McCarthy, Miriam

From: McCarthy, Miriam
Sent: 11 August 2004 11:53
To: Carson, Ian
Subject: RE: Ferguson &Crawford -UTV Insight

Ian,

Re answer to Q2, I agree with Colm that this may need to be strengthened. In ensuring accuracy, am I right in saying that prior to May/june 2002 you did not chair the Med Directors meeting in your capacity as DCMO but on a more informal basis as RVH med director and professional advisor to CMO. Is there a point at which we can say the first formal CMO/ Med Directors meeting took place (possibly December 2001)?

Also re Q1, as far as I can recall, Raychel was transferred to and died at the RBHSC, therefore stating that Dr Nesbitt called the Royal to advise of the death may generate yet more questions from Trevor

Miriam

-----Original Message-----
From: Shannon, Colm
Sent: 11 August 2004 10:32
To: Campbell, Dr Henrietta
Cc: Gowdy, Clive; Carson, Ian; McCarthy, Miriam
Subject: Ferguson &Crawford -UTV Insight

Back in June(15th) Altnagelvin issued a statement to UTV setting out the sequence of events following Rachel Ferguson's death in June 2001. (Copy attached)
<< File: Raychel - Insight 3 - June 15th Statement.doc >>

On 16th June Trevor Birney came back to Altnagelvin with further questions. Altnagelvin didn't immediately respond but are expecting UTV to come back to them in the next few weeks. Attached is their suggested response to the additional questions, which will only be issued if they receive a further request from UTV.

Can you let me know whether you are content with their response. I think the answer to Q.2 needs to be strengthened. My understanding of the discussion with the Deputy CMO was that this was not part of the formal discussion during the meeting and was raised in a general discussion after the meeting had concluded. It would also be important to double check all the dates they refer to. The Trust has also copied their suggested response to Hugh Mills for his comments
<< File: Raychel - additional questions - June 04 2nd statement.doc >>
On a general point, during Trevor's telephone conversation with Altnagelvin he stated that "Altnagelvin seems to have acted properly and decisively." Why, he asked did they do this? What prompted Altnagelvin to do this when other hospitals in similiar circumstances did not? It is, he said "very important for the public to understand why Altnagelvin did what they did and other hospitals didn't." It is clear that he will attempt to use this to criticise Sperrin Lakeland and perhaps the Royal, as well as the Department for not having clear guidelines in place. I have organised a meeting of the PR's from each of the relevant Trusts to ensure that we adopt a common approach should UTV return to this subject.

Colm

Questions about the breadth of the GMC's investigation

- I understand that the GMC will limit its investigation to aspects of the clinical care that Lucy received. The Trust have already investigated Lucy's death through their internal case review. I can now confirm that there will also be a root cause analysis conducted. This will look specifically at the Trust's process and systems and will take between 4 and 6 months to complete.

Questions about the Royal failing to realise the implications of Lucy's death

- I of course am not a clinician and have not seen any clinical notes relating to this case. What I know is that Lucy was in the Royal for only a short time before she died. Senior staff at the Children's Hospital recognised that her death was unexplained and reported it to the coroner. The full investigation to try to identify the factors that led to Lucy's death was conducted, quite appropriately by Sperrin Lakeland Trust to which Lucy had been admitted.