn't investigated properly at all. Would you support what I have already called in the newspaper where I have called for a further intensive inquiry because I think it's the only thing that would restore confidence in the health service in Fermanagh. Would you support that claim?

CMO
Denzil I actually prefer to wait until the GMC looks at it because I feel that they are the proper people to tell us whether or not there was medical negligence or irresponsibility. Now I know that you have a right to take your view on that now on what you've seen, but I will actually want to hear what the GMC say because I think that they are properly

DMcD
Will they look at the investigation procedure?

CMO
Well, within the whole context of what was done about medical care that will arise

DMcD
So the GMC are going to look at the investigation process?

CMO
The coroner and I think I'm right in saying this, the coroner has referred all his papers and conclusions to the GMC so it is comprehensive

DMcD
(unclear)look at the investigation

CMO
Well the issue around how it was established and within the medical network with the Western Board, that clinical network which is Altnagelvin and Erne, those papers have all gone to the GMC and will be looked at

DMcD
And have you written to the Crawford family?

CMO
I have written to the Crawford family

DMcD
Do you know that they were very unhappy about the tone of your letter?

CMO
Well I knew that almost anything I would have wrote would have

DMcD
You could have had a meeting, you could have said, I would like to meet you.

CMO
I have offered a meeting. (Unclear) can I read you the letter and tell me if I wrote

DMcD
Would you like to meet the family?

CMO
I would love to meet with the family and I'll tell you why, because having been forced through the media to talk about Lucy, I feel that I would want to meet them because there can be nothing worse than hearing this middle aged woman rabbiting on and I really feel that they have been hard done by.

DMcD
The main thing about the letter was that the tone of the letter didn't indicate any desire by you to meet them, you said that you would be prepared to meet them if they thought (unclear)

CMO
I would be very happy to meet them. Now please be fair with me here Denzil.

DMcD
Unclear

CMO
I would be happy to meet them and I mean happy, happy please Denzil be fair to me. I know that nothing I say would in any way help the family now but I'm asking you as an individual does that not imply to you

DMcD
Are you asking for my personal opinion?

CMO
No, no I'm not

DMcD
Unclear

CMO
Of course it could, everything that everybody wants could be written better

DMcD
(Unclear) doesn't indicate that you have any desire to meet them

CMO
Oh Denzil,

DMcD
It indicates that, if you want a meeting, I will meet you

CMO
And do you know why I said that? I mean, a letter from me, I'm going to come down and meet you. How awful would that have been? They have to feel that they would want to meet me, otherwise, what could be worth

Kevin Mulhern
I think the fact that the CMO offered the meeting indicates that the CMO was happy to meet with them and (unclear) Crawford family at a very difficult time the opportunity to either accept or not accept the meeting. But I think by the CMO writing to them and offering them that meeting shows that there was willingness from the CMO to meet with them.

CMO
Now you have to be fair to me Denzil and not drive this as a further wedge. I'll tell you I actually in my life I try to be honest (unclear) and caring, and to have this misrepresented and to have what I have said picked over, the bones of it, I can't cope with that.

DMcD
The letter as far as I'm concerned wasn't an issue, I'm just telling you what the family's perception was

CMO
And you said it in the Irish News, you know

DMcD
It wasn't in the Irish News

Colm Shannon
Unclear

DMcD
I didn't refer to the letter in the Irish News. In fact, my references to this in the Irish News were minimal

CMO
I know, yes

Colm Shannon
Unclear

DMcD
In the context of what we're talking about today, that isn't an issue for me. I do have to be perfectly frank with you, I do have one or two concerns about some of the things that you've said that hasn't clarified

CMO
Well you put them in the paper and I'll try and respond

DMcD
(unclear) over a few of the points

CMO
Well what it would allow me to do is to go back through the literature because obviously what you want is to get to the root of what the physiological medical issues are around fluid replacement and hyponatraemia. Denzil, I have to admit that I am not an expert in this and don't try to set me up as someone who is trying to be, because I'm not. So on all of these issues, when an absolute imperative exists around the detail and the expert view, you can't come to me to have it in here in my head. What I can do is get you the references or refer you to the experts who can do that. You can't ask of me what I'm not. I'm a public health doctor, I'm not a paediatric (unclear). That's why picking over the bones of what I say divert the issue about how we properly ensure that fluid replacement is as it should be, because when I want that to happen, I go to the experts.

DMcD
Well certainly the main criticism in that area would be towards the Sperrin Lakeland Trust (unclear) and the point that I would make would be for you to be able to do your job properly, advising the population of Northern Ireland, did the Sperrin Lakeland Trust fail you in that because they didn't inform you to begin with and I don't think you've said anything today that would make me believe that they've been in contact with you (unclear). So how can you learn lessons from a death that hasn't been properly investigated, or hasn't been investigated at all?

CMO
Well the Minister will, in her interview with you, tell you what procedures are being put in place throughout the UK and particularly the procedures that are being put in place here in Northern Ireland to make sure that issues such as Lucy's death might be dealt with in earlier stages. I fully admit, and have done, that four years ago, they were imperfect and not at all comprehensive and what we need is a system, which allows proper reporting which can be systematically then analysed and teased out so that important issues emerge. I have to admit that over the past four years, attention has been focused on stopping 3000 people dying each year because they smoke. Thousands

more die early because they're not getting access to a proper diet and many more die because of all the big lifestyle issues that are of concern. So for me in terms of priorities, it's saving the 3000 who die from smoking, which always has to be top of the list. Somebody has to look after that but we do also need a way of picking out the one or two deaths which actually are important and which mean that you can put proper systems in place. But those are two separate issues, one focusing on the individual, the other focusing on population and public health of thousands, and that is my job. Now, that's not to say that the other job is a lesser one but we do need to get that right.

DMcD
There are two elements for me, one is the reporting (unclear) you need the untoward death to be reported to you to take action, but also, you need information about that untoward death, which a proper investigation would uncover. There was no proper investigation in this case.

CMO
And I would fully expect that guidelines on how to properly investigate untoward events would be part and parcel of what is being done throughout the UK to make this better. All of it coming out of Shipman that all of those things are trying (unclear) are also relevant to Lucy's death and Raychel's death.

DMcD
It would appear that you're suggesting that you're not happy with the Sperrin Lakeland Trust investigation in this case.

CMO
No, what I'm saying that we have not had guidelines, proper guidelines which are up-to-date, which are in place for the proper investigation of untoward incidents and deaths and that is work that will need to be taken forward. Our role as a Department is development of strategy and policy, and a strategy and policy on proper investigation is what we need to do. Denzil, if there is anything that I've been (unclear) about or that you feel I haven't answered

properly, I want to do that and will you let me know rather than go to press and say she wouldn't do this or she wouldn't do that. I'm anxious, I promise you,

DMcD
Unclear

CMO
If I feel that I can give you the answers that you need (unclear) because that's only proper. There are other people who have a different role and you need to go to them. Minister has an entirely separate and very important role (unclear)

Colm Shannon
Unclear

CMO
Now I can promise you that I would welcome that so I don't want you going out there and saying she wouldn't answer or she tried to be dishonest or evasive, because it's not what I'm about. So anything that you feel I've been unhelpful with, write to me, and if I have the knowledge or if I can get the knowledge, I'll answer, but I'm not the expert.

TAPE ENDS