INTERVIEW WITH HENRIETTA CAMPBELL - ISSUE PROGRAMME

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You have ultimate responsibility for learning the lessons from untoward events in hospitals, that's a damming indictment. What happened to Lucy?

Well first Fergal, I need the opportunity to say how deeply tragic these incidents have been and myself and everyone else in the Health Service deeply regrets the death of any child, but for these two beautiful children to have died, lessons have been learned, lessons continue to be learned, but sympathy for the family has to be the utmost.

It does, but what happened to Lucy?

With Lucy we saw the first case of what was a very rare occurrence written up in the medical journals only recently and the outcome of Lucy's death the lessons were not leant early enough to prevent a second death.

But you are not recognizing the coroners results in that statement, because the coroner said that Lucy Crawford died as a result of mal-administration of fluids, it was the wrong fluid and it was too much.

At that time, in the year 2000, the fluids being used in every pediatric unit in Northern Ireland and in most pediatric units throughout the UK were the fluids that were being given to Lucy, what we now know is that from a few cases written up in the medical journals in some children. Very few children, but in ....

I am sorry, that's ignoring that the coroner said, the coroner said that the Doctor dealt the wrong liquid at the wrung dose, it is has nothing to doe with how the victim responded to it, that's what happened, isn't it, that's what happened to Lucy...

In retrospect yes, what was being used at that time was in common practice throughout the UK and wider afield.

You are now accepting fully what the coroner said, when did you learn that this untoward event had happened?

We learnt about this untoward event, Lucy's death, when Rachel died and the coroner saw that he had two cases being presented to him which looked similar in terms of the tragic outcome, please let me finish..... So the coroner noticing a pattern reported those two cases to me.

So without the death of Rachel Ferguson, you wouldn't have known about the death of Lucy Crawford, an untoward event, that you should have known about and you wouldn't have known about it but for the death of Rachel Ferguson.

We had no system within the Health Service at that time for the reporting of all deaths of children.

So there is no system for telling you how Lakeland Trust administered fluids to a child that led to that child's death and you don't know about it, who's fault is that, are you accountable for that, are you accountable or are the Sperrin Trust accountable?

Within the Health Service it is recognized that until quite latterly there has been no system throughout the UK, please I need to finish this important point .... Throughout the UK there has been no system of gathering together evidence from

untoward incidents which are very rare but which together across the UK begin to show a pattern and begin to show that systems need to change.

The rarity in this was the administration of the dose and not the victim, why didn't you learn, you are the Chief Medical Officer, ultimately responsible for learning the lessons from this day and you are telling me here tonight that you didn't know about an untoward even because the system failed, is that good enough?

The rarity in this event and you do have to return to the medicine the physiology behind these two events, now you must let me finish, there is no point me coming here and just being shouted at, the public have a right to know what the issues are... The rarity in these two events was the abnormal reaction which is seen in very few children to the normal application of fluids.

I am sorry, because you seem to be ignoring and you are going back on what you accepted a moment ago, do you accept fully the coroners findings .... The coroner said that it was the wrong dose and too much, now you are back tracking on that, do you accepted the coroners findings?

In the knowledge of the evidence which has been in medical journals over the past 4 years since Lucy's death, yes that is true, but in the light of what was known in the medical community throughout the whole of the UK in the year 2000 when poor Lucy died there were very few people who would have known what was going wrong apart from one or two experts who had begin to notice this very abnormal reaction in certain children.

And of course when the Trust when to investigate it, you would have thought that they might have identified wouldn't you the rarity that you described, but instead they produced a review which didn't point the finger at mal-administration which effectively and technically covered up this death, because you would never have found out about it because you have ultimate responsibility and you still didn't learn until Rachel Ferguson died.

From the papers which the coroner has sent to me and I am beginning to read and which the coroner has been sharing with me we have been discussing these issues, the coroner and I together both recognize that these two tragic deaths brought together as a pattern, then allowed us to put tow and two together and to recognize that there were some strange but rather unique feature which needed to be taken attention of.

But the Sperrin and Lakeland Trust didn't conclude that, the Sperrin and Lakeland Trust didn't tell you, the Sperrin and Lakeland Trust in Lucy Crawford's case kept it to itself and you didn't know, now should somebody in the Health Service in Fermanagh have responsibility for that, should Hugh Mills consider his position in relation to that?

Going back to the year 2000 it would not have been unusual for a doctor or a group of experts not to have recognized that happened to Lucy, it is easier to do that in the knowledge of what has been presented to us through the medical journals in the last 4 years.

But you are ignoring what I have pointed out to you, that you wouldn't have known and the Trust were certainly not telling you anything about Lucy Crawford's death and yet you have now recognized it as an untoward event, an event that the population in Northern Ireland have learnt lessons from and you haven't been able to learn those lessons and didn't learn them in the last 3-4 years.

Oh, I absolutely agree that if we had had in place a system for the reporting of all deaths to some central source, untoward deaths that we could have begin to learn lessons earlier, but these go back to a point that I made earlier, the systems were not in place throughout the Health Service, they do need to be in place UK wide to pick up the very rare issues, but that is being addressed, the national patient safety agency is now in place for early indications and untoward incidences such as this.

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